

Guy's and St Thomas' NHS Foundation Trust

RJ1

Community health inpatient services

Quality Report

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Date of inspection visit: 7-10 September 2015
Date of publication: 24/03/2016

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)
RJ1X5	Pulross Intermediate Care Centre		SW98AE
RJ1X6	Guy's & St Thomas' NHS Foundation Trust Community Services	Amputee Rehabilitation Unit, Lambeth Community Care Centre	SE11 4TX
RJ1X4	Minnie Kidd House		SW12 9NU







This report describes our judgement of the quality of care provided within this core service by Guy's and St Thomas' NHS Foundation 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 Guy's and St Thomas' NHS Foundation Trust and these are brought together to inform our overall judgement of Guy's and St Thomas' NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community inpatient services at Guy's and St Thomas' NHS Foundation Trust as 'good' overall. We found that the services were organised with patient safety as a priority. The rehabilitation services were patient centred and involved them and people important to them. Feedback from patients and relatives was very positive and we observed staff to be caring and compassionate in their approach. A recent successful recruitment campaign meant that the services were adequately staffed, and there was low use of bank and agency staff. Staff were engaged in improving the service and received regular appraisals, supervision and were supported to develop their skills further. There was a robust governance and risk management structure in place and staff were supported to report and learn from incidents.

Staff followed infection prevention and control procedures, all areas we inspected were clean and the environment and equipment was well maintained. Patients had their meals together in the dining area and most patients told us they enjoyed the food provided and were supported if necessary.

Patients were given sufficient information about their environment and what to expect during their admission. Their opinions were sought and listened to. Patients and those close to them were part of the decision making process and they agreed clear and realistic goals to work towards. Staff told us there was a commitment to successful rehabilitation and we saw evidence of good multi-disciplinary working across nursing, therapy and medical teams.

We observed patient records were well managed however nursing, medical and therapy staff recorded their interventions in different formats. This meant that staff supporting patients did not always have access to each other's notes and there was a potential risk of the healthcare professionals not being aware of a patient's progress or changes in treatment or care. Medicines were managed appropriately, although not all patients were given the opportunity to self-medicate, if appropriate for them to do so.

Admissions and discharges were well managed although some discharges were delayed due to difficulties in organising ongoing care.

Summary of findings

Background to the service

Guy's and St Thomas' NHS Foundation Trust provided community inpatient services for the population of the London boroughs of Lambeth and Southwark. Patients were admitted from several acute hospitals and sometimes from the own home to prevent hospital admissions. There were two rehabilitation wards and a continuing care unit providing a total of 60 inpatient beds in the community.

Pulross Intermediate Care Centre was situated in Brixton and provided general rehabilitation for patients following falls, fractures, infection and some neurological conditions. Most patients admitted there were elderly however, the ward also provided rehabilitation for younger adults. During our visit at Pulross Intermediate Care Centre, we spoke with five patients, eight staff and reviewed five patient records. The unit was full on the day we visited.

The Amputee rehabilitation Unit was situated on the first floor of Lambeth Community Care Centre and provided 12 beds for specialist rehabilitation following limb amputation. Staff on the unit cared for patients over 18 years of age. We spoke with four patients, seven staff and reviewed four patient records during our visit. There were 10 patients on the unit on the day we visited, with one admission planned for later that day.

Minnie Kidd house is a 28 bedded specialist unit providing nursing care for patients meeting the continuing care criteria. Patients at Minnie Kidd house were mainly elderly although staff cared for younger adults. All patients had complex nursing needs including patients who had long term tracheostomies. We spoke with 3 patients, 1 relative and reviewed 5 sets of patient records. There were 26 patients on the unit on the day we visited, with one new admission planned for that day.

Our inspection team

Our inspection team was led by

Chair: Ellen Armistead Deputy Chief Inspector Care Quality Commission

Team Leader: Margaret McGlynn Interim Head of Hospital Inspection Care Quality Commission

The team inspecting this core service included an inspector and a specialist advisor.

Why we carried out this inspection

This was a scheduled comprehensive trust inspection.

How we carried out this inspection

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

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 the 8, 9 and 10 September 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We spoke with 12 people who use services and 20 members of staff. We also spoke to two relatives and received 10 comments cards. We observed how patients were being cared for and reviewed nine care or treatment records of patients who used the services.

Summary of findings

What people who use the provider say

Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered.

The Friends and Family Test was completed by patients and comments and suggestions were welcomed by the

team. Comment cards were displayed on the ward notice board and all were very positive. We received a number of comment cards from patients and their relatives in the run up to the inspection and comments received were overwhelmingly positive.

Good practice

- Amputee Rehabilitation Unit had a robust multidisciplinary action plan to address the high risks of falls in this patient group and reduce the number of falls on the unit.
- Patients on the Amputee Rehabilitation Unit had access to acupuncture as part of their pain management plans. Patients were complimentary about this service and felt that their pain was better managed as a result of the acupuncture service.
- The Amputee Rehabilitation unit was one of only two units in England to offer open wound prosthetic rehabilitation.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The trust should explore ways to allow patients, who are assessed as able, to self-medicate at Pulross Intermediate Care Centre.
- The trust should ensure patients at Minnie Kidd House have access to specialist seating assessment.
- The trust should ensure that all staff are up to date with their mandatory training.
- The trust should standardise record keeping so that staff can have access to the full MDT documentation in chronological order.

Guy's and St Thomas' NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

There was a proactive culture of safety and incident reporting across the community inpatient units. Safety performance was good, with very low rates of hospital acquired pressure ulcers. The risk of patient falls had been identified as high and we saw evidence of action plans put in place to reduce the number of falls with good effect.

We found staff knew their responsibilities in reporting incidents, they received feedback and were able to describe changes in practice as a result of incident investigations. Arrangements were in place to ensure staffing numbers and skill mix was appropriate to support the delivery of patient care safely.

The environment was fit for purpose and we observed good infection prevention and control practice. Medicines were managed effectively, although not all patients were given the opportunity to self-medicate as part of their rehabilitation.

Records we reviewed were comprehensive, clear and legible. We observed medical and nursing staff used paper

records and Allied Health Professionals used an electronic system. This could potentially lead to important information not being readily accessible to the whole of the team supporting the patient.

Safety performance

- The community inpatient units of Guy's and St Thomas' NHS Foundation Trust participated in the NHS Safety Thermometer scheme used to collect local data on specific measures relating to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area. There was a strong focus on patient safety led by the ward managers in the three units. Staff we spoke with, including allied health professionals (AHP), were clear in their roles in maintaining this.
- The data we saw for the period from April 2015 to August 2015 indicated that there had been no hospital acquired pressure ulcers or catheter urinary tract infection on the inpatient units. The incident data we reviewed was for the adult community directorate but incidents reported for the inpatient units were related to medication errors,

Are services safe?

pressure ulcers patients were admitted but mainly patient falls. However the number of incidents relating to falls had decreased from 19 to 11 when compared to the same period last year. The number of falls on the Amputee Rehabilitation Unit (ARU) was higher due to the nature of the rehabilitation taking place and the nursing and AHP leads we spoke with told us of the on going work to continue to reduce falls on that unit.

- The information on harm free care was clearly displayed at the entrance of each unit along with the expected and actual staffing levels for that day. On the days of our announced inspection we observed that the three units had the required number of nursing staff on duty.
- There had been no healthcare acquired infections reported in the previous year and no serious incidents.
- There had been no Never Events reported. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Incident reporting, learning and improvement

- Incidents were reported using an electronic system and staff at all the locations told us that they were encouraged to report incidents and near misses and were able to describe incidents they had reported and their outcomes.
- Staff told us that feedback from incidents was discussed at the monthly staff meeting. Incidents resulting in urgent changes to policy or practice were discussed at the daily handover meetings. We saw evidence of shared learning from incidents in the staff meeting minutes, which was emailed to staff and a paper copy made available in the staff room. At Minnie Kidd House, the manager also held reflective sessions with staff following incidents to allow for a team discussion and shared learning.
- Monthly clinical governance meeting took place at each of the locations. These were regularly attended by the nursing and AHP leads and a social worker and pharmacist attended when able. Incidents were discussed at those meetings and the learning from these incidents was shared across the inpatient units and across the multidisciplinary teams (MDT). Learning from serious incidents from other locations in the trust was shared via email and as part of the weekly message from the chief nurse.

Duty of Candour

- Staff we spoke with were able to demonstrate knowledge on the duty of candour and had a clear understanding of their responsibility. We were told at every location we inspected that the trust required all staff to display open, honest and transparent behaviour and to communicate with patients and families if an incident occurred and involved them.

Safeguarding

- Nurses we spoke to were able to explain their understanding of safeguarding and the principles behind safeguarding adults and children. They were clear about the escalation process and were able to access the safeguarding team for advice and guidance. This understanding was more developed for more senior staff we spoke to and some junior and unqualified staff had an understanding of safeguarding principles but said they would ask senior staff for advice before reporting.
- All clinical staff were required to complete level 2 adult safeguarding training and the trust had a target of 95% compliance with adult safeguarding training. Data provided to us indicated that nursing and midwifery registered staff had achieved a rate of 97% and 81% of AHPs had completed the safeguarding training in the adult community staff group.

Medicines

- Medicines were stored safely and appropriately on the three inpatient units we visited, including items which needed to be stored in refrigerated conditions. Temperature checks had been carried out on drug fridges and recorded daily, indicating that the fridges were maintained at the correct temperature.
- On admission to the inpatient units, patient's medications were transcribed onto a medicine administration record (MAR) in line with the trust policy. We noted that the majority of reported medication errors had been as a result of transcribing; the unit manager informed us that measures had been taken to minimise such errors. Nurses wore a red apron to minimise disruptions while transcribing and a second transcribing check was carried out by the senior nurse on duty. The nurses were also undergoing competency based sign off for transcribing by the ward pharmacist.

Are services safe?

- A pharmacist was allocated to cover the three units and undertook clinical checks, countersigned transcription checks and arranged supply of medicines for discharge.
- We observed a nurse giving medicines in a safe and caring manner and accurate records were made at the time of administration, including omitted doses and reason for omission.
- At Minnie Kidd house the nurses told us that the drug round could take over two hours as most patient had complex needs and a large proportion of patients needed their medication administered through a percutaneous endoscopic gastrostomy(PEG)) tube. This meant that the nurses were unable to assist the nursing assistants with other duties during that time.
- At Pulross Intermediate Care Centre, we observed that one patient was having supplementary oxygen and although the nurse looking after this patient was able to describe the reason the patient required oxygen, the oxygen had not been recorded on the MAR sheet and there was no signage in the room to indicate flammable risk. We highlighted the issue to the ward manager, who assured us he would investigate and rectify these as a matter of urgency.
- All medications for patients at Minnie Kidd House was supplied by hospital pharmacy as patients were under the care of hospital consultants. However patients at Pulross Intermediate Care unit were under the care of a GP who prescribed most of the medications and this was supplied by local pharmacies. We saw that prescription pads were kept in locked cupboards but their serial numbers were not recorded in line with current guidance.
- At the Amputee Rehabilitation Unit, patients were able to self-medicate as part of their rehabilitation and preparation for home following an assessment with a nurse. However self-medicating was not available to patients at Pulross Intermediate Care Centre. Although many patients were discharged with some kind of support, this was not always the case. Patients were encouraged to increase their independence in other ways but not with medicines. This could be a risk to their health when they were discharged if they did not have the skills to manage their own medicines.

Environment and equipment

- We saw resuscitation equipment readily available in all the units, with security tabs present on each. Systems

were in place to check equipment daily to ensure it was ready for use. Records showed that equipment had been checked daily in line with the trust policy. At Minnie Kidd House, suction equipment was also checked daily. The manager informed us that the unit only had four suction machines however they were able to obtain additional suction machines through the trust's equipment library if required.

- Equipment stores were well organised, well-stocked and clean and dirty equipment was segregated appropriately. A wide range of appropriate therapy and mobility equipment was in use and was clean and in good condition. Staff at Minnie Kidd house told us they would like to have a standing hoist in order to meet the needs of individual patients.
- The environment on each unit was bright and airy and patients were able to access the dining room for their meals. Gardens and outdoor space was available at each unit and patients were encouraged to make full use of these when the weather permitted.
- Staff and patients told us the bathroom and toilets on the Amputee Rehabilitation Unit or ARU were small and cramped and patients often found it difficult to manoeuvre their wheelchairs. The bathrooms also had automatic door, with delayed closure. The delayed closure could compromise patient's privacy and dignity however staff were using portable screens to prevent this from occurring. Staff also told us that the bathroom did not meet the needs of bariatric patients but they carried out individual risk assessment and took steps to mitigate risks. We saw in the records we reviewed and patients told us they received a bathroom assessment on admission and the therapy staff assigned each patient a bathroom that best met their needs.

Quality of Records

- Patient records were stored securely in locked rooms on each ward and nursing notes were kept at each patient's bedside. Records had symbols at the front to highlight whether a patient was at high risk of falling and/or was living with dementia.
- We reviewed 14 completed set of records (five at Pulross Intermediate Care Unit, 4 at the Amputee Rehabilitation Unit and five at Minnie Kidd House) and found evidence of comprehensive risk assessments such as risk of falls, pressure areas, nutrition and use of bed rails. These were reviewed and updated regularly by the multidisciplinary team.

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- Patients had individual care plans and we saw evidence of the patient and their family being involved in the care planning. The green fundamental care stickers, devised by and used across the trust, were used to record daily personal care activities and level of assistance required. We also noted completed falls prevention pathway, with clear action plan and evidence of regular reviews.
- There was some inconsistency in where documentation relating to care was recorded. The medical and nursing team used paper based records but the therapy team were using an electronic system across all three sites. This could potentially lead to some important information not being available to the whole MDT. At the ARU, the therapist documented a summary of therapy progress in the paper based records twice weekly to keep other members of the MDT up to date.

Cleanliness, infection control and hygiene

- There were dedicated staff for cleaning ward areas and they were supplied with and used nationally recognised colour-coded cleaning equipment. The units we visited were clean and all the patients we spoke with were satisfied with the cleanliness. There were cleaning schedules in place and at the Amputee Rehabilitation Unit; this was clearly displayed on bathroom doors.
- We looked at the equipment used on the units, including commodes and bedpans, and found them to be clean. Labels indicated when they had been cleaned and by whom.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required.
- We observed staff complying with infection control policy; being bare below the elbow and washing their hands. Posters displaying correct hand washing techniques were available over the sink area.
- Alcohol sanitising gel were available at the units' entrances and was mounted at each patient bedside. Monthly hand hygiene audits were carried out by the infection control link nurses on each unit and the audit results showed 100% compliance for Pulross Intermediate care centre and Minnie Kidd House for the period of April to August 2015. The Amputee Rehabilitation Unit had only submitted data for June and July 2015 and compliance was 99% and 100% respectively for these months.

- There were a small number of single rooms with en-suite toileting and showering facilities at Pulross Intermediate Care Centre and the Amputee Rehabilitation Unit. These were used for patients requiring isolation precautions and signage reminding staff and visitors of infection control precautions was displayed on the doors of these rooms. These signs were removed when used for patients not requiring isolation precautions.

Mandatory training

- Staff told us that mandatory training was booked by the unit managers in order to ensure safe staffing levels at all times. Most staff we spoke with were aware of the training they had completed and were able to identify the sessions that were outstanding.
- The target set by the trust for mandatory training completion was 95%. Staff working in the community inpatient units had achieved this target for some training such as Equality and Diversity and Manual Handling. However this target had not been achieved for other courses such as IPC which was 51.9% for Minnie Kidd House according to data supplied by the trust.
- We looked at the training folders on each of the inpatient units and noted a report dated September 2015 at Minnie Kidd House indicated that only 17 out of 30 staff members were up to date with their mandatory training. Most of the training were out of date by a few months and the manager was aware of this and told us some staff had already been booked on their training.

Assessing and responding to patient risk

- The use of the National Early Warning Score (NEWS) was well implemented across the community inpatient units and staff we spoke with could clearly describe the escalation process in the event of deterioration in a patient. Staff were able to access a senior nurse on call for advice if required as well as the site nurse practitioners at St Thomas' site. We saw evidence of completed NEWS in the records we reviewed.
- Patient falls had been identified as a significant risk across the inpatient units and we saw evidence of comprehensive assessments and action plans in place to reduce falls. At Pulross Intermediate Care Centre, the patients were assessed by the therapy team within 12 hours of admission and a mobility chart was devised to guide the rest of the MDT in the safe transfers and mobility of each patient. Clear colour coded stickers and

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wrist bands were used to indicate a patient's risks of falling. At the Amputee Rehabilitation unit, posters were displayed at each patient bedside and in the bathrooms and toilets to remind patients of the steps they should take to reduce the risk of falls, such as having appropriate footwear and applying the brakes on their wheelchair.

- MDT handover sheets were used which included patient allergies, resuscitation status, moving and handling requirements, diet and fluids, nursing needs and MDT plan. At Pulross Intermediate Care Centre and the Amputee Rehabilitation unit, the nurse in charge ran a 'board round' in the morning with the therapy team. This kept the MDT up to date with events of the night before and reviewed patients' progress and discharge plans.

Staffing levels and caseload

- The vacancy rate for nursing staff across the inpatient units was 21.7% for the period of April to July 2015. The managers told us that the trust had successfully recruited additional nurses recently so they were optimistic that the vacancy rates would improve, once these nurses were in post. There were no vacancy for therapy staff at Pulross Intermediate Care Centre and the Amputee Rehabilitation Unit had a vacancy of rate of 1.6% for the last year.
- Nursing bank and agency usage for the period of April to July 2015 was 11.9%. Bank and agency staff were used mainly to escort patients to their appointments and to provide one to one care when patients had been assessed as requiring this level of support.
- The sickness rate for the inpatient units was 4.2% for the period of April to July 2015, above the target of 3% set by the directorate. Senior managers told us the higher sickness rate was due to some long term sickness and sickness was managed in line with the trust policy.
- We saw evidence that all agency staff underwent a structured induction to the trust and to the units they were allocated. Senior nurses told us that the same agency and bank staff were used where possible, which helped with continuity of care for patients.
- The use of acuity or dependency tools was not standard across the units. The nursing leads monitored the caseload and were able to obtain additional staff to ensure patient safety by putting in a request to the

deputy director of nursing. They gave us examples of this happening, such as when patients were identified as needing one to one supervision due to their high risks of falls.

- On the days of our announced inspections, we found that all the units were staffed as planned. We reviewed the rota and found that this was the case almost daily, with some rare occasions where a unit had one staff member less than planned. The unit managers were supernumerary and they were available to support the team clinically.
- The medical and therapy staffing was organised differently across the three sites:

Pulross Intermediate Care Unit:

- On admission to the unit, all patients were temporarily registered with a local GP practice and remained under the care of that doctor throughout their stay on the unit. The manager informed us they were able to get repeat prescriptions from the surgery and the GP visited patients at the unit when required, although this was not often. Out of hours cover was provided by the local out of hours GP service.
- Additional medical cover was provided by medical consultants from St Thomas' hospital site, who were present on the unit twice weekly. They carried out a full ward round on Tuesdays and also attended the MDT meetings on Thursdays. The consultants were able to review patients as required after the meeting.
- Staff we spoke with felt that their caseload was manageable although most patients had reduced mobility, were at risks of falls and often needed assistance of two people to transfer. The therapy staff commented on the length of time it took for patients to have their personal care completed, hence therapy sessions sometimes had to move from the planned time to make allowances for this.
- The therapy staff on the unit worked over seven days and also integrate with the community therapy team, whereby staff from the unit worked one day a week as part of the community rehabilitation team seeing patients in their own home. Staff commented that this was a good learning experience and enabled them to follow patients after their discharge from the unit

Amputee Rehabilitation Unit:

- Medical cover was provided by a consultant from St Thomas' hospital who carried out a ward round on

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Mondays and Fridays. The consultant also attended the ward MDT meeting on Wednesdays and any new referrals were triaged and discussed after this meeting. Telephone advice was available on the days that the consultant did not visit the unit.

- Therapy was provided by a team of seven, which included physiotherapist, occupational therapist and rehabilitation assistants, led by a clinical lead physiotherapist. Therapy staff told us they were able to provide the rehabilitation required, patients had two to three sessions a day with their current staffing arrangements. Therapy services are delivered over six days with the nursing staff continuing with rehabilitation plans on Sundays.

Minnie Kidd House:

- The unit had two vacancies, one for a qualified nurse and the other for a nursing assistant. The manager reported that the current staffing level was three nurses and seven nursing assistants for the day shift and two nurses and four nursing assistants for the night shift. The manager and staff felt that an extra nurse was required for the day shift to allow for more clinical supervision and joint sessions with the nursing assistants. However there were no safety issues identified with the current staffing levels.
- Medical cover was provided by the acute trust medical consultants, who carried out a ward round three times a week. Telephone advice was available on the other days and out of hours cover was through the on-call medical team at St Thomas' Hospital.

Managing anticipated risks

- Patients admitted to the inpatient units were considered to be at high risk of developing pressure ulcers due to their decreased levels of mobility. Pressure ulcer risk assessments were completed on admission and appropriate pressure relieving equipment was readily available. We saw evidence of completed positioning charts for patients and the tissue viability nurse visited the units weekly to provide additional guidance.
- Pulross Intermediate Care Centre accepted patients from the community in order to prevent hospital admissions for patients who were not managing at home. The manager informed us that patients had to be seen by their GP and declared medically fit prior to being accepted. This is because the unit was unable to care for medically unwell patients.

Major incident awareness and training

- Major incident and fire escalation plans were in place and available on the units. These were incorporated into local induction and orientation information for all new staff including agency staff. Staff we spoke with told us that fire drills were carried out yearly however they did not practice dealing with a medical emergency, such as cardiac arrests.

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 found positive examples of evidence-based practice being utilised throughout the hospitals. We also saw how outcome monitoring, national, and local audit data was influencing practice.

Multidisciplinary working was embedded and staff worked together to help patients achieve their goals. There was good collaborative working with other teams from the acute hospital site and community. Admission and discharges were generally well planned although there were still a significant number of delayed discharges attributed to delays in organising ongoing care.

Medical records provided evidence that nutrition, hydration and pain relief were managed effectively and patients we spoke with confirmed this. Patients who required assistance with eating and drinking were supported well.

The induction programme prepared new staff for working in the specific units. Staff received performance appraisal and gave examples of training and development as a result of their appraisal

Evidence based care and treatment

- Policies were evidence based and in line with national guidance for falls, NICE CG161 and pressure ulcer management, NICE CG29 . The trust also participated in the National Audit of Intermediate Care and therapists provided rehabilitation in line with guidelines from relevant professional bodies.
- At the Amputee Rehabilitation Unit, a comprehensive audit of falls had been undertaken and the main reasons for falls were identified as: lack of suitable footwear, decreased falls awareness and falls during transfers, especially in bathrooms. The action plan introduced as a result comprised of all patients receiving a 'Falls' booklet and a therapy assessment of their transfer ability on the day of admission. Patients were also allocated a specific toilet/bathroom on the unit, with equipment in situ to meet their needs. The therapy staff also provided patients with suitable footwear, when appropriate. More frequent falls groups had been introduced to further educate patients on the

risk of falls and steps they could take to minimise those risks. The action plan had helped to reduce the number of falls on the unit and re-audits were ongoing to monitor adherence to original action plans and identify any new trends in the reasons for falls. The therapist at the Amputee Rehabilitation Unit audited their service provision against guidelines from the British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR), such as number of patients being given information on how to get off the floor, in the event of a fall

- Audits were measured at a local level and fed up the organisation through the monthly governance meetings at each unit. An audit of medication errors showed that the majority of errors happened during transcribing. As a result, measures such as senior staff checking all transcribed MAR sheets and transcribing competencies had been introduced. Staff we spoke with told us that audit results were shared and acted on to improve the service. Staff gave the example of the falls audit findings and how changes had been implemented to reduce falls as a result

Pain relief

- Pain was assessed as part of the two-hourly patient checks performed on all the inpatient units. We saw evidence of staff administering additional pain relief to patients prior to therapy sessions. Therapy staff and patients told us this allowed for better participation and hence patients were able to achieve their rehabilitation goals.
- At the Amputee Rehabilitation Unit, staff were aware to monitor for phantom limb pain and patients also had access to non-pharmacological pain relief in the form of acupuncture to further control their pain.
- Patients we spoke with on the units reported that their pain was being adequately managed and staff administered additional pain relief if they expressed any pain.

Nutrition and hydration

- The nutritional needs of each patient was assessed on admission and a referral to a dietician was initiated if



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necessary. All patients were weighed weekly to ensure that their nutritional needs were being met and those who required assistance with feeding were clearly identified. All patients had easy access to drinks by their bedside and at the dining tables during mealtimes. Patients told us that snacks were also available between meals on request.

- Special dietary requirements were catered for, although a patient who was vegetarian reported that there was limited choice. Friends and family were able to bring in food that patients liked and staff encouraged this especially if the patient was at risk on the nutritional assessments. Patients at risk were also prescribed 'build up' drinks by the dietician.
- At the Amputee Rehabilitation Unit and Pulross Intermediate Care Centre, all patients had their meals together in the dining room and staff were on hand to assist as required.
- The trust recently underwent a Patient Led Assessment of the Care Environment (PLACE) and the community inpatients units scored over 98% for the food provided.
- At Minnie Kidd House, nine out of the 28 patients were receiving enteral nutrition through a PEG tube.

Patient outcomes

- Patients and their family were involved in their rehabilitation, goal setting and discharge planning at the time of their admission to the Amputee Rehabilitation Unit and Pulross Intermediate Care Centre. Discharge dates were set and agreed as a goal; and individual needs and rates of recovery were considered at multidisciplinary meetings.
- The therapy teams used a range of recognised outcome measures such as the Goal Attainment Score (GAS), Timed up and go (TUG), and the 2 Minute Walk Test (2MWT) to monitor progress made during rehabilitation. Patients at the Amputee Rehabilitation Unit has achieved a TUG of 20 seconds faster when compared to patients receiving non specialist rehabilitation on the old pathway and the 2MWT of 60 metres compared to 35 metres. The Montreal Cognitive assessment (MoCA) test was also used to determine level of cognitive impairment and rehabilitation sessions were then tailored to meet the needs of individual patients. We saw results of audits which showed patients were making good progress against these outcomes.

- At Minnie Kidd House, staff informed us that a multidisciplinary review was undertaken to review care plans and the patients and their family were present at those meeting so their views could be taken into account. We saw evidence of these meetings in the records we looked at.
- The trust used a score card to monitor performance against a range of trust-wide targets. Targets included hospital acquired infections, falls and nutrition assessment, medication errors and acquired pressure ulcers. These scorecards were used across the inpatient wards and were not specific to the inpatient rehabilitation units.

Competent staff

- The appraisal rate for community adults were 64% for nursing and 74% for AHPs. Staff we spoke with on the inpatient units told us they had an appraisal in the last year and they were able to discuss any training needs with the manager. When a training need was identified they were supported by the manager to attend relevant courses to further their development.
- Therapy staff had structured weekly in-service training sessions. These sessions were often multidisciplinary and various healthcare professional such as 'prosthetist' delivered specialist training on a regular basis.
- Therapy staff were supported to attend external training and conferences such as the BACPAR conference. Senior therapy staff told us about audits or research projects they had presented at conferences such as this.
- All staff had received full trust induction and local induction, this included information about and emergency procedures for each site.
- Staff at Pulross Intermediate Care Centre were very proud of the fact that a few of the nurses had recently completed their mentorship training. This meant the unit was now able to take more nursing students on placement.
- Link nurses were available on the units for infection prevention and control, safeguarding, tissue viability, falls and were able to further support colleagues in these areas.
- Staff at Minnie Kidd House received additional training on managing patients with tracheostomies from specialist teams at St Thomas' hospital and some of the nursing assistants had undergone competency based training on suctioning tracheostomies.

Are services effective?

Multi-disciplinary working and coordinated care pathways

- The teams at Pulross Intermediate Care Centre and Amputee Rehabilitation Unit included registered nurses and nursing assistants, physiotherapists, occupational therapists and therapy assistants. Medical consultant from St Thomas' site, a social worker, pharmacist and the tissue viability nurse also visited the units on specific days. Community dieticians and speech and language therapists made visits to the wards according to patient needs. At Minnie Kidd House, the team consisted of nurses and nursing assistant with community therapist, dietician and other specialist input from St Thomas' Hospital with visiting when required.
- Prosthetist and therapist joined the vascular ward round at St Thomas' hospital so patient could be identified early on in their care pathway.
- Multidisciplinary meetings took place once a week and involved the ward manager, physiotherapist, occupational therapist, medical consultants and the social worker. The pharmacist attended these meetings when able. MDT meetings were used to discuss patient progress, review discharge plans and ensure ongoing support would be in place on discharge.
- All new referrals to the Amputee Rehabilitation Unit and Minnie Kidd House were screened and discussed with the MDT. At Pulross Intermediate Care Centre, the admissions coordinator screened and processed all new referrals and involved the rest of the MDT in more complex cases.
- The weekly ward round from the tissue viability nurse on the Amputee Rehabilitation Unit was joined by the lead therapist as wound management was key to prosthetic rehabilitation. The prothesist also carried out joint sessions with the physiotherapist when patients were being fitted with their prosthetic leg for the first time.
- At Pulross Intermediate Care Unit, we observed a group exercise session run jointly by therapist and nursing assistants. We also observed a therapist carrying out a joint session with the nursing staff to transfer a patient out of bed. Staff told us that these sessions happened often for staff training or to review patient's progress.
- Nursing staff told us the mobility chart produced by therapists were helpful when transferring or mobilising

patients. They were confident to discuss any difficulties experienced with the therapy staff or suggest changes to the mobility chart if they felt that the patient was improving.

- At Minnie Kidd House, patients were assisted to sit out of bed. We noticed that although staff had access to different types of chairs the patients did not receive a specialist seating assessment and the nursing staff chose chairs that they felt was suitable. Although the patients we observed sitting out were safe, a specialist seating assessment would ensure that individual needs regarding posture, muscle length and comfort would be catered for.

Referral, transfer, discharge and transition

- Staff reported that discharges were well planned and the patients and their family were kept fully informed at all times. Patients and relatives we spoke with during the inspection confirmed this. Delayed discharges happened regularly. They were due mainly to difficulties in obtaining the right package of care or arranging alterations or adaptations to patients' homes. The team worked closely with the social worker and the local authorities to minimise those delays but due to the complex care packages required, this was not always possible.
- The therapy team worked closely with the community therapist to ensure the patients received ongoing rehabilitation in their own home, when this was indicated. The ward and community therapy team at Pulross Intermediate Care Centre worked from the same location and the ward therapist also carried out community visits one day a week, which allowed for close working relationship and seamless care for patients. Patients discharged from the Amputee Rehabilitation unit were followed up as outpatient at another centre, Bowley Close, and physiotherapists rotated between the two sites. For patients who lived further afield, ongoing therapy was provided by their local community therapy teams and patients attended regular reviews with the physiotherapist and prothetist at Bowley Close.
- Approximately two discharges at the Amputee Rehabilitation Unit were planned each week and the staff liaised with the acute trust to plan admissions and ensure the unit was used to its full capacity. The average length of stay at the unit was seven weeks, however staff

Are services effective?

said that patients would only be discharged once their goals had been achieved, hence discharge dates were brought forward or pushed back depending on each patient's progress.

- The average length of stay for Pulross Intermediate Care Centre for the period of January to July 2015 was 35 days. We noticed during our visit that nine out of the 20 patients were delayed discharges due to reasons such as equipment delays and delays in care packages being set up. Some staff we spoke with at the Pulross Intermediate Care Centre felt that the admission criteria needed to be reviewed as a large number of patients did not progress and required assistance of two carers on discharge. We requested details of how the unit was monitoring the delayed discharges and the plans to address this issue but did not receive this information.
- At Minnie Kidd house, once the referral had been screened by the MDT, a specialist nurse went to assess the patient at the referring trust and then coordinated the admission once a bed was available. For Pulross Intermediate care centre, the admissions coordinator liaised with the referring trust to coordinate admissions.
- The waiting list and discharge dates were regularly reviewed to ensure that each unit was making best use of the available beds.

Access to information

- The intranet was available to all staff and contained links to current guidelines, policies, procedures and standard operating procedures and contact details for colleagues within and out of the organisation. This meant that staff could access advice and guidance easily.

- Staff also received regular newsletters and Chief Nurse messages which included medicine alerts and details of new NICE guidelines.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Senior nursing staff and therapists told us they were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and when a patient would need a Mental Capacity assessment in relation to certain decisions. More junior staff who were not so confident in their understanding of MCA 2005 told us they would seek advice from senior colleagues.
- At Pulross Intermediate Care Centre and the Amputee Rehabilitation Unit, patients agreed to rehabilitation as part of the admission criteria and verbal consent was sought prior to any interventions. However, we noticed that the section on consent had not been completed in all therapy electronic records we reviewed during the inspection. Therapy staff explained that consent was recorded as part of each session rather than consent to therapy as a whole.
- Nursing, therapy and medical staff undertook Mental Capacity Act 2005 training via e-learning as part of the mandatory training schedule.
- The manager at Minnie Kidd House described how they supported a patient with uncontrolled diabetes to go out. The patient had been assessed as having capacity to make this decision and therefore there was no attempt to stop them from leaving. However staff made arrangements to ensure their safety such as arranging for a taxi and informing them of when they needed to return for their insulin. The capacity assessment for this patient was clearly documented in his records.

Are services caring?

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

Summary

The inpatient units were calm and bright and patients told us they were happy there. Feedback given by patients, carers and relatives was continually positive, although some patients told us certain members of staff expressed their religious view too openly. We observed staff being friendly towards patients, and treating them and visitors with understanding and patience. There were some concerns expressed about difficulty in understanding certain members of staff

Patients told us that they were usually involved in decisions about their care, and were kept up to date with their progress. Care offered by staff was kind and compassionate and promoted people's independence, privacy and dignity.

Emotional support was provided by staff during their interaction with patients and in some units through a counselling service. There was a chaplaincy service available to all patients if they required it.

Compassionate care

- Patients told us that they were treated with dignity and respect by all members of the hospital team. We observed patients being addressed by their preferred name, staff knocking on doors before entering, and curtains being pulled around beds before treatment or private conversations taking place.
- We received positive feedback from patients we spoke with and we also received a large number of comments cards from the three units, which were all overwhelmingly positive. Patients commented on how 'staff went out of their way to help' and 'everyone here has time to speak to you and they treat you like family.' They gave an example where staff had organised a card to be signed by other patients and ordered a cake to celebrate a patient's birthday.
- The response rate from the Friend and Family Test (FFT) was 60% for Pulross intermediate care unit for the period of February 2015 to July 2015, with an average of 80% saying that they would recommend this service. The response rate for the Amputee Rehabilitation Unit was lower at 50% but 100 % said they would recommend the service.

- A patient at the Amputee Rehabilitation Unit told us how therapy staff made a video of their therapy sessions so they could share their progress with their family. The patient also told us that the unit 'gives you faith in the NHS again' and 'I would give it 10 out of 10'.
- However patients told us some members of staff, at the Amputee Rehabilitation Unit, were a bit too outspoken about their religious beliefs and this could upset certain patients. Three out of the 10 patients on the unit told us of this and the patients had also spoken to each other and were planning on informing the ward manager. We also highlighted this to the manager and she assured us she would investigate further and take the appropriate action.
- Relatives told us about how staff offered them a hot drink and towel to dry themselves when they arrived on the ward on a rainy day. Relatives we spoke with explained that there was always someone available to answer questions and update them on their family member's progress.
- At Minnie Kidd House, we observed kind and caring interaction between patients living with dementia and the nursing staff. The staff spoke to patients in a calm and reassuring manner and explained what medication was being administered.
- We observed an exercise class at Pulross Intermediate Care Centre and positive interactions between staff and patients. The exercises were adapted for each patient so everyone could participate and we observed staff laughing and joking with the patients.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us their care plans had been discussed with them and they were aware of the goals set with the therapy team. Patients and their families were kept informed of their progress and any changes in their discharge plans.
- The units displayed visiting times however, this was flexible and by prior agreement patient's visitors could attend therapy sessions to see their progress. Visitors were able to take their relatives out in a wheelchair and make full use of the gardens.

Are services caring?

- The noticeboard at each patient's bedside detailed their named nurse and therapist so patients and their relatives knew who to approach for information
- Cards with the ward contact details and the name of the manager were available at the reception at Pulross Intermediate Care Centre so relatives could telephone the ward directly to enquire about their relatives when unable to visit.
- At Pulross Intermediate Care Unit, we saw how staff encouraged a family member to come and assist with personal care tasks as the patient was often distressed when staff were attending to them. Having the family member present calmed the patient but also allowed the family member to prepare themselves as they were due to care for their relative on discharge.
- At the Amputee Rehabilitation unit, staff took into account the activities and occupations that patients were aspiring to return to. These goals were discussed and therapy sessions were tailored to give patients a realistic chance of achieving them. Patients were taken out on trips, to local shops and some museums, so they could familiarise themselves with using a wheelchair or a prosthetic leg to access different areas. Patients were encouraged to go on trips with their family members, once assessed as safe to do so.
- We saw that comments cards were readily available on all the units and staff were available during visiting hours to answer questions from friends and family.

Emotional support

- Patients at the Amputee Rehabilitation Unit had access to counselling services twice a week and staff told us that all patients were initially referred and on going sessions were then tailored to meet individual patient needs. Patients we spoke with found these sessions beneficial. Patients were offered a 'buddy'. Buddies were patients who had been at the unit previously and therefore able to support new patients going through a similar experience.
- A chaplaincy services was available to patients and arrangements were made to arrange visits for different faiths.
- The unit managers were available to speak to relatives and at Minnie Kidd House, a meeting was held every three months as patients were often there for life.
- At the Amputee Rehabilitation unit, posters were displayed to provide information on activities and support available from the Limbless Association.
- A relative told us how staff were always asking how they were. Staff were keen to hear how they were coping with the travelling to visit their spouse. The relative felt that they really cared and on days that they were unable to visit, staff would ensure that their spouse knew that they had called and was well.

Are services responsive to people's needs?

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

Summary

The service was planned and delivered to meet people's individual needs and there were good procedures in place to manage patient flow at each unit. The admission criteria were clear for the Amputee Rehabilitation Unit and Minnie Kidd House and ensured that only patients whose needs could be met at the units were accepted. Patients received timely assessments and care plans were individualised to meet the needs of each patient. We saw evidence that staff were trained in caring for people living with dementia and activities were adapted to ensure patients with cognitive impairment could participate fully.

The range of activities available for patients varied between units and the art therapist post at Minnie Kidd House had been vacant for the last year. The unit managers informed us there were plans in place to explore the use of volunteers to provide additional social activities for patients.

Complaints or concerns were usually investigated and resolved at local level and the service received very few written complaints.

Planning and delivering services which meet people's needs

- The Amputee Rehabilitation Unit was set up two years ago as the trust and local commissioners had identified a gap in the provision of intensive rehabilitation to lower limb amputees. Patients were referred from local acute trusts and sometimes from further afield with funding approved by the patient's local Clinical Commissioning Groups (CCG).
- The services at Pulross Intermediate Care Centre and Minnie Kidd house were currently under review by commissioners. The nursing and therapy leads we spoke with explained that the review was looking at how some beds at Pulross Intermediate Care Centre could be used for more specialist neurological rehabilitation. The unit currently had 20 beds for general rehabilitation but the plan was to carry out more general rehabilitation in the patient's own home by making full use of the various

community therapy services available in the trust. At Minnie Kidd House, there was a proposal to accept referrals from other local authorities to make the service more sustainable.

- There was a range of activities available at the Amputee rehabilitation unit aimed at increasing patient's independence and improving their quality of life during their stay. Patients participated in breakfast clubs run by the therapy team and were able to go for trips with the staff. Staff had set up movie nights and at the weekend volunteers from a local community group carried out activities such as singing, afternoon tea and games.
- Each unit provided patients with an information pack on admissions which detailed the philosophy of the unit, visiting times, mealtimes and what to expect during their stay. It also provided information on how to raise concerns.
- Some patients on the unit had been seen by the community therapy team and a mobility chart and exercises programme put in place for nursing staff to follow. However we saw that a patient who had been on the unit for a few months was still awaiting a physiotherapy assessment. The manager informed us a referral had been sent and a letter received to inform her that the patient had been placed on the waiting list. We saw evidence of this in the patient's records.
- Minnie Kidd House employed an art therapist to carry out activities with patients however this role had been vacant for the last year. The manager, who had been in post for 6 months, told us she was actively trying to recruit into this post. In the interim, she had appointed a bank activity coordinator to run one session a week.
- Therapy staff at Pulross Intermediate Care Centre arranged group exercise classes and a breakfast club for patients but the unit currently did not have access to volunteers to further engage in activities with patients. The manager informed us that a volunteer was due to start soon but was currently still undergoing the relevant checks.
- On the day of our visit, we observed 8 out of 20 patients on the board at Pulross Intermediate Care Centre had been identified as delayed discharges.

Are services responsive to people's needs?

Equality and diversity

- 94% of nursing staff and 99% of therapy staff had received training on equality, diversity and human rights.
- Staff at the three inpatient units told us the trust could cater for patients who required an alternative diet due to their religious or cultural needs.
- Translation services were available and staff we spoke with were clear about how to access these services

Meeting the needs of people in vulnerable circumstances

- Staff were trained in how to care for patients living with dementia and we saw that patients with cognitive impairment were assisted with their food choices and supervised in the dining room. Staff also had access to a communication aid box for patients with complex communication needs.
- Staffing levels were adjusted and extra one-to-one care offered to patients who were at risk of falls due to their cognitive impairment.
- At the Amputee Rehabilitation Unit, lower limb amputees told us they had difficulty in using the bins provided as these were all foot operated pedal bins. Patients told us the issue had been raised with staff but they were yet to get any feedback.
- At Minnie Kidd House, we noted that care plans were in place to assist staff in dealing with a verbally abusive patient and staff's priority was the patients' safety at all times.

Access to the right care at the right time

- Patients at Pulross Intermediate Care Centre and the Amputee Rehabilitation Centre Unit had access to therapy seven days a week and six days a week respectively. A therapy assessment was undertaken within 12 hours of admission and initial goals were set.
- Staff at the units were able to take blood samples and a regular collection service was available. Patients were transferred to the acute trust for any radiological investigations.
- When patients had to attend appointments at other locations, staff arranged for transport and escorted the patients.

Learning from complaints and concerns

- Information about the complaints process was available to patients. There was guidance on how to make a formal complaint and how to contact the Patient's Advice and Liaison service (PALS). Patients we spoke with were aware of how to complain and said they were comfortable to raise any concerns should they have them. One relative told us staff responded appropriately when they raised a concern and they were very pleased with the way the concerns were dealt with.
- Managers told us that complaints were usually resolved verbally at a local level. We reviewed the complaints data provided by the trust and found there were no formal complaints received about the community inpatient units for the period July 2014 to June 2015.

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.

Summary

The Inpatient units were managed under Adult Community services and each unit had a clear vision and staff were able to verbalise future plans. There was a robust governance structure across the community inpatient services. The management team had a good oversight of the risks within the services and any mitigating plans were in place. We saw very good local leadership in all of the community inpatient units and this was reflected in the staff culture. The multidisciplinary leadership around reducing falls was excellent and led to positive outcomes.

Public engagement varied between the units although there were plans to recruit more volunteers. Staff felt connected to the acute sites and received regular communication from the trust board, although they had never received visits from board members

Service vision and strategy

- The community directorate had a clear vision and strategy which incorporated the community inpatient facilities. At location level, the managers we spoke to could tell us about the vision for their service and how they are working with staff and commissioners to constantly evaluate the service provision.
- The senior staff acknowledged delayed discharges was an issue, mostly at Pulross Intermediate Care Unit and to a lesser extent at the Amputee Rehabilitation Unit. Delayed discharges were a regular agenda item on the monthly governance meetings but senior staff were unable to describe any plans in place to tackle the issue of delayed discharges.

Governance, risk management and quality measurement

- The community directorate has a clinical governance structure and implements a quality agenda across the directorate. Quality and governance issues were discussed at the bi-monthly Adult Community Clinical Governance Committee (ACCGC), Community Clinical Effective Committee (CCEC), and Patient Safety Working

Group (PSWG). Governance also formed part of the agenda for the directorate's quarterly business meeting and the monthly adult services performance and governance meeting.

- There was a community quality and performance scorecard to report on patient safety, clinical effectiveness and patient experience and quarterly quality reports to commissioners on quality and patient safety issues.
- Monthly quality bulletins were produced and emailed to all staff. Staff we spoke with told us that the quality bulletins were also printed and available in the staff room. Important points raised in the bulletin were highlighted at the team meeting.
- The nursing and therapy leads had good oversight of the key risks to the inpatient service. They were able to identify and describe the highest risks and actions in place to mitigate these risks. 'Falls' was a regular item on the clinical governance agenda and patient safety working group.
- There was a risk register in place, and the nursing and therapy staff had identified all the key risks and there were actions in place to mitigate these risks. The risk register was reviewed as part of the clinical governance meetings and the contents of the risk register largely supported our inspection findings which showed they were aware of and monitoring the issues.
- Clinical governance issues were discussed at service and team level through monthly designated clinical governance meetings at each unit. These meetings were attended by the MDT staff groups and discussions from these meeting were fed back to staff at ward level through team meetings.

Leadership of this service

- The inpatients units was managed as part of the community adults directorate with a director of nursing overseeing the service. The deputy director of nursing for inpatient services supported the ward managers and visited the units regularly as well as attending the monthly governance meeting. The manager at Minnie Kidd house had been in post for six months, after being seconded from the Amputee Rehabilitation Unit. This

Are services well-led?

decision was taken as the director of nursing had recognised that Minnie Kidd house required some strong leadership and the new manager at the Amputee Rehabilitation Unit had worked on the unit for a while and was ready to take on one of a leadership role. The nursing and therapy staff we spoke with on the wards told us that the environment was friendly, supportive and they were confident in raising any issues with their manager.

- A nurse on rotation told us that they felt valued by the team and enjoyed working at Pulross Intermediate Care Unit and as a result had decided to apply for a permanent post there at the end of their rotation.
- A new post of clinical lead therapist had been created and appointed to at the Amputee Rehabilitation unit. The therapists we spoke with told us this new post enhanced the support they received and the overall leadership of the unit. We saw evidence of the therapy and nursing leads working together to manage the unit however both acknowledged this was an area that required further work.
- The staff we spoke with were aware of 'clinical Friday', a trust wide initiative whereby senior nurses worked clinically alongside staff on Fridays, however they told us that this had only happened on a few occasions in the community inpatient units. Staff were aware of the executive team, especially the chief nurse, but reported that the executive team had never visited the units.

Culture within this service

- Staff said they "worked as a team" and were "there for each other". They told us the culture of multidisciplinary teamwork between all levels of staff had a positive impact on the care and wellbeing of patients. Staff described the organisation as "an excellent place to work" and there was a focus on "putting the patients first".
- Staff told us that the culture across the inpatient units was open and honest and managers encouraged discussions and welcomed ideas to improve patient care. Incidents were discussed to reflect and share learning and there was a no blame culture in place.

Public engagement

- The inpatient units engaged with various organisations like 'Friends of Minnie Kidd House' and 'Friends of Lambeth Community Care Centre', where the Amputee Rehabilitation Unit was based. These voluntary organisations helped to organise social activities for patients but were not used to inform governance across the locations.
- Comment cards were displayed on ward noticeboards along with "You said, We did" actions. A trust wide group had been set up to carry out a review on noise at night and ways to improve this following feedback from patients.

Staff engagement

- The trust participated in the staff FFT survey and results of these for the period of April to June 2015 showed that 91% of staff were likely or extremely likely to recommend the trust to friends and family if they needed care or treatment. 71% would recommend the trust to friends and family as a place to work. Both of these figures were better than the national average.
- The trust engaged staff with different projects such as the 'Safe in our hands' campaign, a trust initiative to improve patient safety and the design of a 'passport' for patients with a urinary catheter.

Innovation, improvement and sustainability

- The Amputee Rehabilitation unit was one of two units in England to carry out open wound prosthetic rehabilitation. This is when patients are able to use a prosthetic leg despite their amputation wound not being completely healed. Staff on the unit had published research into the successful early rehabilitation of patient still experiencing problems with wound healing.