Sandwell and West Birmingham Hospitals NHS Trust

RXK

Community health inpatient services

Quality Report

Tel: 0121 507 6300
Website: www.swbh.nhs.uk

Date of inspection visit: 16 February, 28, 29 and 30 March and 10 April 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXK10	Rowley Regis Hospital		

This report describes our judgement of the quality of care provided within this core service by Sandwell and West Birmingham NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sandwell and West Birmingham NHS Trust and these are brought together to inform our overall judgement of Sandwell and West Birmingham NHS Trust

Summary of findings

Ratings

Overall rating for the service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Overall rating for this core service

We rated the service inadequate because:

- Medicine management was a concern at Rowley Regis, with 28 medication related incidents in 2016. Staff reported an incident related to medication on 21 days between 1 January and 16 February 2017.
- Staff did not undertaken mental capacity assessments in accordance with the requirements of the Mental capacity Act 2005. We found patients whose liberty had been deprived without staff following the requirements of Deprivation of Liberty Safeguards 2010.
- The service used a high level of agency staff due to a lack of substantive staff, and ward managers did not have oversight of the competencies of the agency staff working at Rowley Regis Hospital.
- We found three of the four care plans reviewed did not contain the most recent best practice, national guidance or evidence base. This could result in staff delivering care that was not in line with current guidance.
- The identification and assessment of risk was inconsistent across the service. We found one example of staffing changes and another relating to the availability of emergency equipment that had not been risk assessed.
- Local risk registers lacked detail and we were not assured on the review of risks, both locally at ward level and across the wider group.
- We found a lack of public engagement, with senior ward nurses stating that patient focus groups used to happen however, these stopped in 2016.
- Staff did not consistently promote patients privacy and dignity during nursing handovers as these took place at the reception desk in view of other staff, visitors and patients. We found handover sheets and test request forms containing patient identifiable information left unattended on reception desks on Henderson ward, Eliza Tinsley ward and McCarthy ward.
- Staff demonstrated a mixed approach to the requirements of the Equality Act 2010. Staff did not consistently utilise alternative communication methods and had mixed knowledge of how to access religious leaders from faiths other than Christianity. Medical staff asked had a blanket approach to reviewing patient care based on their age. Nursing staff had a mixed understanding of how to support patients that were transgender, non-binary gender or had a sexual orientation other than heterosexual.

However:

- We found nursing and therapy documentation to be detailed, accurate and timely. However, we did find nursing staff using "N" during night shifts instead of documenting a specific time and date.
- Staff complied with relevant infection prevention and control requirements and we found good standard of cleanliness throughout the hospital.
- We found good multidisciplinary working and discharge planning on all three wards visited.
- Staff delivered care in a kind and compassionate way. Staff involved patients and those close to them in decisions about care and discharge planning.
- Senior staff planned services to take account of the needs of the local population.
- The service received a low number of complaints, six in total, in 2016. Group clinical governance meetings discuss all complaints.
- Local leaders were visible within clinical areas, and we saw regular engagement with staff, patient and visitors throughout the inspection.

Summary of findings

Background to the service

The trust delivered its community inpatient service from three geographical locations, Rowley Regis Hospital, Leasowes Hospital and Birmingham City Hospital. During this inspection, we visited Rowley Regis Hospital.

Rowley Regis hospital consisted of three wards, Henderson, Eliza Tinsley and McCarthy. Henderson ward accepted patients requiring up to four weeks of rehabilitation, for example following a join replacement. Eliza Tinsley and McCarthy were 'ready for discharge' wards. They accepted patients that were ready for discharge, however were waiting on additional services or support (for example a care package or availability of care placement) to be put in place. All patients admitted to Rowley Regis hospital had to be medically fit and have an agreed discharge pathway.

The three wards each had 24 beds, including four side rooms for patient requiring additional privacy or those with an infection. Each ward had one side room with en suite facilities.

All three wards at Rowley Regis hospital were nurse led, with GPs providing face-to-face advice once a day, Monday to Friday. Nursing staff sought additional medical advice out of hours from NHS 111 or, in an emergency, via an emergency ambulance and 999.

Referrals into the service were made through a 'trusted referrer system' and could be made by nursing, medical or therapy staff (such as physiotherapists or occupational therapists).

During the inspection, we visited Henderson, Eliza Tinsley and McCarthy wards. We spoke with 17 staff, including all three ward managers, therapists, GPs and the service leads. We spoke with seven patients and two relatives across all three wards. We reviewed 28 patient records, 18 medication charts, staff rotas, policies, procedures and meeting minutes.

Our inspection team

Our inspection team was led by:

Team Leader: Tim Cooper, Care Quality Commission

The community health inpatient team included one CQC inspector and one specialist nurse.

Why we carried out this inspection

We inspected this core service as part of the trusts focused inspection of community inpatient services.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 28, 29 and 30 March 2017. We observed how people were being cared for and met with people who used the services and their careers, who shared their views and experiences of the core service. We also reviewed patients care records.

We carried out two unannounced visits on 16 February and 10 April 2017. Prior to the announced inspection, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?

Inadequate

Are services safe?

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider MUST:

- Review the process for assessing and documenting assessments in accordance with the Mental Capacity Act 2005.
- Ensure patients are not deprived of their liberty for the purpose of receiving care or treatment without lawful authority, in line with Deprivation of Liberty Safeguards 2010.
- Ensure that all staff have regard for the protected characteristics under the Equality Act 2010, and support patients in a way that is respectful and promotes their dignity.
- The service must comply with the requirements of the Data Protection Act 1998, and ensure staff keep service user's personal data safe and secure at all times.
- Ensure risk assessments and safety reviews are considered and undertaken where changes to service provision is made.
- Ensure risk registers are accurate, contemporaneous, and reviewed and update routinely, as required.
- Ensure that all professionals document contemporaneous and acute information within patient's medical records.
- The service must ensure that staff work in accordance with medicine management policies, procedures and national best practice and legislation.

The provider SHOULD:

- Staff should review the use of magnetic information boards above patient bed spaces and ensure these accurately reflect the needs of the patients.
- Senior staff should ensure all staff feel supported within their roles, providing support, training and guidance as required.
- Wards should ensure that patients and their significant others have access to information on how to provide feedback, positive and negative, on the service and care provided.
- Senior staff should ensure signage within ward areas is consistent and supports the needs of patients and visitors.
- The service should review how and when it reviews delays to patient care, and what aspects of patient care are monitored.

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated safe as inadequate because:

- Medical documentation was brief and lacking detail and explanation.

Inadequate

Are services safe?

- Medicine management was a concern at Rowley Regis, with 28 medication related incidents in 2016. Staff reported 21 incidents related to medication between 1 January and 16 February 2017.
- We found clinical areas and surrounding corridors cluttered due to a lack of storage space for large equipment, such as wheelchairs, beds and mattresses.
- Wards had high agency usage during 2016, with an average of 37.8% of shifts filled by agency staff. McCarthy ward was reliant on between 64% and 86% agency use between April and December 2016, due to staff vacancies.
- We found concerns over the availability of resuscitation equipment across Rowley Regis hospital, and the standard procedure in the event of a cardiac arrest.
- Staff were unaware of the implementation of new sepsis protocols within the trust.

However:

- Staff understood how to report incidents and we saw evidence of learning from incidents.
- Safeguarding knowledge and understanding amongst staff was good.
- Staff managed controlled drugs safely and in accordance with legal and regulatory requirements.
- Cleanliness and infection control precautions were well embedded across the wards visited.
- Rowley Regis hospital scored 99% for cleanliness and 98% for the maintenance, condition and appearance of the hospital in the 2016 Patient-Led Assessment of the Care Environment (PLACE).

Safety performance

- The service monitored safety performance using the NHS safety thermometer; a nationally recognised way of reporting falls, urinary tract infections (UTI), harm free care and venous thromboembolisms (VTE) incidents. We reviewed data between January and December 2016.
- Rowley Regis hospital had seven falls with harm in 2016, with two on Eliza Tinsley, two on McCarthy and three on Henderson. The falls with harm on Henderson ward all occurred during December 2016.
- The hospital had ten new pressure ulcers during 2016, with four on Eliza Tinsley and six on Henderson ward. McCarthy ward recorded no new pressure ulcers in 2016.
- For catheter acquired UTIs, the hospital recorded seven in 2016, with four on Eliza Tinsley, one on McCarthy and two on Henderson ward.
- None of the three wards reported a new VTE during 2016. In 2016, an average of 90.4% of patients had harm free care. On average McCarthy ward achieved harm free care for 99% of patient, Eliza Tinsley 84% of patients and Henderson ward an average of 88% of patients had harm free care in 2016.
- Ward managers displayed monthly results on each ward and had a good understanding of the areas for improvement.
- Senior nursing staff had noted an increase in falls on Henderson ward. Following a root cause analysis (RCA) of each fall, staff now undertake bedside handovers to limit the amount of time patients are left unsupervised. The ward manager had implemented 'tag nursing', ensuring that throughout the day at least one member of staff was within each bay of patients at all times. Senior staff had shared this learning across all three wards and we saw this happening on Henderson and McCarthy.

Incident reporting, learning and improvement

- Incident reporting was good across the service. Staff demonstrated a good knowledge of how to report an incident and what should be reported.
- Rowley Regis Hospital reported 347 incidents, no serious incidents and no never events in 2016.
- Never events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Twenty-eight of the incidents reported in 2016 related to medication errors including prescription, dispensing and storage incidents. Between 1 January and 16 February 2017, the service reported 21 medication incidents, including missed doses and not having access to prescribed medication.
- We requested the action plan following the high levels of medication incidents across Rowley Regis Hospital. The trust told us the concerns regarding medication incidents in January and February 2017 were related to medication omissions across Henderson and Eliza Tinsley, and both wards had improvement plans. However, the trust did not collate this information and

were unable to provide assurance in this format when requested; therefore, we were unable to make a judgement on the quality or progression with the improvements.

- We found learning from incidents embedded across the hospital. Following all reported medication incidents, senior nursing staff held one to one discussions with the nursing staff involved and ensured staff reflected on the incidents. Ward managers had implemented red tabards for nursing staff to wear during medication rounds to reduce interruptions, as this was identified as a contributing factor to previous errors. However, senior staff had not monitored improvement plans to provide assurance that changes made had had a positive effect.

Duty of Candour

- Duty of candour was integrated into the electronic reporting system. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Where an incident triggered duty of candour, this would be flagged on the incident reporting system.
- The group director of nursing demonstrated a good underpinning knowledge of the duty of candour regulation and could describe how and when to trigger duty of candour. Ward staff also demonstrated a good understanding of duty of candour, with ward managers able to give examples of when it could be used.
- The group directors told us the service had not raised an incident requiring duty of candour between September 2016 and February 2017.

Safeguarding

- All staff asked understood their responsibilities in relation to safeguarding patients. Staff knew how to contact the safeguarding lead nurse and could name her. The trust had a safeguarding policy in place; however, the policy was due for review in August 2016.
- Staff of band six and below undertook safeguarding adults level one and those of band seven (ward manager) and above undertook safeguarding adults level two training, as part of their mandatory training every year.
- We were unable to clarify the number of staff that had completed the required levels of safeguarding training due to the breakdown of data sent by the trust. See the mandatory training section for more information on this.

Medicines

- Controlled drugs (CD) were stored securely and checked daily. Two registered nurses had completed the required daily checks during January, February and up until the inspection date in March 2017. We checked 10 controlled across Henderson, Eliza Tinsley and McCarthy ward, which included eight ward stock CDs and two patient own CDs. We found all medication was in date and matched the controlled drugs register on each ward.
- A ward manager explained the process for disposing of unwanted or out of date controlled drugs. A member of pharmacy would attend the ward with chemicals designed to destroy medication. A registered nurse and member of pharmacy staff would oversee the process and then record in the CD register once complete.
- We reviewed 18 medication charts, six on each ward, during the announced inspection. We found all medication prescribed appropriately, with clear legible writing, signed by a prescriber and reviewed by a pharmacist.
- A medicines management audit on McCarthy Ward showed that there had been 14 medicines management incidents in January 2017 and seven medication management incidents up to the date of the unannounced inspection in February 2017. The ward sister told us that the incidents mainly related to omitted doses. Changes had been made across all three wards within Rowley Regis to reduce the likelihood of these incidents reoccurring, including the introduction of 'do not disturb' tabards for nurses.
- During the announced inspection, staff wore red disposable tabards when undertaking medication rounds to reduce unnecessarily interruptions. This helped to prevent against potential errors occurring during the drug round. However, during the follow up unannounced, we found staff on McCarthy ward undertaking medication rounds without wearing the red tabards.
- We found medication rooms secured with keypad entry. However, during the follow up unannounced

inspection, we found the medication room door on Henderson ward propped open and with no staff present. We informed the nurse in charge who closed the medication room door; however, a member of staff propped the door open again. We raised our concerns with the ward manager who assured us that they would remind all staff that they should keep the door closed when not in use.

- A pharmacist visits each ward four times a week to give advice and review medication charts. We saw evidence of pharmacy review, with green ink, on all medication charts looked at. However, pharmacy visits had not increased and the pharmacy team had not been engaged in the review process following an increase in medication related incidents in January and February 2017.

Environment and equipment

- All clinical environments visited appeared well maintained throughout. We looked at multiple pieces of equipment during the inspection and found all to be within their required service dates. Rowley Regis scored 98% for the condition, appearance and maintenance of the environment in the latest Patient-Led Assessment of the Care Environment (PLACE), from 2016.
- Where required, all equipment, for example portable suction, were left plugged in and charging when not in use.
- We found consistent monitoring of medication fridge temperatures on each ward visited. We reviewed records for January, February, and up to the inspection date in March 2017 and found no abnormal temperature readings or other concerns. We found the medication room on Eliza Tinsley ward to be very warm during the inspection. The ward manager told us they would escalate to pharmacy on any occasions where the room felt excessively warm.
- We found flooring and location of hand washing facilities in line with the requirements of the Department of Health Building Note 00:09 and Building Note 00:10.
- Staff used appropriate waste disposal methods, for example placing used gloves and aprons in clinical waste bins and disposing of needles in sharps bins.
- However, storage of full waste bags was a concern as we found clinical and domestic waste storage rooms unlocked and accessible. During the follow up unannounced, we found the lock on the clinical waste storage room on the ground floor was faulty and we escalated this to senior staff who assured us they would report the fault. The trust confirmed this happened following the unannounced inspection; however, did not provide a copy of the incident form submitted as requested.
- Resuscitation trolleys were available on each ward. However, staff had access to one defibrillator between all three wards, which were split over two floors. Senior staff told us they were unaware of any risk assessment had been completed for this. Ward staff raised concerns over resuscitation equipment, stating that the entire resuscitation trolley would be taken to the first floor via the lift. Staff told us the lifts "regularly" breakdown and were concerned about being stuck in the lift with resuscitation equipment.
- The trust told us the current arrangements for resuscitation equipment were "proportionate" and no risk assessment or review had been undertaken.
- All three ward areas were cluttered due to limited space to store equipment and supplies. We found beds and mattresses stacked in corridors outside wards when patients had been moved onto specialist pressure relieving equipment. Staff used bathrooms to store other equipment such as moving and handling equipment.
- The wards had access to bariatric beds and we saw this in use on a patient during the inspection.

Quality of records

- We reviewed 28 patient records during the inspection, including medical, nursing and therapy entries.
- We found nursing and therapy documentation to be detailed, accurate and legible. We found completed risk assessments for patients including malnutrition universal screening tool (MUST), Waterlow scores and personalised care plans for patients with additional needs, for example specific dietary or feeding requirements.
- However, we found one record on McCarthy ward where nursing documentation did not match the observation chart. Within the same records, we found a medication chart that was not up to date and staff wrote N instead of the time in patient records during the night shifts.

- Medical documentation was lacking in detail in all 28 records looked at and often difficult to read. All records reviewed had limited medical documentation within them and with limited clear, contemporaneous medical plans.
- We found medical records stored in locked trolleys when not in use in the majority of cases, which is in line with the Data Protection Act 1998 on the storage and security of personal information. Staff locked or logged off computers when not in use to protect patient information.
- However, we did observe a member of staff on Henderson ward leaving a handover sheet at reception, which contained sensitive patient information. We raised our concerns to the nurse in charge who removed the handover sheet immediately and disposed of it in the confidential waste.
- We found blood and other samples on reception desks on all three wards with patient identifiable information showing. This meant staff, visitors and other patients could gain access to patient's personal and sensitive information, such as their address, date of birth and diagnosis. However, staff were regularly within sight of the reception desk, which reduced the risk. This included administration, nursing and medical staff.
- During the second unannounced inspection, we found multiple patient records on McCarthy ward on the reception desk. Staff told us this was due to the records requiring refiling following patient discharges. A member of staff was within sight of the records at all times, except on a couple of occasions of less than a minute when the administration staff opened the main ward door for visitors.
- Staff had access to confidential waste bins to dispose of confidential information, for example, handover sheets, at the end of shifts.

Cleanliness, infection control and hygiene

- We found levels of cleanliness to be consistently good across all three wards visited.
- Hand sanitising gel was available at the entrances of each ward and we observed staff using this on entering and leaving clinical areas. We observed staff reminding visitors to the ward to use hand gel before entering and leaving.
- Ward managers undertook hand hygiene audits each month. We reviewed audit data from April 2016 to March 2017 and found Henderson, Eliza Tinsley and McCarthy wards consistently scored over 92%, against the trust target of 95%. Henderson wards average monthly compliance was 97%, Eliza Tinsley ward 99% and McCarthy (between September 2016 and March 2017) was 98%. Staff undertook audits in line with the World Health Organisations "Five Moments of Hand Hygiene".
- Personal protective equipment (PPE), including gloves and aprons, were readily available and we observed staff using and disposing of PPE appropriately. We observed all staff (nursing, medical, therapy and support) complying with the principles of being 'arms bare below the elbows'. This helps prevent the spread of infections between patients. We observed medical staff removing ties or ensuring that they were tucked into shifts to reduce the risk of cross infection.
- All three wards (Henderson, Eliza Tinsley and McCarthy) reported no MRSA, MSSA or clostridium difficile infections between September 2016 and February 2017.
- Each ward had one side room with designated washing and toileting facilities. Should two or more patients require nursing in isolation, senior nursing staff told us patients would be offered a commode for toileting and bowls for washing.
- Wards used cleaning wipes to clean equipment (for example commodes, medical equipment and bed spaces) between patient uses, and we observed this during the inspection.
- Ward managers undertook monthly ward cleanliness (target 95%) and uniform (target 100%) audits. Between April 2016 and March 2017, Eliza Tinsley ward achieved an average of 97% for ward cleanliness and 96% on average for uniform. Henderson ward scored on average 95% for ward cleanliness and 98% for uniform between April 2016 and February 2017. McCarthy ward, on average, scored 95% for ward cleanliness and 99% for uniform compliance between September 2016 and March 2017.
- Rowley Regis hospital scored 99.8% for cleanliness in the latest PLACE results from 2016.

Mandatory training

- Staff undertook mandatory training each year, which included basic life support, information governance and conflict resolution.
- We requested mandatory training data for each ward area, split into registered nurses, healthcare assistants

and other clinical staff, for example physiotherapists. However, the trust was unable to provide the data as requested and provided figures for "ancillary staff" (reablement team) and "other/mixed" (ward services staff). We requested clarification on this data; however, the trust was unable to provide any further clarity of distinction between the data.

- The trust told us the mandatory training year ran from October to September and all staff were required to be competent before 1 October 2017. However, ward managers monitored staff compliance with mandatory training on a monthly basis, covering the previous 12 months.
- Between April 2016 and March 2017, an average of 81.6% of staff on Eliza Tinsley ward were compliant with mandatory training. An average of 86.9% of staff on Henderson ward had remained complaint with all mandatory training between April 2016 and February 2017. On McCarthy ward, an average of 73% of staff were compliant with mandatory training between September 2016 and January 2017. This was against a trust target of 95%.

Assessing and responding to patient risk

- During the unannounced inspection in February 2017, we found staff undertook initial risk assessments for pressure ulcers on all patients; however, staff did not reassess in accordance with the care plan.
- We reviewed three sets of medical records during the unannounced in February 2017 and found inconsistencies in the completion and actioning of risk assessments on Eliza Tinsley ward. Staff had completed pressure ulcer risk assessments for two patients with pressure damage. Of these, one patient had all preventative measures implemented to reduce the risk. The second patients' care plan stated that the dressing should be changed twice weekly; however, at the time of inspection this had not been done for a week.
- The third set of medical records reviewed showed a patient had been assessed as at risk of falling on 11 February; however, this had not been reviewed or updated at the time of inspection.
- During the announced inspection, we found one patient on McCarthy ward who had been transferred from another NHS provider where the referrer had not alerted staff to a deterioration in the patient condition before leaving the acute hospital. A nurse on McCarthy ward had taken a handover of the patient 12 hours previously but this had not been reviewed prior to transfer. However, the response of staff to the patient when they arrived was proactive and in line with trust policy. A GP and senior nurse reviewed the patient immediately and a documented plan was made in relation to any further deterioration. The nursing staff completed national early warning score (NEWS) assessments as required and the patient was reviewed by a GP the evening of their admission, and the following morning.
- NEWS is a national recognised system for assessing deterioration in patients by giving the patient a score based on physiological factors, such as their temperature, pulse rate and respiratory rate.
- We reviewed 28 medical records throughout the announced inspection and found all had appropriate risk assessments for pressure ulcers, nutrition and falls and staff had reviewed and updated these as required.
- We reviewed the services' sepsis pathway and found this to be in line with The UK Sepsis Trust current guidance. The trust had implemented the national sepsis screening tool from The UK Sepsis Trust; however, two senior nurses were unaware of this when asked.
- Nursing staff undertook handovers between shifts in two stages to promote the safety of patients through visible staffing. Staff had an overview of all patients at the ward reception so all staff were aware of patients with 'do not attempt resuscitation' orders in place, those at risk of falling and patients at risk of deterioration. Staff then undertook bedside handovers for each patient. This ensured patients could raise concerns and staff were present within each bay to support patients.

Staffing levels and caseload

- We found actual registered nurse (RN) and healthcare assistant (HCA) staffing numbers met the planned staffing levels for Eliza Tinsley, Henderson and McCarthy throughout the inspection period, including both unannounced inspections, and for the upcoming rota.
- Planned staffing for Henderson ward was: early shift three RNs and five HCAs, late shift three RNs and four HCAs and night shift two RNs and three HCAs. Eliza

Tinsley and McCarthy had the same planned staffing of: early shift three RNs and four HCAs, late shift three RNs and three HCAs and night shift two RNs and three HCAs.

- However, the service did not meet planned staffing for senior nursing staff between January and March 2017.
- The January and March 2017 ward managers and matron (Band 7 management) meeting minutes state that "a band six (junior sister or charge nurse) will hold the fire bleep during night shifts". However, data given to us by the group management team during the inspection showed that of the 90 night shifts in January, February and March 2017, a band six nurse covered six, with the remaining 84 covered by a band five staff nurse. The data showed a band five bank RN covered three of the 84 shifts, who, although substantive members of staff at the trust, did not routinely work at Rowley Regis Hospital.
- The band 7 management meeting minutes also stated the three ward managers should cover day shifts to ensure "sufficient substantive cover at all times" of senior nurses. The data supplied to us during the inspection showed of the 180 daytime bleep shifts requiring cover between January and March 2017, a ward manager covered 19, a junior sister or charge nurse covered 148 and a staff nurse covered 13 shifts.
- Henderson, Eliza Tinsley and McCarthy had high agency use throughout 2016, with an average of 37.8% of shifts filled by agency staff in 2016. Agency use across all three wards increased throughout 2016. Between January and June 2016, McCarthy ward filled 39.5% of shifts, Henderson ward 26.3% and Eliza Tinsley 11.7% with agency staff. The use of agency staff increased between July and December 2016, when McCarthy ward filled 69.1% of shifts, Henderson 50.2% and Eliza Tinsley 30.5% with agency staff. Combined, all three wards had an average agency use of 37.8% in 2016.
- As of 20 March 2017, McCarthy ward had a registered nurse vacancy of 3.4 whole time equivalent (WTE) and 3.6 unregistered WTE vacancies. Henderson ward had 3.2 WTE registered and 4 WTE unregistered staff vacancies. Eliza Tinsley had no registered nurse vacancies and 2.9 WTE unregistered staff vacancies.

Managing anticipated risk

- The service had a winter pressure plan in place for times of increased pressure on beds. The winter pressure plan was part of the trust wide plan for dealing with extra service users during winter months.
- As of January 2017, Rowley Regis hospital has no onsite security overnight. However, this has been mitigated by an external security firm providing regular unannounced visits overnight to the site to ensure staff and the building are safe and secure.

Major incident awareness and training

- The trust had a business continuity plan in place for in the event of a major incident, including localised internal major incidents (such as fire or flood), trust wide and within the wider healthcare infrastructure (for example in the event of a major incident within Birmingham city).
- Rowley Regis hospital had information for 'bleep holders' and lead nurses with actions in the event of an incident happening. All senior nurses spoken to understood their responsibility in relation to this.
- Staff asked could explain their responsibilities in relation to an incident happening locally, such as fire, floor or power failure.

Inadequate

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as inadequate because:

- We found staff did not undertake mental capacity assessments in line with the Mental Capacity Act 2005, or apply for deprivation of liberty orders in line with Deprivation of Liberty Safeguards 2010 legislation. Of the eight records reviewed, none contained a detailed mental capacity assessment, and four did not contain any deprivation of liberty application.
- Senior nursing staff did not have oversight of the competencies of agency staff working on the wards.
- We reviewed four care plans and found three (diabetes, falls and catheter care) were not referenced to the latest evidence base or national guidance. However, the sepsis pathway was in line with the latest national guidance from The UK Sepsis Trust.
- Community beds had no access to the electronic hospital records of patients within Sandwell and West Birmingham NHS Trust. Senior staff told us there were no formalised plans to bring community beds in line with the acute divisions in terms of telemedicine.
- We found delays in patients accessing specialist nutritional intake.
- We found no learning or plans to inform and drive improvement particularly from audit results.
- The service did not monitor delays in admission, transfer and discharge of patients.

However:

- We found good multidisciplinary working amongst nursing, therapy and medical staff.
- We found good discharge planning and referrals to other healthcare professionals where patients required additional support or clinical review.

Evidence based care and treatment

- Staff provided care in line with trust policies and care pathways; however, these were not always in line with the latest national guidance.
- We reviewed care plans for diabetes care, falls and catheter care, and found all three contained references to national guidance. However, this was not always the most up to date guidance.
- The diabetes care plan did not reference the National Institute for Health and Care Excellence (NICE) guidance NG17 Type 1 Diabetes in adults: diagnosis and management or NG28 Type 2 diabetes in adults: management. It also did not reference NICE quality standard QS6 Diabetes in adults.
- The falls risk care plan referenced NICE CG161 Falls in older people: assessing risk and prevention, published in 2013; however, had not been updated to reflect the latest NICE quality standard QS86 Falls in older people, published March 2015 and updated January 2017.
- We reviewed the services' sepsis pathway and found this to be in line with The UK Sepsis Trust current guidance. The trust had implemented the national sepsis screening tool from The UK Sepsis Trust; however, two senior nurses were unaware of this when asked.
- We found staff assessed the needs of patients in a timely manner and referred where required to allied health professionals. We reviewed the records of one patient on Henderson ward who staff had referred to the community dietician due to a specific, non-oral, feed regime.

Pain relief

- Medical staff prescribed in line with the British National Formulary. We reviewed 18 prescription charts and found nursing staff administered pain relief as prescribed and required.
- Staff assessed patient's pain as part of routine observations; however, we found no evidence of the reassessment of pain following the administration of pain relief. Patients asked felt staff controlled their pain well and received pain relief as required.
- Staff did not have access to a specialist nurse or doctor for pain relief advice, and decisions relating to the prescription and review of pain relief were the responsibility of the GP. However, we found no evidence that this affected patient care.

Inadequate

Are services effective?

Nutrition and hydration

- Staff used a 'red tray' and 'red cup' system to highlight the patients that required additional help with eating and drinking. Staff served patient food and drink on a red coloured tray or using a red plate or cup to visually see those patients requiring assistance to eat. This allowed staff to target support at those patients to ensure they had the support required to maintain a good level of nutritional intake. However, we found that patients had red trays and cups regardless of the need for assistance. This could lead to staff overlooking patients who could not feed themselves.
- Patients had magnetic boards above their bed space for staff to attach pictograms to highlight specific needs, including if patients were nil by mouth or on a special diet. However, we did not see these in use across any of the wards despite seeing patient with specialist feed regimes and diets.
- Patients had a choice of meals, which included those suitable for specialist diets such as vegetarian.
- We reviewed one set of records for a patient receiving percutaneous endoscopic gastrostomy (PEG) feeds and found staff received no feed regime prior when the patient was transferred to Rowley Regis. Rowley Regis hospital does not have access to PEG feeds without prescription. The community dietician recorded an interim feed regime, however was unable to fully review the patient for 12 days after admission. We raised concerns regarding this with senior nursing staff during the inspection who assured us they would follow up the referral with the dietetics team. We found this had been done during the unannounced inspection and a dietician review had been undertaken. However, staff do not raise delays in accessing community dieticians as incidents and therefore we were unable to assess the frequency of delays within the service.
- Staff completed fluid balance charts appropriately, where required, for patients and we saw evidence of these within patient records.

Technology and Telemedicine

- The trust had implemented a system of recording patient observations electronically, which in turn alerted medical staff to a deteriorating patient. However, Rowley Regis hospital had not had this technology implemented and were unable to access the electronical system from the hospital.
- All patient records at Rowley Regis hospital, including medication, were in paper form. Senior staff did not provide a date for the implementation of telemedicine at Rowley Regis or other community and satellite sites.

Patient outcomes

- The service participated in the West Midlands Quality Review Service (WMQRS) programme for 'transfer from acute care hospital' and 'intermediate care'. In the latest report, published October 2015, the service achieved 18 of the 33 quality standards for intermediate care. The quality standards not achieved included "medical care", which looked at the availability of medical staff seven days a week, the review of patients requiring medical assessment and the availability of a prescriber to be available within two hours to prevent admission. 'IT systems' including access to and the use of electronic patient records to enable 'patient administration' to take place. 'Audit' was another area not achieved, which included achievement of expected timescales for patient pathways, compliance with record keeping standards and compliance with evidence based clinical guidance.
- The trust had not participated in the National Audit of Intermediate Care (NAIC) between 2012 and 2015. The NAIC formed part of the Healthcare Quality Improvement Partnerships (HQIP) statutory and mandatory requirements for clinical audit, meaning NHS trust have a requirement to participate in the NAIC. However, the trust stated they planned to participate in the NAIC audit in 2017.
- We requested information on other local and national audit programmes the service participated in; however, the trust did not respond to our request.
- We found no evidence of learning from outcomes of audits and the service could not evidence changes because of the participation in national or local audits.

Competent staff

- Staff undertook a yearly appraisal with their ward manager. We reviewed appraisal data and found that as of 1 February 2017, all registered nurses on Eliza Tinsley ward had received an appraisal since April 2016. On Henderson ward, 92.3% of registered nurses had received an appraisal between April 2016 and March 2017. On McCarthy ward, 66.7% of registered nurses had received an appraisal since April 2016. This was against a target of 95% compliance.

Inadequate

Are services effective?

- Ward and group managers were aware of the low compliance on McCarthy ward and sighted the reopening of the ward in 2016 as the reason for low compliance, as not all staff required an appraisal.
- New members of staff (and those undertaking bank and agency shifts) completed a local induction package before their first shift. We saw completed induction packages for the staff on duty at the time of the inspection, which included emergency procedures, layout of the ward, access to medication rooms and the daily routine of the ward.
- However, senior nurses did not have oversight of the competency and skill level of agency and bank staff. We asked two ward managers of the extended competencies the agency staff working during the inspection had, for example non-oral feeding, catheterisation and intermediate life support. Neither ward manager knew the competencies of the staff working, or had a system in place to monitor these before agency staff arrived.
- We raised our concerns with the ward managers and group management team on site, as, particularly at night, agency or bank staff occasionally staffed wards without any substantive members of staff.
- Substantive staff received competency training in areas such as male catheterisation, non-oral feeding techniques (for example PEG or tube feeds) and intermediate life support. All three ward managers identified the risk to patients who may deteriorate due to the lack of medical assistance and distance to the nearest emergency department. Therefore, all registered nurses had been upskilled from basic life support to intermediate life support.
- We raised concerns regarding the competency of staff nurses undertaking 'nurse in charge' duties overnight, including responsibility for all three wards, the hospital site and grounds and to take the lead in emergency situations (for example fire, flood or cardiac arrest). One staff nurse told us they had not undertaken any additional training to date for the role and did not feel competent undertaking the role. The staff nurse told us they had not received any direct support from senior nurses on the ward, for example completing 'shadow shifts' to learn before undertaking shifts independently.
- We requested information on the additional training, including a breakdown of the training undertaken by staff nurses undertaking 'nurse in charge' shifts at weekends and overnight. The trust told us staff have undertaken fire response team leader training, staff coordination and key management duties training. However, the trust did not provide a syllabus, as requested, of these training courses or details of how many staff had completed the training.

Multidisciplinary working and coordinated care pathways

- We found good internal multidisciplinary team (MDT) working across Rowley Regis hospital. Nursing, therapy and community staff worked well together, attending MDT meetings, including discharge meetings, to discuss patients.
- We observed therapy and nursing staff working together within clinical areas. For example, therapy staff worked with nursing staff during the delivery of personal care to assess the progress of patients in caring for themselves.
- Nursing and therapy staff worked well alongside GPs, identifying and referring those requiring review efficiently and in a timely manner using a communication book on each ward.
- However, we found little evidence of MDT working outside of the hospital. For example, social workers did not attend daily discharge meetings. The service did not undertake a weekly MDT to review all patients with GPs, community and social care staff to plan patients care and discharge.

Referral, transfer, discharge and transition

- Acute sector staff referred patients into Rowley Regis using a 'trusted referrer' process. The trusted referrer process enabled the ward staff to understand, assess and plan care prior to the patient arriving on the ward.
- Staff referred patients to other specialties whilst a patient at Rowley Regis hospital. All patients on Henderson ward required input from either a physiotherapist or occupational therapist. Referral into this service was done at admission, and we saw discussions between nurses and therapists regarding patients throughout the inspection.
- The service audited the number of inter-ward transfers at Rowley Regis hospital.
- We found delays in discharging patients due to the complex commissioning arrangements in place within the wider health and social care economy. However, the service did not formally monitor delayed discharges from Rowley Regis hospital.

- Staff planned patient discharges in a coordinated and multidisciplinary manner. Nursing, therapy and community staff attended daily discharge meetings and discussed patients ready for discharge, identifying any early interventions to speed up discharge. We found evidence within all notes looked at of discussions regarding discharge. A discharge coordinator visited each ward Monday to Friday mornings and coordinated the discharge process for patients with complex needs or those not being discharged to their own home.
- We reviewed data supplied by the trust regarding the number of discharges before midday. Between April 2016 and March 2017, Eliza Tinsley ward had an average monthly discharge rate of 52 patients. Of those, staff discharged an average of 17 (32.6%) before midday. Henderson ward had an average of 24 discharges a month with an average of seven (29.1%) being before midday. Data for McCarthy ward covered September 2016 to March 2017 and showed an average of 29 discharges a month, with an average of one (3.4%) patient achieving discharge before midday.

Access to information

- Staff had access to relevant information relating to the care of each patient, including test results.
- Prior to transferring a patient, staff undertook a verbal assessment process with the referring professional, known as the 'trusted referrer' process. This ensured that all relevant information regarding a patient was identified prior to transfer.
- However, we found one patient on McCarthy ward where staff had not been informed of a specialist feed regime prior to the patient's arrival. Staff sought advice from the community dietician and referred the patient to the dietetics team for formal review.
- Staff did not have access to the electronic records held elsewhere within Sandwell and West Birmingham Hospital Trust. Staff told us that this made the process more difficult as they were unable to access the latest observations, test results and information regarding a patient prior to transfer.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The way staff undertook capacity assessments, documented findings and deprived patients of their liberty was not in line with the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards 2010. We found care deliver that was not consistently in line with the Human Rights Act 1998, specifically Article 5 (right to liberty and security) and Article 8 (respect for your private and family life, home and correspondents).
- However, staff demonstrated a good knowledge of consent and when this would be required. We observed staff requesting consent from patients prior to undertaking clinical observations (for example blood pressure) and during personal care.
- Staff had mixed knowledge and understanding of the Mental Capacity Act 2005. Staff could explain what capacity was and the importance of assessing capacity. Admission documentation completed by nursing staff had an area to assess and document capacity and if patients were free to leave the ward.
- Staff had mixed knowledge and understanding of Deprivation of Liberty Safeguards 2010 across all areas visited. We identified four patients across the hospital that medical staff had assessed as lacking capacity and reviewed their medical records.
- Two patients on Eliza Tinsley ward lacked capacity. The medical staff had documented "no capacity" within both patient records; however, medical staff had not documented a formal mental capacity assessment or stated the situation in which the assessment related.
- A mental capacity assessment should be undertaken on a situation specific basis, including 'to deliver health care', 'serious medical treatment' or 'change of accommodation'. Staff should clearly document the situation to which the assessment relates.
- One patient on Eliza Tinsley had an urgent Deprivation of Liberty Safeguards application submitted (lasting seven days), but no substantive Deprivation of Liberty Safeguards application had been submitted. A substantive application should be made at the same time as an emergency application.
- The second patient had not had a Deprivation of Liberty Safeguards application completed; however, staff told us they were unable to leave the ward. We raised concerns with the ward manager who assured us staff would complete this the following day, which they did. However, it stated the reason for the application as "dysphasia" (an impairment of language skills). We requested a GP review and complete a full mental capacity assessment on the patient, which they informed us they did. However, the documentation still stated "no capacity", and again was not situation specific. The ward manager stated nursing staff used

flash cards and visual aids to communicate with the patient; however, the GP had not used these additional aids during the assessment process. This could have impeded the ability of the GP to fully assess the capacity of the patient.

- One patient on Henderson ward had not had a Deprivation of Liberty Safeguards application submitted, despite a lack of capacity and the inability to freely leave the ward. We raised our concerns with the nurse in charge who stated that because the patient had not asked to leave, a Deprivation of Liberty Safeguards application is not required. This was not in line with the Deprivation of Liberty Safeguards 2010 legislation and we requested an application be completed, which staff did the following day.
- A patient on McCarthy ward had "no capacity" documented within their medical records; however, as with the previous documentation found, no expansion or detail relating to the assessment. Staff had completed a Deprivation of Liberty Safeguards application for this patient.
- During the follow up visit to Rowley Regis, we reviewed a further two records for patients that lacked capacity. On Henderson ward, the patient did not have a formalised mental capacity assessment documented within their medical records. However, staff had submitted an emergency and substantive Deprivation of Liberty Safeguards application.
- Staff had assessed a patient on McCarthy as not having capacity and not free to leave to ward. However, staff had not completed a Deprivation of Liberty Safeguards application for the patient since admission 14 days earlier. We raised our concerns with two GPs and the nurse in charge; however, the staff were unaware why the patient required a Deprivation of Liberty Safeguards application as they had not expressed a desire to leave the ward.
- We escalated our concerns to the deputy director of nursing following the unannounced follow up inspection who assured us they would follow up with the wards to ensure staff undertook mental capacity assessments and Deprivation of Liberty Safeguards applications better moving forward.
- We requested MCA and Deprivation of Liberty Safeguards training compliance amongst staff. The trust told us that staff undertake training as part of Safeguarding Adults Level Two training; however, not all staff undertake this training, with staff at band six (junior sisters and charge nurses) and below undertaking Safeguarding Adults Level One.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring good because:

- We observed staff delivering care in a way that considered patient privacy and dignity.
- Patients and family members we spoke to gave positive feedback about the care they or their relative had received.
- Senior staff had invested in privacy protection curtains within side rooms to promote patients dignity when staff enter and leave side rooms.
- Staff involved patients and family members in decisions about their care, including discharge decisions.
- We found staff of all professions and grades supporting patients and families during times of distress and after receiving bad news.
- Rowley Regis scored 88% in the latest Patient-Led Assessment of the Care Environment from 2016 for maintaining privacy and dignity, which was in line with the rest of the trust and other large NHS nationally.

However:

- Nurse handovers did not promote the privacy and dignity of patients, as they occurred at ward reception desks with patients and visitors nearby.

Compassionate care

- We spoke with seven patients and two relatives during the inspection, and observed staff interacting with patients and visitors on Henderson, Eliza Tinsley and McCarthy wards. All patients spoken to told us that they were happy with the care provided and that staff were kind and caring.
- One patient told us “staff here are so lovely, they would do anything for you if you ask them.” A second patient stated (in relation to the staff) “I love it here they are all so friendly”.
- We observed nursing and therapy staff encourage patients to mobilise within their abilities throughout the day, not just during formalised therapy sessions. Staff supported patient to independently use toilets and move between rooms to promote their independence prior to discharge. All interactions between patients and staff were positive, reassuring and non-derogatory, with as much time as needed spent with each patient.
- We reviewed Friends and Family Test data for Rowley Regis hospital between November 2016 and February 2017. We found a mixed response rate and results from across all three wards. In November 2016, Henderson, Eliza Tinsley and McCarthy all achieved over 90% for patients recommending the ward for care. In December 2016, 88% of patients would recommend Henderson, with 6% not recommending the ward. Eliza Tinsley and McCarthy wards did not receive any responses in December 2016.
- January 2017 was similar to the previous month, with Eliza Tinsley and McCarthy receiving no response. Henderson scored 88% for recommending and 6% for not recommending the ward. In February 2017, the wards received the following recommendation scores: Henderson 84%, Eliza Tinsley 95% and McCarthy ward 90%.
- The latest Patient-Led Assessment of the Care Environment scores from 2016 show Rowley Regis scored 88.1% for maintaining patients privacy and dignity, which is in line with the rest of Sandwell and West Birmingham NHS Trust sites and better than the national average for large NHS providers.
- Between April 2016 and March 2017, Henderson ward received an average of 2.7 compliments a month from patients and relatives, and Eliza Tinsley received an average of 4.6. McCarthy ward received an average of 0.5 compliments a month between September 2016 and March 2017.
- During handovers, staff discussed patients at the wards reception desk. We observed patients and visitors around the reception desk during these times who could overhear handover. This did not promote the privacy and dignity of patients as staff discussed confidential medical information.

Understanding and involvement of patients and those close to them

- All staff delivering patient care took time to comfort and explain to patients any aspects of care they did not understand. We observed a nurse taking time to explain the medication that a patient had been prescribed and answering all the questions the patient asked.

Good

Are services caring?

- On McCarthy ward, nursing staff recognised the distress of a patient living with dementia upon discharge, as the patient did not want to leave with a patient transport service. Staff cancelled the transport and spoke to the relatives, and arranged for a safe discharge into the care of the patient's relatives.
- Therapy staff took time with patients to explain treatment plans and the expected progression following treatment. We observed therapy staff involving patients in the decisions about when to undertake exercise routines, and understanding the patient's discharge environment. We observed therapy staff tailoring sessions to meet the needs of the patient, for example to include the use of stairs, a bath or making food and drink safely.
- Staff on Henderson ward supported a family following the admission of a patient who deteriorated on the ward. Ward nurses, matron and GPs discussed the options with the family to ensure the patient remained safe and the wishes of the family taken into account.

Emotional support

- Ward staff provided emotional support to patients, visitors and each other. We observed staff listening and reassuring patients following upsetting news and when they became distressed due to confusion.
- We observed a student nurse spending time with a distressed patient, offering reassurance and helping to calm them down.
- On Henderson ward, we observed staff sitting with a patient following some bad news about their condition. We observed nursing staff taking the time to listen and reassure the patient, and asking other staff to undertake some of their work to enable them to spend uninterrupted time with the patient. We observed staff regularly checking the patient over a four hour period and providing reassurance and support as required.
- A family of a patient due to be transferred to Henderson ward had complained about care provided at another NHS trust. The group matron visited the family and patient at the NHS trust to review the patient to ensure suitability of the transfer and provide reassurance to the family around the transfer of care. Once on the ward, the family told us they were “extremely grateful” to matron for supporting them before the transfer of care, and that all the staff on Henderson ward were “really good”.
- Therapy staff provided positive reassurance to patients undertaking exercise regimes. We observed therapy staff encouraged and reassured patients throughout the four weeks of rehabilitation on Henderson ward to ensure patients were able to manage their condition at home before discharge.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive requires improvement because:

- Staff had a mixed approach to the requirements of the Equality Act 2010. Medical staff did not always utilise alternative communication methods when appropriate. Medical staff also expressed views consistent with a blanket approach to aspects of care based on a patient's age rather than medical condition.
- Nursing staff demonstrated a mixed approach to supporting people who identified as a minority sexual orientation or gender. Nursing staff also had a mixed knowledge of how to access religious leaders from faiths other than Christianity.
- The layout of clinical areas did not promote the wellbeing of patients who were visual impaired or had dementia.
- Evidence of learning from complaints was limited, with time frames set out in improvement plans missed.

However:

- We found service planning met the needs of the patients.
- The service had specific inclusion and exclusion criteria for patients admitted to a reablement or 'ready for discharge' bed.
- Staff had a good understanding of the needs of patients with dementia and we saw individualised care delivered to patients and families.
- The service had received six complaints in 2016, with Henderson ward receiving no formal complaints.

Planning and delivering services which meet people's needs

- Eliza Tinsley and McCarthy were 'ready for discharge' wards, for patients that required some support before discharge or with planning their discharge but had no medical needs. Henderson ward was an intermediate care and reablement ward, providing nurse, physio and occupational therapy led care to patients requiring up to four weeks rehabilitation before their discharge.
- All three wards had specific admission criteria due to being nurse and therapy led, with no onsite medical staff. Admission criteria included, patients must be medical stable, be likely to benefit from up to four weeks of therapy care and patients have a suitable and safe environment in which they can be discharged.
- Admitting staff assessed patients using a 'trusted assessor referral' system. This allowed the referring and accepting clinicians to plan the best pathway for the patient, for example, admission to Rowley Regis, discharge home with a care package in place, or to remain in acute care for longer period.
- Staff undertook discharge meetings with nursing, therapy, medical and outside agencies, where needed, to ensure those patients with complex or changing needs can still achieve a safe discharge from hospital.

Equality and diversity

- Staff had a mixed awareness of the need to promote equality and diversity within clinical areas in line with the Equality Act 2010.
- Staff had access to telephone, face-to-face and written translation services. All staff asked knew how to access translation services. On Eliza Tinsley, nursing staff used communication and image cards to communicate with a patient who was unable to communicate verbally. However, medical staff were observed not using these alternative communication methods during an assessment of the patient. Senior nursing staff did not raise this with the doctor at the time of the assessment, despite their presence during the assessment.
- Staff could access religious leaders if patients or family members requested them. A Church of England minister visited all clinical areas each week to speak with patients and families. Staff were unsure how to contact religious leaders that were not Christian.
- Patients did not have access to a hearing loop within the ward areas. One senior nurse told us a hearing loop was available at the hospitals reception desk; however, none of the staff had been shown or trained how to use it.
- We asked a senior nurse how they would support a patient who was transitioning or transitioned their gender. The senior nurse stated that they would seek advice from the trust's lesbian, gay, bisexual and transgender (LGBT) network to ensure that staff provided the correct support.

Requires improvement

Are services responsive to people's needs?

- We saw patients sexual orientation documented, where asked for, within their records. When asked how staff ensured the accuracy of this, one nurse in charge told us staff generally presume a patient's sexual orientation based on their circumstances, for example heterosexual if they were in a relationship with a person perceived to be of the opposite sex or gender. The nurse in charge told us this would happen despite an option on some documentation to select "not known". The nurse in charge stated that sexual orientation would be more applicable if the ward treated younger patients as it does not usually apply to older people.
- Two doctors told us that they do not routinely review certain aspects of a patient's care, for example a 'do not attempted resuscitation' order, as the patients they treated were "old and likely to die soon anyway". This is not in line with requirements of the Equality Act 2010 or the Human Rights Act 1998. We explained to the medical staff concerned why this would be considered inappropriate; however, they did not demonstrate an understanding as to why this was. We raised this with trust director who stated the GP clearly and specifically described, that the vast majority of DNACPR forms in the community are instigated for palliative care patients who are expected to die in the near future, not that patients were elderly and likely to die fairly quickly.
- The trust had a Mutual Respect and Tolerance policy in place and had produced an information leaflet for staff summarising the main points. The leaflet was available to all staff via the intranet and to patients via the trusts public website. The guidelines set out in the leaflet explain what constitutes inappropriate behaviour, how to challenge it and where to get further support.
- Staff completed equality and diversity training as part of their mandatory training. We requested a breakdown of mandatory training from the trust; however, the trust was unable to provide this for Rowley Regis hospital. Therefore, we were unable to evaluate compliance with, or appropriateness of, this training.

Meeting the needs of people in vulnerable circumstances

- Staff knowledge and understanding of the additional support people with dementia may require was good across all clinical areas.
- A senior nurse told us that staff utilise 'All about me' booklets with patients who have dementia, which allowed families to document patients likes, dislikes and home routines. However, we did not see these in use during the inspection.
- Digital reminiscence therapy (DRT) was available for staff to use with patients who had dementia. This was a digital programme that allowed relatives, staff or patients to choose music, pictures or sounds that reminded them of past events. Relatives could record key phrases, for example, "it is time for dinner", to bring familiarity to the patients stay in hospital and reduce anxiety.
- On McCarthy ward, we found a good example of staff individualising care for a patient with dementia. The patient was due to be discharged, however refused to leave the ward with an ambulance crew. Staff organised and supported the family to transport the patient home to reduce the patient's anxiety and ensure that the patient and family remained safe.
- Relatives were able to stay overnight as often as they wanted to for patients with complex needs, such as dementia or a learning difficulty. Staff provided relatives with fold out beds that could be placed next to the patient, or had access to separate overnight accommodation room within the hospital.
- Rowley Regis scored 94.2% for having a dementia friendly environment in the latest Patient-Led Assessment of the Care Environment from 2016. This was the highest score across the trust, which, on average, scored 89.1%. Rowley Regis scored significantly better than other large NHS trust sites, which scored 78.9% on average.
- Staff ensured that patients were not discharged unless their home environment was safe for them. A patient on McCarthy ward was discharged home with increased care needs and lived with their elderly spouse. Staff arranged a care package with the community nursing teams to ensure that the patient could safely be discharged home, which is where they wanted to be.
- A senior nurse on Eliza Tinsley raised concerns over the flooring and design of the building in supporting patients with a visual impairment or those with dementia. The floor had been repaired following damage but with patches of different coloured flooring. The senior nurse told us patients often think there are

steps or dips due to the colour change on the floor. Staff told us they have seen patients become unsteady when walking with aids (such as walking sticks and frames) due to this.

- We noted that, with the exception of the bays on Eliza Tinsley, all other walls, floors and doors on each ward were a similar colour. We found inconsistencies in the signage of bathrooms and toilets across all three wards, with some having large text and distinctive pictograms and others having little or no signage at all. This, combined with indifferent wall and floor colours, could lead to increased confusion amongst patients with dementia, as they may be less able to orientate themselves, and to those patients with a visual impairment, reducing the ability to distinguish between walls and doors.

Access to the right care at the right time

- The service did not admit directly from the community, instead acute hospitals within the area transferred patients requiring short-term rehabilitation or support prior to being discharged.
- We found no delays in patients admitted into the service. The group managers told us they were not aware of any delays to the admission of a patient due to the lack of bed capacity. Each ward manager supported this. However, we found no evidence of the measurement of this or data collection concerning delays in admission to Rowley Regis Hospital.
- Physiotherapists and occupational therapists were available Monday to Friday daytime on all three wards at Rowley Regis Hospital. Physiotherapists and occupational therapists reviewed each patient receiving therapy input and undertook interventions as required. We observed an example of therapists changing the routine for a patient as the patient was not happy with the time allocated to undertake exercises.
- However, we found delays in dietetic reviews of patients by a community dietician. One ward manager told us that patients usually wait between one and two weeks to be reviewed by a community dietician. The trust did not collect data relating to the length of time taken to review patients by dieticians. We found one patient had waited 10 days for an urgent review by a dietician, as the patient had a specific, non-oral feed regime that had not been communicated by the acute trust that transferred the patient originally.
- A GP visited the hospital between 8am and 12pm Monday to Friday to review patients across all three wards. Monday to Friday 8am to 5pm, nursing staff could contact a GP surgery for advice or to review a patient. Nursing staff used the NHS 111 service for medical advice outside these hours, or telephoned 999 for an emergency ambulance where required.
- Between December 2016 and February 2017, Henderson unit (rehabilitation and reablement) transferred 15 patients back to an acute setting due to either an inappropriate initial transfer or deterioration once admitted. Across all inpatient rehabilitation services, 43 patients were transferred back to an acute setting between December 2016 and March 2017.

Learning from complaints and concerns

- Rowley Regis hospital received six complaints between January and December 2016. Of these, four related to McCarthy ward and two to Eliza Tinsley ward. Henderson ward received no formal complaints in 2016.
- The trust did not uphold the two complaints from Eliza Tinsley. The trust upheld two and partial upheld two complaints from McCarthy ward.
- The two upheld complaints related to "poor standard of care" and "aid not provided to patient". The partially upheld complaints both related to discharge and the remaining two complaints related to privacy and dignity and "poor care" on Eliza Tinsley ward.
- Group governance meetings discussed complaints monthly and fed into ward level improvement plans. However, we reviewed ward improvement plans during the February 2017 unannounced inspection and found many improvement actions overdue or ongoing. We did not see any details, shared learning or changes made following complaints documented within the group governance meeting minutes.

Inadequate

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led inadequate because:

- Experience amongst ward managers was limited, with two of the three in post for less than six months, and new to the role of ward manager, however they were experienced clinicians.
- Ward managers meeting minutes were repetitive and we were not assured of sufficient review of agenda items.
- Identification and assessment of risk was not consistent across the group. We found two examples where senior staff had not undertaken a risk or impact assessment on a situation prior to, or following, a change or implementation; for example, the change and reduction of hospital wide staff overnight and having no immediate access to a defibrillator within all clinical areas.
- The review of documented risks at ward level was limited, and we were not assured staff updated the risk registers regularly and that they reflected the risks identified during inspection.
- We found a lack of public engagement from the service, with the service stopping patient focus groups in 2016.
- We found a lack of challenge amongst staff to poor practice or practice that did not meet the expectations of the trusts values and promises.

However:

- Ward managers were visible and accessible to staff, patients and visitors, with their offices located within clinical areas.
- There was an established governance structure in place across the group.
- The majority of staff felt well support within their roles and confident and comfortable to discuss concerns with their line managers.
- The trust had a vision and strategy, and had developed 'promises' (or values) to support the achievement of the vision.

Leadership of this service

- The organisation was split into clinical groups with community inpatient care under the therapy and community group (TCG). A group management team, consisting of a group director of nursing, group head of nursing and clinical directorate lead, managed the TCG.
- The TCG was split into three divisions, with inpatient services part of the 'iBeds' division, managed on a day-to-day basis by a matron. A ward manager, supported by a team of senior staff nurses, managed each Henderson, Eliza Tinsley and McCarthy wards.
- Experience amongst ward level senior nurses was limited, with two of the three ward managers promoted to the role three months prior to the initial unannounced inspection in February 2017. The trust gave no formal training or supervision to the new ward managers on commencement of their role. However, all three ward managers told us they felt confident within their roles, and supported by each other and through monthly senior nurse meetings with the divisional matron and they were all experienced clinicians. Staff told us that they felt well support by their line managers and they promoted a culture of openness and inclusivity amongst all levels of staff.

Service vision and strategy

- All staff spoken to were aware of the trust wide vision and strategy, including how community services fitted into the vision of the new Metropolitan Hospital site.
- The trust vision was "to be the best integrated care organisation in the NHS".
- The trust had developed six strategic objectives in line with the vision, which were: "21st century infrastructure", "safe, high quality care", "care closer to home", "good use of resources", "an effective organisation" and "accessible and responsive".
- The trust designed the "care closer to home" objective to enhance the pathways and integration between the acute care sector and community, primary and social care partners to provide "a range of seamless and integrated services". The care closer to home project was ongoing at the time of inspection.
- The group management team told us the service worked to a vision that focussed around providing the

right care to patients in the right way and this focussed around the needs of the patient. However, the vision was limited in detail and the trust did not provide CQC with a strategy for implementing the vision.

- The trust had developed nine promises (or values) to support the achievement of the strategy, which included: "be polite, courteous and respectful", "admit mistakes and do all I can to put them right", "go the extra mile" and "value your point of view". We did not see the trusts values displayed within ward areas; however, staff were aware of them and we observed staff demonstrating the values, for example "be polite, courteous and respected", "be caring and kind" and "make time to listen to you".

Governance, risk management and quality measurement

- The service had a clearly defined governance structure in place to support the delivery of high quality care and the trust and group visions. Ward managers met with the group's matron, who communicated concerns to the group management team. The group director of nursing met with the chief operating officer monthly and they raised concerns regarding the therapy and community group, which were then discussed at board level.
- The group leadership team told us ward managers and the group matron met every month. However, we requested minutes from the previous two meetings and the trust provided minutes from January and March 2017. The meeting minutes had regular agenda items, plus some additional items added into the March meeting, including liability claims, sickness and 'do not attempt cardiopulmonary resuscitation'.
- However, with the exception of four additional agenda items (which had no information underneath them) within the March minutes and a sentence stating it was the first meeting of the year in the January minutes, both sets of meeting minutes were identical with no variance in the text. Both sets of minutes stated the next scheduled meeting was February, despite the March meeting being after this. The March minutes did not state who attended the meeting other than the group matron. We clarified on site that these were the correct minutes and informed by the group leadership team that they were correct.
- We were not assured from these minutes that the bi-monthly meetings between ward managers and matron were effective or reflected the needs of the wider group itself. We were not assured that the group took effective minutes of meetings, making oversight of progress and accountability difficult.
- The group director of nursing provided a link from core service level to the board of directors, attending monthly meetings chaired by the trusts chief operating officer.
- We found ward managers and the groups leadership team were aware of the positive aspects within the group and the areas for improvement, and actions taken and planned to improve services. For example, the change of night staff ratios to include less registered nurses and more healthcare assistants following a review into the care delivery needs overnight.
- Each ward, the group and the wider trust had individualised risk registers. We reviewed the risk registers from Henderson, Eliza Tinsley and McCarthy wards and the groups leadership team. The ward level risk registers contained six risks. McCarthy had one risk documented, which was around the provision of a 24 bed ward without substantive staff or ward manager. The risk had reviews clearly documented and appropriate updates and control measures in place. The risk had a review summery to track updates and actions, control measures were documented, and a responsible person named for each action. However, McCarthy ward had reduced the number of vacancies from 14.79% in June 2016 to 4.4% in March 2017 and a substantive ward manager was now in place. Staff had not updated the risk register since October 2016 and it did not fully reflect the current situation.
- The risk register for Henderson ward contained two risks relating to the risk of slips, trips and falls by patients, visitors and staff, and the risk of staff sustaining an injury from a needle or other medical sharp. However, neither risk had a date when staff added the risk, a review date or measurable actions with an identified lead. Control measures had been documented; however, none had dates for achievement or a responsible person assigned.
- The risk register for Eliza Tinsley contained the same two risks as Henderson wards risk register, with identical documented control measures. It also contained a third risk relating to an increase in falls. However, with the exception of the description of the risk, staff had not documented any control measures, actions, responsible persons or reviews that had happened or were planned to happen.

Inadequate

Are services well-led?

- We were not assured that ward managers regularly reviewed and updated their risks, that the documented risks fully reflected those found during inspection or that ward managers had a robust way of measuring the impact of changes.
- The groups risk register contained eleven risks. The risk register was detailed and contained existing control measures, additional actions, a responsible person, last review date and frequency of reviews. However, the risk register did not state when the risk had been added. We found security overnight at Rowley Regis hospital had been added to the groups risk register with a review frequency of "fortnightly". No date had been documented, and therefore we were not assured that this risk had been reviewed fortnightly as documented.
- We requested the last three therapy and community group clinical governance meeting minutes and the trust provided details of meetings from September 2016 and January and March 2017. The minutes showed standard agenda items including infection control, complaints and incidents and staffing. However, the minutes did not detail the date of the meeting, who was invited and attended, any actions that were required or who had responsibility for improvements. The January 2017 meeting minutes stated that ward risk registers were being created by ward manager; however, we reviewed the ward risk registers for Henderson, Eliza Tinsley and McCarthy ward, which had risks dating back to February 2016. We were not assured of the effectiveness of the therapy and community group clinical governance meetings from the information provided by the trust.
- We requested the risk assessment or review relating to having one defibrillator between Henderson, Eliza Tinsley and McCarthy wards. Two ward managers asked were unaware if a risk assessment had been completed. The trust told us that "the arrangement was proportionate" as a second defibrillator was located in the day services unit, which was also on the ground floor, but not easily accessible at night. Neither ward manager asked knew of a standard operating procedure for in the event of a cardiac arrest on McCarthy ward (on floor two), and told us staff just know what to do.
- We requested the risk assessment or safety review concerning the reduction of staff on the hospital reception and registered nurses overnight. We asked two ward managers, the group leadership team and the group director of nursing about this and none were aware of the trust undertaking a safety review or risk assessment before or since the changes took effect. The trust told us that during the consultation on changing staff at night, no formal risk review was undertaken as the impact on staff was "not felt to be onerous", and senior staff were monitoring the impact of the changes. However, the group had included security at Rowley Regis on the group-wide risk register.

Culture within this service

- Staff communicated a positive culture within the service. Staff were positive that the culture within the service was improving, particularly due to the employment of more substantive staff, creating a closer team ethic across the hospital.
- We found all wards at Rowley Regis hospital worked closely together and supported each other. This was particularly evident amongst the ward managers who not only supported each other but also ensured that one was on site Monday to Friday 8am to 4pm to support junior colleagues across the hospital.
- However, one junior nurse told us that they felt unsupported whilst undertaking their role of 'site manager' overnight. We asked the group management team and ward manager concerned and neither were aware of the concerns. The group management team emphasised the importance of staff safety overnight and assured CQC they would review the current system to ensure staff felt supported and safe overnight.
- We found a lack of challenge amongst nursing staff to behaviour that was inconsistent with the vision and values of the trust. We found multiple examples during the inspection where nursing and medical staff had not challenged staff from all disciplines, despite identifying concerns. For example, the lack of using alternative communication methods when medical staff assessed a patients mental capacity who has no verbal communication, nursing staff not completing Deprivation of Liberty Safeguards applications (despite patients meeting the criteria), medical staff displaying values inconsistent with the Equality Act 2010 and nursing staff leaving medication room doors open despite this being against trust guidance.

Public engagement

Inadequate

Are services well-led?

- The service gathered feedback from patients and relatives through the Friends and Family Test and ad hoc feedback to staff. However, ad hoc feedback was not formally recorded and fed back into the wider team.
- The service did not engage in patient focus groups to gage feedback on services. One ward manager told us the service used to hold patient groups, however these stopped sometime in 2016 and the service had not restarted them since.
- We found no feedback forms displayed in clinical areas or corridors and no information about how to feedback a concern, complaint, comment or compliment.

Staff engagement

- Staff participated in the annual staff survey.
- Staff had the opportunity to attend monthly staff meetings in each ward area visited and staff told us they felt listened to and included when making suggestions for improvements.
- Prior to changing night staffing from three registered nurses to two, senior managers consulted all staff affected for their views. Staff had the opportunity to give feedback and make further suggestions before the trust brought in the changes.
- Staff suggested to the group leadership team that registered nurses should be reduced on night shifts, and increase healthcare assistants, as the needs of patients did not require three registered nurses. The group leadership team consulted all staff affected and made the decision to implement the suggested changes.

Innovation, improvement and sustainability

- The service had employed two further ward managers, making three in total, to drive improvement and deliver senior nurse leadership within each ward area.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10 (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular – 10 (2) (c) having due regard to any relevant protected characteristic (as defined in section 149(7) of the Equality Act 2010) of the service user. The provider must ensure that staff have regard for the protected characterises within the Equality Act 2010, and do not discriminate against service users, visitors or staff in anyway. The provider must ensure that staff do not base care decisions on the perceived characteristics of service users. For example, the implementation of a 'do not attempt cardiopulmonary resuscitation' form based on the age of a service user, or presuming the sexual orientation of a service user based of their relationship or marital status. The provider must ensure that service users can access information, and be assessed, in a way that utilises their strengths. For example, ensuring that alternative communication methods are available, considered and used, where appropriate, for patients who cannot vocalise easily.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. The provider must ensure that all staff have regard for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010 when assessing patients and delivering care. The provider must ensure that when staff undertake a mental capacity assessment on a service user that this is detailed, compliant with legislation and best practice, and is undertaken in a way and at a time that recognises the patient abilities. The provider must ensure that all patients whose liberty is being deprived for the purposes of providing health care have an appropriate mental capacity assessment and a deprivation of liberty safeguard application is considered and applied for where necessary, in line with the 2005 Act and 2010 legislation.
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – 17 (2) (a) assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activities (including the quality of the experience of service users in receiving those services)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – 17 (2) (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity The provider must ensure that risk assessment and safety reviews are undertaken where required to ensure the health, safety and welfare of staff, patients and visitors is not compromised through changes to the delivery of the service. The provider must ensure that risks are identified locally and appropriate mitigating actions put in place to ensure patients and staff are not at risk. Documentation relating to the oversight, review and implementation of risk and mitigation must be robust and appropriately evidence discussions and decisions made. The provider must ensure that all staff work in accordance with national best practice, local policies and procedures, and legislation when undertaking medicine management duties (including the prescribing, dispensing and storage of medication). 17 (2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Requirement notices

The provider must ensure that patient records are accurate and compliant with relevant legislation, such as the Mental Capacity Act 2005.

Entries within patient's records must be contemporaneous and omissions from records must not compromise the delivery of care.

The provider must ensure that mental capacity assessments are documented in full, referencing the 'two stage test' and why the capacity assessment is being undertaken (for example the provision of healthcare).

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 10 (2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular – 10 (2) (c) having due regard to any relevant protected characteristic (as defined in section 149(7) of the Equality Act 2010) of the service user. We found staff did not have regard for the Equality Act 2010 when delivering care to patients. GPs told us they do not routinely review 'do not attempt cardiopulmonary resuscitation' forms due to patients being "old and likely to die soon anyway". A nurse in charge told us that a patients sexual orientation (where documented) would be presumed

This section is primarily information for the provider

Requirement notices

based on their perceived relationship status as sexual orientation "would be more applicable if the ward treated younger patients as it does not usually apply to older people".

We found GPs assessing patients who did not verbally communicate without using an alternative communication method, despite this being embedded by nursing staff as the preferred method of communication.

Staff did not challenge poor practice concerning the Equality Act 2010. We found nursing staff did not challenge medical staff over their chosen communication methods or the review of patients care records.

Staff did not know how to contact religious leaders of faiths other than Christianity, specifically Church of England. One member of staff stated that the ward does not see people from other faiths very often so there was not a need to know.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (5) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. We reviewed six patient records for patients who lacked capacity at the time of the announced inspection and second unannounced inspection. None of the patient records had a clearly documented mental capacity assessment in line with the requirements of the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

We found GPs did not use alternative communication methods when assessing the mental capacity of a patient on Eliza Tinsley ward. This is not in line with the Mental Capacity Act 2005 or Equality Act 2010, and the completion of an accurate and contemporaneous assessment would have been difficult.

We found a mixed understanding across all clinical areas as to the requirements of the Deprivation of Liberty Safeguards 2010 legislation, with the majority of medical and nursing staff lacking understanding as to when an application under the Deprivation of Liberty Safeguards 2010 legislation should be made.

We found three of the six patient records reviewed (where a deprivation of liberty safeguards application was needed) did not have a deprivation of liberty safeguards application of any kind submitted. One patient had an emergency deprivation of liberty safeguards application submitted but no substantive application.