Your Healthcare Community Interest Company

1-328569033

Community health inpatient services

Quality Report

The Cedars Unit, Tolworth Hospital
Red Lion Road
Tel:020 8274 7051
Website:

Date of inspection visit: 15 -17 & 30 November 2016
Date of publication: 09/06/2017

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)
1-727827967	The Cedars Unit	The Cedars unit	KT6 7QU

This report describes our judgement of the quality of care provided within this core service by Your Healthcare Community Interest Company. 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 Your Healthcare Community Interest Company and these are brought together to inform our overall judgement of Your Healthcare Community Interest Company.

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
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 this service as good because:

- The admissions policy and procedure ensured that patients were suitable for the nurse-led care provided.
- Medicines were stored securely and medicine audits had been used to good effect to improve practice.
- The provision of four nurse prescribers on the unit meant that patients' pain could be relieved in a timely manner.
- Multi-disciplinary team working was embedded within the unit.
- GPs on the Unit had access to a consultant community geriatrician. This was in line with national guidance and is an example of good practice.
- People were treated with dignity and respect and relationships with staff were positive.
- There was consideration for the needs of patients living with dementia and reasonable adjustments had been made on the unit that were suitable for these individuals.
- There had been a low number of complaints and the responses provided to those received had been appropriate.
- Average waits for patients to access the unit were low.
- Staff on the unit were positive about their local leadership and the support that was provided to them.
- The risk register reflected the issues that the unit faced.

However:

- The unit had not reported deaths that had occurred on the wards as part of their statutory requirements.
- There were high nursing vacancies and a high staff sickness level. In addition there was no acuity tool used for assessing staffing levels and this meant that staffing could be stretched, resulting in delays to patient care, particularly when patients had a higher dependency.
- Although the unit collected safety information, it was not openly displayed in the ward environment and was not used as part of regular safety discussions on the wards. Levels of harm free care reported in July 2016 were extremely low at 68%.
- Although patient outcomes were collated and looked at as part of individual care, this was not used to assess the overall outcomes on the unit or look for themes or improvements.
- Walking frames were removed from some patient's beds at night, meaning that they were not being encouraged to be independent.

Summary of findings

Background to the service

The Cedars Unit is an adult community inpatient service within the community adult, health and social care services provided by Your Healthcare Community Interest Company. Cedars Unit comprises two wards (Elm Ward and Chestnut Ward) at Tolworth Hospital, Surbiton. Elm Ward is for male patients and has 15 beds and Chestnut Ward is for female patients and has 20 beds. Both wards provide sub-acute care, treatment and rehabilitation, including neurorehabilitation for adults which focused on maximising the functional, physical ability of the patient before returning home.

Admissions are open to patients over the age of 18 that are registered with a Kingston GP and are suitable for the nurse-led rehabilitation care the unit provides. In the year from April 2015 to March 2016, the unit had 337 admissions, the majority as 'step-down' care from an acute hospital and a smaller number as 'step-up' care with a referral from the community.

Our judgements were made across the two community inpatient wards. Where differences occurred we have highlighted them in the report.

As part of our inspection we spoke to 10 patients, four relatives, four senior nurses, five nurses, three healthcare assistants, six allied health professionals, one GP and three support staff. We conducted a formal interview with one senior manager. We also reviewed comment cards from 11 patients and we observed episodes of care at different times of day as well as meetings and handovers conducted on the wards.

Our inspection team

Our inspection team was led by:

Team Leader: Roger James, Care Quality Commission

Chair: Professor Iqbal Singh, consultant physician

The team included CQC inspectors and a variety of specialists including a physiotherapist, occupational therapist and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

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 between 15 and 17 November 2016 and an unannounced visit on 30 November 2016. Before and after the visit we held focus groups with a range of staff who worked within the service, such as nurses, non-clinical staff and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

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?

Summary of findings

- 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 ensure that all deaths are notified to the Care Quality Commission.
- The provider should review the governance process for assurance of the management of deaths of service users in accordance with the serious incident framework.
- Minimum and maximum fridge temperatures should be monitored within Cedars Unit to ensure medicines remain at the correct temperature and are safe to use
- Cedars Unit should consider displaying safety thermometer information within the wards.
- Cedars Unit should consider how safe levels of staff are calculated and documented when dependency needs of patients admitted are variable.
- Cedars Unit should consider implementation of documented team meetings as a method of communicating key learning.
- Elm Ward should ensure that discussion about patients, including handovers are held in areas where they cannot be overheard by other patients on the ward.
- Cedars Unit should consider what activities could be provided for patients on the wards.
- Cedars Unit should look at ways that they could use the outcomes that they collate, such as Barthel scores; in order to see if these could be benchmarked or collated to review themes.
- Cedars Unit should look at nurse competency recording to ensure that all staff have the skills to do their job

Your Healthcare Community Interest Company

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Although the unit collected safety information, it was not openly displayed and was not used as part of regular safety discussions on the wards. Levels of harm free care reported in July 2016 were extremely low at 68%.
- The unit had not reported deaths that had occurred on the unit as part of the statutory notifications to CQC.
- Staff did not record minimum and maximum fridge temperatures. Therefore the provider could not demonstrate that medicines were continually stored at safe temperatures
- There was no acuity tool used for assessing staffing levels and this meant that staffing could be stretched, resulting in delays to patient care, particularly when patients had a higher dependency.
- There were high numbers of nursing vacancies and a high sickness absence rate. Although some shifts were filled by bank or agency staff, some shifts remained unfilled.
- It was unclear how learning from incidents across the unit was shared, as information from incidents was only shared at handovers, where not all staff may be present.

However:

- Medicines were stored securely and medicine audits had been used to good effect to improve practice.
- Premises were clean and well maintained.
- The unit had good support under a service level agreement from GPs.
- The admissions policy and procedure ensured that patients were suitable for the nurse-led care provision.

Safety performance

- Cedars Unit collected safety thermometer data in relation to care provided to patients. The NHS Safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including pressure ulcers, catheter-related urinary tract infections and falls. However, this data was held by the information unit at the provider's head office and was not made available to nursing staff. This meant that safety performance did not appear to be reviewed regularly.

Requires improvement

Are services safe?

- Between November 2015 and June 2016, the percentage of harm free care was reported as a total for the whole provider and included Cedars Unit and community adults nursing services. This was recorded as over 96% with a high of 99% in June 2016. However, from July 2016 the reporting process changed and Cedars Unit reported separate figures. In July 2016, only 68% was recorded as harm free which is low and this was equivalent to 33 out of 48 patients in the unit having harm free care. August 2016 data was not submitted; however September and October 2016 were 80% and 87% respectively, which was a slight improvement.
- The safety thermometer information was not displayed on the walls so that staff and visitors could be made aware of safety performance on the wards. It was not possible to compare this information with national data due to the small numbers involved.
- There had been an average of one case a month of venous thromboembolism (VTE) recorded over the last twelve months. A snapshot survey of VTE was carried out against the 82 admissions between July and September 2016. This showed that 100% of patients had a VTE assessment within 24 hours of admission and prophylaxis given where appropriate.
- Data provided to us showed a low number (one per month on average) of pressure ulcers were developed by patients on the unit. We observed that any patients who had skin lesions or a skin integrity concern were discussed at the nursing handover and the care plan communicated.
- The number of recorded falls with harm was low with only five recorded in total over the period of December 2015 to October 2016. Falls were recorded on Datix (incident reporting system) as incidents however the numbers were not displayed on the unit. There were some inconsistencies with falls recorded on Datix. One incident record in June showed a patient had been transferred by emergency ambulance, due to sustaining a head injury after a fall, but the safety thermometer data showed no falls for that month. On both wards, we saw falls risk assessment tools were sometimes used to determine the risk of patients falling, with action and evaluation taken to prevent falls or further falls.
- The urinary tract infections (UTIs) over the year reported on the safety thermometer varied from none in seven months over the last year to 2% in July 2016.
- Safety performance on falls, pressure ulcers and UTIs was not documented as being discussed within the sisters meetings or heard being discussed at the handovers we attended.
- Patients would not routinely have a falls risk assessment completed on admission to the unit. We were told that this was only completed if a patient had fallen previously. If it was identified as a need it would be completed by a physiotherapist.

Incident reporting, learning and improvement

- Incidents were recorded and reported using the provider's electronic recording system which had changed to 'Datix web' on 1 April 2016. Staff told us they understood the importance of reporting incidents.
- Between April 2016 and October 2016, 47 incidents had been reported on the unit; 18 of these were classified as no harm, 21 as minor harm and eight as moderate harm. The most common theme noted was patient falls.
- Some incidents were logged that related to admissions from a local acute hospital. The unit had set up a concerns form that was sent to the hospital and we saw copies of two of these completed with feedback from the hospital as to what actions or learning had taken place. A nurse on the unit reported that there were sometimes issues with inappropriate admissions or night admissions from the local hospital. Although this nurse told us that they would complete a concern form, they told us they 'couldn't really see the point, as you never hear anything back.'
- There were no team meetings held on the wards. We saw minutes that showed that incidents were discussed at the sisters meetings held every month and were told that this information would be cascaded by the ward sister at handovers. Staff told us they learned about incidents that had happened with a specific patient, such as a fall, at the handover. However; it was not clear how staff not present at the handover would be updated.
- We saw minutes of adult governance meetings, attended by the clinical lead nurse, that showed some specific incidents had been discussed where a root cause analysis had been completed. However, incidents across the services were not routinely discussed at this meeting.
- The unit had reported no deaths within the last year; although five patients had died on the unit. These were

all expected deaths and we were told that these patients were receiving end of life care. Providers must report all deaths as a statutory notification to CQC and therefore this should have been completed.

- The unit did not carry out mortality reviews and when we raised this with the provider, we were told that it wasn't required within the community setting. However, the Serious Incident Framework applies to all NHS funded care and we would expect to see supporting decisions on management of deaths of service users and whether it should be reported as an incident. In the absence of any local mortality review process, it is difficult to understand how the provider would be assured that the death of the service user was attributed to the course of the illness or medical condition that treatment was being provided for.

Duty of candour

- Staff we asked were aware of the provider's duty of candour policy and practice. There had been no incidents on the unit that met the criteria for duty of candour, however we saw written response to complaints that had been provide to patients and these included a written apology.
- Staff felt the provider was open and honest when something went wrong with patient's care and treatment.

Safeguarding

- Cedars Unit had three safeguarding alerts raised with the local authority since January 2016. One of these had involved a member of staff that had mistreated a patient. The unit had carried out appropriate action as soon as this had been reported and suspended the member of staff. They no longer worked for the service and the relevant authorities had been informed so that the person would not pose a risk to other patients elsewhere.
- A second alert related to a continual healthcare assessment not being completed prior to discharge of a patient. Learning had documented as being shared with the inpatient ward sister.
- There were issues with the computer system that held the record of staff training and the training compliance data was only available for the whole organisation. Compliance for the organisation was 60% for safeguarding adults and for safeguarding children was 53%. However, senior managers said they could not confirm how accurate these figures were.
- The head of safeguarding had recently attended a sisters meeting and provided feedback to those present on recent safeguarding alerts within the unit.
- Staff on the wards including non-clinical staff were aware of what constituted abuse and the actions they would take to protect the safety of patients from abuse. Staff would report concerns to the senior sister or ward managers.

Medicines

- Pharmacists from Kingston Hospital visited the wards on weekdays under a service level agreement and were part of the clinical team. They accompanied the GP on ward rounds, reconciled patients' medicines on admission, made clinical interventions and arranged discharge medicines. The wards had access to the out of hour's pharmacy service at Kingston Hospital for advice and emergency supplies. Nurses told us how much they valued the support from the pharmacy team.
- Medicines were stored securely and appropriately on both wards. Medicines were delivered from Kingston Hospital on weekdays and additional deliveries could be arranged at weekends. An emergency cupboard was also situated near the wards for additional medicines that may be required. Medicines requiring cold storage were stored in locked fridges and the temperature monitored daily. However, staff did not record minimum and maximum temperatures. Therefore the provider could not demonstrate that medicines were continually stored at safe temperatures.
- The wards held some emergency medicines (such as adrenaline for anaphylaxis) which were checked regularly and our review indicated that they were all in date.
- Controlled drugs were stored securely and checked regularly by nurses. The pharmacist audited the controlled drugs and destroyed any not needed safely and made appropriate records. All controlled drugs were ordered for named patients and used only for those patients.

Requires improvement

Are services safe?

- GPs, nurses or pharmacist prescribers wrote prescriptions for patients on the unit. Independent non-medical prescribers were supported to prescribe within their competence. GPs were available for consultation by phone after they had left the unit.
- Prescriptions and medicines administration records were clearly written and included allergy information, and venous thromboembolism (VTE) assessment. Medicines reconciliation information was included to ensure safe and appropriate prescribing. We saw that unless a patient was admitted at the weekend, all medicines reconciliation was done within 24 hours.
- An audit of medicine charts on one day in April 2016 had shown 69 unsigned doses of medicines. Of these, eight doses were categorised as high risk medicines. Since then, a review of training was completed and a system of checking on the wards was adopted. A re-audit in July 2016 showed six unsigned doses of which none were high risk medicines. This showed a substantial improvement. During the inspection, we saw no unsigned doses and codes were used appropriately to show where medicines had been omitted for a reason.
- Patients told us they received their medicines on time and when they needed them. They knew if their medicines had been changed and could ask for pain relief when they needed it. Some patients were able to keep some medicines with them to use and nurses checked that they had done so safely. Patients told us that this was beneficial as they were used to doing this and could then manage more easily when they went home. This process was in line with the medicines policy. Some patients required additional support with their medicines when they were discharged. Nurses and pharmacists assessed their ability to manage their medicines and monitored dosage systems were offered where appropriate.
- Safety alerts and information about medicines were passed from the pharmacy team to the clinical lead and on to the wards. We saw an example of this and nurses could tell us how it impacted on their practice. Nurses completed annual medicines management training and a three yearly drug calculation test.

Environment and equipment

- Cedars Unit consist of two adjoining wards totalling 35 beds. This was run with two teams of nursing staff, one for Elm Ward with 15 beds and one for Chestnut Ward with 20 beds. Chestnut Ward also had a day room. There was a small inpatient gym in Chestnut Ward that was used by all patients on the unit for rehabilitation.
- Extra space and storage was highlighted by staff as a concern. Beds were close together in bays and there was no space, apart from manager's offices for speaking to patients and relatives in a private environment. The lack of communal areas meant that patients spent a large amount of the day sat by their beds.
- As the purpose of Cedars Unit was to provide a rehabilitation service to meet individual needs, there was access to a variety of equipment such as wheelchairs, hoists, standing and walking aids. Staff told us they were able to access pressure relieving equipment promptly. A random check of equipment during our announced inspection on both wards showed that all the moving and handling equipment on the unit had been serviced within the last six or 12 months.
- On both wards machines to record patients' observations were safety checked.
- The emergency equipment and medication, including resuscitation equipment had been checked each week; however the portable oxygen cylinder on the resuscitation trolley on Elm Ward was past its expiry date. We highlighted this to the nurse in charge and arrangements to change this were done immediately.
- There was no portable oxygen with the resuscitation equipment on Chestnut Ward. We were told that oxygen would be taken from the store room in the event of urgent need. There was a list of equipment on the outside of the bag used to store resuscitation equipment, however this did not match the equipment actually within the bag. The bag was also not sealed, so it would be unknown if anything had been removed before it was next checked.
- Not all the equipment recommended by the Resuscitation Council UK for basic life support provision at a community hospital was available within the bags on both wards. For example, there were no oropharyngeal airways (a device used to maintain a patients airway) in the bag on Chestnut Ward and only one size of airway in the bag on Elm Ward. Portable suction equipment was available in both wards.

Requires improvement

Are services safe?

- Piped oxygen was available for one bed within each of the bays across the unit. We were told that if a patient was admitted that required oxygen then they would move the patients as required to make it accessible.
- Storage facilities for equipment within the unit were well-organised. Single use equipment such as syringes, needles, dressings and oxygen masks were readily available on the ward. We checked ten items of equipment within the stores and found that they were all within dates.
- The premises were in a good state of repair and decoration and were accessible to patients who used wheelchairs. In the Patient-Led Assessments of the Care Environment (PLACE) survey 2016 for Cedars Unit, the average score for the condition, appearance and maintenance was 96% compared with the national average of 93%. Building maintenance was provided by the consortium who owned the building. Staff knew who to contact, including details if urgent support was required out of hours.

Quality of records

- Cedars Unit used a 'paper-light' system of record keeping with the medical, nursing notes, care plans and some risk assessments kept electronically, while other records such as early warning score (EWS) charts, fluid and nutritional charts remained on paper. We reviewed 21 medicine administration records (MAR), six EWS used to record observations of patient's vital signs and to prompt staff to take action and four random electronic sets of medical and nursing records. On our unannounced visit, we also reviewed three complete records for each ward as part of pathway tracking. Physiotherapists and occupational therapists recorded their care plans and therapy notes in the electronic medical notes. The physiotherapists followed the guidance from the Chartered Society of Physiotherapists as their recording standard.
- A number of staff reported that there were issues with the electronic records system, which had been changed in February 2016 and said that sometimes it crashed and did not saved the data. The electronic system migration was recorded as a very high risk on the directorate risk register.
- The hospital used one agency nurse who had their own smart card issued so that they were able to access the electronic patient records.
- There were multiple folders for each area of patient record. For example, a trolley containing discharge summaries and some risk assessments were kept in a notes trolley on Elm Ward. Although this trolley was not locked, it was kept next to the nursing station and so unauthorised access to the records was not possible. Separate folders containing nutritional assessments, EWS and fluid charts, were kept behind the nursing station. Elm Ward entered weekly Waterlow (a tool for skin assessment) and Barthel scores (a tool used to measure patient's performance in their rehabilitation) as entries on the electronic patient record.
- In Chestnut Ward, the discharge summaries for patient admitted from hospital and risk assessments were kept in the sister's office. Separate folders for other assessments and Barthel scores were kept within the same office. We checked four of these and found all of them had completed Waterlow, pressure area assessments, Malnutrition Universal Screening Tool (MUST) and weight checks completed each week, however not all the bowel charts were completed.
- Although the split of different elements of a patient's record may have made it more difficult for staff to review the whole patient record, we were told that both the electronic and paper copies were incorporated into the daily medical review and could be accessed throughout the day as required and it was not reported as an issue.
- Audits of patient records were carried out quarterly. This looked at whether the following information was documented; patient demographic and GP details; record organisation; patient care, consent and risk and information and security. We saw the results of the audit of five records carried out in June 2016. The results showed consent had been documented in all records prior to care interventions, however there were a number of un-validated entries. The more recent audit of five records in August 2016, found that care plans were of a good standard and only one record had un-validated entries. Improvements required were that two records did not have completed bed rail assessments. We checked six records for bed rails assessments during our inspection and found them all to be completed.

Cleanliness, infection control and hygiene

- Hand sanitising gel was available throughout the unit and in bottles at the end of each bed. There were sufficient sinks for hand washing. Staff provided wipes for patients to clean their hands with before mealtimes.

Requires improvement

Are services safe?

- There had been no hand hygiene audits conducted on Cedars Unit within the last 12 months. We were told that there had been a vacancy for the provider Infection Prevention and Control (IPC) lead, and no audits had been requested. The unit had undertaken a repeat of the '15 Step Challenge' audit in February 2016 that had last been undertaken in 2013. The purpose of this was to aid staff in observing and measuring the first impressions of the wards. This had been published in June 2016 and noted in the report that some staff did not use the hand sanitisers. On our inspection, we observed most staff washing their hands appropriately between patient contacts, however we saw that one member of staff did not.
- We observed that staff adhered to 'bare below the elbows' policy and had access to personal protective equipment (PPE). Bare below the elbow (BBE) audits had been conducted in May 2016 and there was 92% compliance. Learning for the one staff member found not to be compliant had been clearly documented.
- There were dedicated cleaners, provided by an external agency for cleaning both ward areas. Two cleaners were available on each ward during the day and one cleaner up until 8pm. We were told that 'deep cleans' happened every six months or as required and although no written records were kept of this. Disposable curtains were changed at the same time and the last dates that could be seen on these were July 2016.
- Both wards looked clean and we observed cleaners carrying out daily cleaning efficiently
- Cleaning rotas were in place and although we saw green 'I am clean' labels, these were not on any equipment, so it was unclear if it had been cleaned within 24 hours.
- The provider took part in the Patient led Assessment of the Care Environment (PLACE). The survey results for Cedars Unit gave a score of 100% for cleanliness compared to the England average of 98%.
- We saw one sharps bin that was located in the store room during the inspection. The bin was on a trolley with other blood taking equipment. The bin was not in the temporary closed position although it was correctly labelled. A sharps bin audit had been carried out across Your Healthcare in March and April 2016 and results communicated to staff in the September 'Quality Matters' newsletter. The results had highlighted the recommendation to temporarily close bins when not in use.
- The wards had appropriate arrangements for managing waste with coloured bags to differentiate domestic from clinical waste.
- We saw records of water flushing for prevention of legionella that were completed every Wednesday and Sunday.
- Cedars Unit reported zero (0) incidences of methicillin resistant Staphylococcus aureus (MRSA) in the reporting period between January 2016 to September 2016. One incident of Clostridium difficile (C. diff) was reported in a patient transferred from a local acute hospital. MRSA and C. diff are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. C. diff is a form of bacteria that affects the digestive system and commonly associated with people who have been taking antibiotics.
- There was one patient with MRSA on the unit at the time of our inspection. This patient was accommodated within a side room and appropriate personal protective equipment (PPE) such as gloves and aprons was available. We observed staff caring for this patient using the equipment appropriately and carrying out appropriate decontamination afterwards. The policy for MRSA was being reviewed at the time of our inspection; however we were told that all patients were screened for this prior to admission.

Mandatory training

- Mandatory training was highlighted by senior staff we spoke with as an area of risk of non-compliance due to lack of oversight and this was listed on the organisational risk register. We were told that staff could access and book training through an online system, but there was no means for line managers to be able to check completion rates.
- Organisation wide data for mandatory training was held, however, due to the issues with the online system, it was not known how accurate these were. The organisation was looking at ways to address the issue.
- Fire training had been done recently at Cedars Unit and we saw a manual record held locally of who had attended.
- We were told by senior managers that Basic Life Support Training (BLS) had been difficult to arrange and that they believed that some staff were overdue a refresher.

Requires improvement

Are services safe?

- All staff we spoke to said they were up to date in their mandatory training, but we were not able to view any of their individual records as they took too long to access on the system.

Assessing and responding to patient risk

- Cedars Unit was based at Tolworth Hospital and did not provide acute medical care.
- The early warning score trigger tool (EWS) had been introduced in 2015 on both wards to calculate when patient's observations signified deterioration in the patient's condition and the action to be taken. The initial assessment of the patient indicated how frequently their observations would be undertaken. No audits reviewing the appropriate use of this tool had been carried out by the nursing team. Laminated sheets explaining the EWS were attached to each machine used for taking observations, however they also included escalation actions that would only apply within an acute setting and therefore had not been adjusted for the unit. Staff told us that all new admissions had four hourly observations for three days and then observations would be taken every 24 hours. If a patient had a raised EWS score, then staff would take observations more frequently.
- Staff on both wards were able to consistently describe what action they would take if a patient was acutely ill and how to respond in a medical emergency. They advised that they could contact the GP for the Unit up to 6.30pm Monday to Friday. Out of hours, they had the option of calling 111 or telephoning the emergency department at Kingston Hospital and discussing the patient with a doctor there.
- The on-call folder held in Cheshunt Ward office contained clear information with telephone numbers and details about how to access assistance in an emergency out of hours.
- From the six EWS charts we looked at on both wards, all the times and dates were recorded accurately. In one EWS charts we reviewed during our inspection, a patient had experienced raised scores overnight. Treatment had been given and arrangements made for a transfer by emergency ambulance to Kingston Hospital.
- Elm Ward recorded Waterlow scores (a means of assessing the risk of development of a pressure ulcer) on the electronic system although pressure area checklists were kept as a paper copy. We saw these were completed in all three electronic records that we reviewed. Chestnut Ward used a manual form for recording Waterlow scores and this was next to the pressure area checklist. All patients on Chestnut Ward received a weekly assessment and this was clearly documented.
- During our announced inspection, we observed staff handovers on both wards. On both wards there was a verbal nursing handover, accompanied by a handover sheet. These covered brief medical information and the care, pain management where relevant, pressure areas to be aware of and the support the patient required, as well as any planned activities that day. Chestnut Ward conducted their handover in the ward office where a whiteboard provided clear information about each patient to support the handover, whilst Elm Ward conducted their handover at the nurse's station.
- An initial assessment was completed on admission by nursing staff including pressure ulcers and nutritional assessments. The physiotherapist also completed an initial assessment for each admission which we were told would include a falls risk assessment if it was relevant. We observed thorough initial assessments completed by physiotherapists and occupational therapists with clear goals and plans given for how the goals would be achieved. However, in two sets of electronic notes that we reviewed, a falls risk assessment could not be located although therapy advice regarding safe transfer was amongst the general nursing notes. Both of these patients had had previous falls and so this would have been an indication for one to be conducted.
- On Cedars Unit call bells were available and patients were encouraged to ask for help when mobilising. During our inspection, call bells were responded to promptly. However, three patients reported there could be delays in getting help when it was busy and said they 'press buzzer and nurses just look at you' and 'not enough of them [staff]'.
- The unit staff completed behaviour charts for patients that presented with challenging behaviour to log their concerns and the actions that had been taken. We saw these completed for one patient on Elm Ward.

Staffing levels and caseload

- Nurse staffing was listed on the adult governance risk register. We were told by senior staff that it was not an ideal situation. There was an overall nursing vacancy level on Cedars Unit of 35%. There was an

establishment of 24.6 whole time equivalent (wte) nurses and 8.5 wte vacancies. Senior staff reported difficulties in recruiting nursing staff and recruitment was ongoing. Nurse staffing was listed on the directorate risk register as a high risk and was being looked at strategically. There was active recruitment to fill the vacancies and we were told of plans to hold an open day for recruitment of staff across Your Healthcare.

- In addition, there was a high level of sickness recorded for the unit with the most common reason being stress and back injuries; however it was not known whether these were always directly attributable to work.
- The unit had nurse staffing covering an early, late or night shift each day. The minimum day staffing was one registered nurse and three health care assistants (HCA) or Clinical Support Workers (CSW) for Elm Ward. Chestnut Wards minimum day levels were two nurses and three HCA/CSWs. In addition there would be one ward sister for the unit available, who was supernumerary to the planned staffing compliment. At night Chestnut Ward planned a minimum of one or two nurses and two HCA/CSWs. We were told on the inspection that at night Elm Ward planned a minimum of one registered nurse and two HCA/CSWs however this was later corrected to one nurse and one HCA/CSW by the Provider.
- On the night of our unannounced visit, there was one nurse and one HCA on Elm Ward which was in line with the minimum levels stated. Chestnut Ward had one nurse and two HCAs, which was in line with the minimum planned levels, despite the ward being full. On the days that we visited during the announced visit, the staff numbers were all over the minimum planned levels.
- The unit was not using staff acuity tools to determine or adjust staffing levels. The level of support individual patients required varied greatly and this was not considered in staffing numbers and the skills required. This meant the provider could not be assured that it was delivering safe care by sufficient staff with the appropriate skills. Some staff reported that managing care needs could sometimes be challenging as there were a number of patients with a higher level of dependency, for example, needing a hoist for mobilisation. In addition, a patient told us of a few nights when the nurses were spending all their time assisting a patient with a high dependency which meant there were delays to help others. Another two patients told us that they had experienced delays to their buzzer being answered, and felt that was because there was not enough staff.
- Staff told us that nursing staff might have to escort patients to other hospital appointments, which could mean that they were short of staff on the unit for a few hours.
- We were told that agency staff were very seldom used; only one had been used recently. The unit preferred to use staff from the bank register to cover vacant shifts. Data provided to us showed that between June and August 2016, there were 75 nursing shifts that were left unfilled. We were told later by the Provider that this had been an error and not included shifts covered by substantive staff who had worked additional days and that the percentage of unfilled shifts was in fact 1.79%.
- Staff told us that they were able to request additional staff to support patients who required 1:1 nursing care and these staff were provided.

- General practitioners (GPs) were employed under a Service Level Agreement (SLA) to provide medical services to the unit on weekday mornings. There were three GPs that attended the wards in order to maintain continuity of care. These GPs had a special interest in elderly medicine and told us of monthly updates they had with an elderly care consultant where they would take case studies for discussion. Outside of these hours, the GPs were available to be called until 6.30pm for advice. Out of hours, 111 would be contacted or nurses could contact Kingston Hospital emergency department. If patients were acutely unwell, they were transferred to Kingston Hospital emergency department.
- There was a full ward round once a week conducted by the GP and ward sister that we observed for Elm Ward during our inspection. This was completed on a Monday for Chestnut Ward and a Wednesday for Elm Ward. The pharmacist usually attended this meeting. Each patient was reviewed at this time for medication, test results, social history and care plan. If a referral to another service was required, then this would be arranged by the GP.
- Each ward would collate any information about the patients that they wanted the GP to review each morning, to make sure that it wasn't missed.

Requires improvement

Are services safe?

- On both wards, patients were receiving support from therapists such as physiotherapists, occupational therapists and a part time dietician.
- Up to four beds on the unit were allocated for neurological rehabilitation. We were told that care for these patients would be led by the Community Neuro Rehabilitation Team (CNRT).
- There were two vacancies out of 16.4 whole time equivalent (wte) physiotherapists and less than one wte vacancy out of 7.7 wte occupational therapists. Numbers of therapists were well within the guidelines set by the Royal College of Physicians 2003 of one occupational therapist and physiotherapist plus support staff per five beds. However, therapy staff told us that due to a shortage of physiotherapists, the weekly group that they ran for inpatients had been cancelled on a number of occasions recently.
- We saw that patients on both wards were assessed on admission by therapists with clear goals and reviews.

Managing anticipated risks

- The wards were situated on the first floor. Evacuation training had been carried out in August 2016 with clear actions for follow up. The provider had an emergency preparedness policy, a major incident policy and a business continuity policy which had all been reviewed in 2016 policy. They set out how the unit would support services in the event of a major incident.
- We saw fire extinguishers were easily accessible on each ward. All of these that we checked were within their service date.
- The unit was part of the Tolworth Hospital estates management. A generator was run by the estates team and was tested each month.
- On our evening visit during the announced inspection, we were able to walk directly onto the unit at 9pm at night. This was a potential security risk to staff and patients. We were told that the main doors to the building were usually made exit only from late afternoon. In addition, security staff from the estate visited the unit regularly at night and staff told us that when they requested security staff urgently, they always came very promptly.

Good

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 good because:

- Policies, procedures and care plans were in line with national guidance.
- The provision of four nurse prescribers on the unit meant that patients' pain could be relieved in a timely manner.
- Multi-disciplinary working was well embedded across the unit.

However:

- Although patient outcomes were collated and looked at as part of individual care, this was not used to assess the overall outcomes on the unit or look for themes or improvements.
- Nurses did not undertake regular competency checks, despite there being an organisation tool to do this.

Evidence based care and treatment

- Prescribing was supported by the Kingston Clinical Commissioning Group (CCG) formulary which was available on-line for all practitioners. Guidelines were approved and adopted by the medicines management committee. An example of this was the Lower Limb DVT Non Ambulatory Treatment Guideline, which we saw being used on the wards. Staff were in the process of completing an audit of antibiotic prescribing. This was implemented in response to an increase in antibiotic prescribing across the services.
- Policies and procedures that we viewed were consistent with National Institute for Health and Care Excellence (NICE) guidance where appropriate such as NICE CG50 relating to responding to the deteriorating patient. Patient's needs were assessed and care and treatment was delivered in line with NICE quality standards relating to the assessment and prevention of pressure ulcers. A newsletter was circulated to staff quarterly called 'Quality Matters', which highlighted new and revised policies for staff to be aware of. New relevant NICE guidance was also raised to senior staff during the adult services governance meeting.
- We reviewed three complete sets of records on each ward as part of pathway tracking. All of these records had completed care plans, although many of the care plans had passed their review date. In both the June and August patient record audits, one out of five records audited had been found to have passed their review date. In four of the six records we reviewed, the notes did not clearly reference the goals that had been set within the care plans making it difficult to see if these objectives were being met. Patients were reviewed by different professionals in all cases which indicated that they had a full holistic assessment. However, one patient who was should have had a falls risk assessment, did not have one documented.
- Discharge planning followed NICE CG27 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'.
- The unit had taken part in the National Audit of Intermediate Care (NAIC) in 2015. This audit aimed to assess progress in services for older people aimed at maximising independence and reducing use of hospital admission and look at national trends. Although some of the outcome recording had not been able to be submitted in time for the NAIC the team had still collated the results and used it as internal learning.
- Named nurses were allocated to patients in both handovers, as advised by the Department of Health (DH), the Royal College of Nursing and NICE, which recommend patient-centred care to improve outcomes and patient experience. However, due to the fragmentation of the records, it could be difficult for staff to see a holistic overview of a patient.
- On both wards, we saw use of tools such as the Malnutrition Universal Screening Tool (MUST) and the Waterlow Pressure Ulcer Risk Assessment Tool. The MUST had been completed for every patient, which was in line with NICE quality standards relating to malnutrition.
- Therapists on both wards used a patient-centred approach in their assessments and therapy focused goals with patients. Meetings and records showed nurses were minimally involved in the goal planning.

The therapists we spoke with were aware of the NICE guidelines for falls assessments and used evidence based tools including the Tinnetti balance assessment and the elderly mobility scale.

- Ward managers told us that they advised nurses to have all the information, including EWS score ready when contacting Kingston Hospital or 111 to discuss a patient. However, a tool like the Situation Background Assessment Recommendation SBAR tool was not used for this purpose. This is a nationally recognised tool to structure and improve information sharing.

Pain relief

- We heard staff discussing the need for pain relief with patients and we saw evidence of therapists undertaking pain assessments. Nurses used a 1-10 pain score and we heard patient's pain being discussed at handover.
- The GP or nurse prescribers ensured all patients were prescribed with paracetamol to be taken as needed so that nurses could provide pain relief to patients at any time. The nursing sister would review any patient likely to be in pain before leaving to make sure that they had adequate pain relief provision. We saw that the wards had stock of morphine sulphate liquid that was prescribed for pain relief if there were delays in obtaining strong pain relief.

Nutrition and hydration

- The provider took part in the Patient led Assessment of the Care Environment (PLACE). The survey results for Cedars Unit in 2016 gave a score of 92% for the food compared to the England average of 88%.
- A dietician supported the unit on a part time basis and told us that referral to them would be done by the nurse and supported by the nurse completion of a MUST tool and in many cases a three day food intake chart. Following this, the dietician would produce a nutritional care plan, including recommendation of extra snacks or supplements if required. In addition, we were told that all patients should be weighed within 24 hours of admission and on a weekly basis. The dietician had carried out MUST training for inpatient and community nurses in May 2016.
- We saw use of the MUST score in both wards which was used to assess the patient's risk of malnutrition. This was used during a patient's initial assessment in line with NICE guidance on nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition. However, some patients had incomplete weight assessments and screening and therefore this was not following the guidance that all inpatients should be screened weekly.
- On Cedars Unit, we were told that protected mealtimes allowed patients to eat their meals without disruption and enable staff to focus on assisting those who required help with their meals. However, there had not been an audit of protected mealtimes and we observed that the GP round was at the same time as breakfast, which meant they were not protected.
- Patients were generally complimentary about the food; there was a dedicated hostess for the unit, who ensured the food was the appropriate temperature before serving it.
- We observed patients being prepared for meals, however all patients sat next to their beds. There was no opportunity for social eating. Staff encouraged and assisted patients as they needed with their meals. We asked nursing staff about the possibility of social eating and they told us that space was limited so it had been tried in the past and proved to be difficult to arrange as fold up tables had to be used. They stated that patients had said that they preferred to eat on their own.
- A green triangle was used to identify patients who were on a special diet with supplements or extra snacks. The dietician had a discussion with the patient about the food options and what the patient liked to eat so and would make these choices clear on a diet plan, which was kept on the unit.

Patient outcomes

- The average length of stay on Cedars Unit between April and October 2016 was 33 days. This was above the target set by commissioners of 29 days. However, if the delayed discharge days were excluded, the length of stay for intermediate care admissions was better than the target set.
- The Barthel Activities for Daily Living (ADL) score was used to measure patient's performance in their rehabilitation. This has 10 variables describing ADL and mobility. A higher number is associated with a greater likelihood of being able to live at home with a degree of independence following discharge from hospital. On both wards we saw this completed each week for every patient, however on Elm Ward it was collected on the electronic record and was harder to view patient progress.

Good

Are services effective?

- The Barthel ADL score was only collated and used in relation to the individual patient progression. The unit did not consider any summaries of the progress that patients made as a group or undertake any benchmarking to determine if any improvement could be made.
- Physiotherapists recorded outcome measures for each patient on the advanced care notes system including goal setting, Goal Attainment Score and Patient Health Questionnaire (PHQ-9) and the occupational therapists used focus goals to increase patient's mobility. These were also only used to monitor an individual's progression and were not looked at collectively for analysis.
- A weight audit had been carried out in February 2016 to review that all patients had been weighed since admission. This found that 100% of patients had been weighed, but did not identify if this had happened within 24 hours or if it had happened every week.

Competent staff

- There was no practice educator on Cedars Unit. Staff completed a competency booklet on induction, however there was no further competency assessment documentation recorded on the unit. It was therefore unclear if staff had the skills and knowledge to respond to the needs of all patients admitted. In a quarterly report, Your Healthcare referred to a competency assessment library that was accessible to all staff on the intranet. However this was not referred to by any staff on the unit.
- A new member of staff reported that they had been supported well since arriving within the last month including being able to shadow for a day. They said they were due to attend a corporate induction in the next month.
- On Cedars Unit there were four independent nurse prescribers and one pharmacist prescriber. We saw dates of workshops held on a quarterly basis that these prescribers had attended.
- One occupational therapist had specialist skills as a moving and handling trainer.
- Staff on Cedars Unit shared learning as it happened at handovers, but staff did not have regular one to one supervision sessions. Staff told us that informal learning was sometimes undertaken after the lunchtime handover. Nursing staff would be tasked with finding out about a particular element of care and would feed it back to their colleagues. In addition, we were told of a clinical supervision session that had been recently started each month that provided nurses and assistants with a place for clinical discussion and learning. Examples of informal learning undertaken were responding to the needs of a transgender patient and use of a particular neck brace.
- Physiotherapists reported that they received weekly or monthly supervision, depending on their level of experience, and currently undertook four month rotations.
- We were provided with data for appraisals for the current reporting year only. Out of 46 eligible staff 35% had completed their appraisals for this year. Although another 35% were listed as being in progress, 30% of staff had not yet had started this process.
- The tissue viability nurse (TVN) provided updates about wound formulary at the sisters meeting and this information was cascaded by the ward sisters to staff.
- Four beds on the unit were allocated for neuro rehabilitation. The Community Neuro Rehabilitation Team (CNRT) would assess patients suitable for admission to these beds and led the care of that patient. There was specific guidance within the care plan for nurses on the wards and the CNRT told us that unit staff were trained in Stroke Training and Awareness Resources (STARS) in order to help neurological patients on the ward.
- Staff on the unit had been supported with funding and study leave to undertake external training modules such as clinical decision making and clinical assessment at university. Staff told us that there were good opportunities for development and progress in the organisation.

Multi-disciplinary working and coordinated care pathways

- Multidisciplinary team (MDT) working was well established on both wards and formed an integral part of the wards. Physiotherapy and occupational therapy attended the unit each weekday, a dietician and social worker on a part time basis and there was access to speech and language therapy. In addition, if a patient was admitted on a weekend, the integrated OT team could provide a new assessment on the unit if they were able to manage it in their workloads.
- On Chestnut Ward, we observed a MDT meeting that happened weekly where each patient was discussed

individually across the team. The ward manager attended, along with a social worker, occupational therapist and physiotherapist. Each discipline had an opportunity to discuss patient outcomes and the care notes system was updated, together with the notice board on the wards. Outcomes discussed were psychological, emotional, bladder, bowel, physiotherapy and occupational therapy goals. Also discussed in this meeting were social support, discharge planning and referrals made if appropriate.

- Occupational therapists told us that they had run some falls prevention classes in the past, however due to capacity on their team currently, these had not happened for a while.
- Occupational therapists (OTs) on the unit worked as part of the integrated OT team and therefore could follow patients into the community to provide continuity of care. They undertook access visits, without the patient, as part of discharge planning when required and checked that equipment the patient would require had arrived and was suitable. They told us that there were no delays in ordering equipment for homes and that they had good communication with the re-ablement team to support patients post discharge. Staff told us that they had used to undertake more home visits with the patient, which was best practice, prior to discharge. However this now needed permission and was not encouraged.
- GPs on the Unit had access to a consultant community geriatrician both by telephone and at regular monthly meetings in the GPs' surgery, where clinical cases and clinical management were discussed. The practice of having access to a consultant in care of older people was in line with national guidance and is an example of good practice.

Referral, transfer, discharge and transition

- For admission to Cedars Unit, patients had to be over 18, to be medically stable, appropriate for rehabilitation and registered with a GP in Kingston. There was a clear eligibility criteria within the admissions policy as the unit was nurse led with no medical cover for most of the time.
- Referrals were mainly received from Kingston Hospital or other acute hospitals; however some (15% between April and October 2016) could come from the community as a 'step-up' admission. A referral form was sent to the single point of access (SPA) in Hollyfield House and patients added to the waiting list were triaged by the senior ward nurses. This included assessing blood results and if required, visiting the patients that were currently within the acute hospital.
- We were told that patients could be admitted with a variety of rehabilitation needs. Many were admitted after a fall, often having sustained a fracture. Others had been involved in a road traffic collision, or may have had a serious illness with a prolonged stay on the intensive care unit. Other patients were having rehabilitation following an operation. Occasionally, a patient was admitted who was receiving end of life care and this care was managed by a local Hospice.
- The aim was that patients would stay on the unit for up to 20 days; however this was reviewed depending on patient need.
- If patients were acutely unwell, they would be transferred to the emergency department at Kingston Hospital and a transfer form was completed if this happened, which we saw a blank copy of.
- We were told that if a patient was considered to be at risk of deterioration over a weekend, a pre-emptive care plan would be made so that staff caring for the patient, were aware of actions they were required to take. Nurses told us that they could also contact the 111 service or Kingston Hospital Emergency Department for advice. They were able to keep the bed for 24 hours for the patient transferred out to avoid unnecessary readmission to the acute hospital if it could be avoided following emergency treatment. Data from April 2016 to October 2016 showed that there were 21 re-admissions or admissions to an acute bed from the unit in this time.
- Patients within the unit would mostly be discharged home or to a residential care facility following their treatment. The discharge co-ordinator on the unit was currently vacant; however the position was recruited to and the unit was waiting for a start date for the successful candidate. Discharge planning commenced when patients were admitted to the unit. Records and conversations with patients and staff demonstrated discharge was discussed when patients were admitted.

Access to information

- Patients on both wards had a mixture of paper and electronic records. The charts and records for each patient were located in different folders within the wards and this made it hard for staff to get an overview of the patient. Chestnut Ward had a large whiteboard

within an office which had key details of all patients listed. This was called 'patient status at a glance' and worked well for reviewing patients as part of the handover. There were plans for Elm Ward to have a similar board; however space had not yet been identified for where this could be placed.

- Patients who were admitted following a hospital stay would have a hospital discharge letter sent with them. All six of the records we looked at had a discharge summary letter. If a patient was admitted from the community or more information was required, a fax would be requested from the patient's GP. Staff we spoke with said there were no issues with accessing information about patients.
- Blood samples could be sent to the local acute hospital for testing and staff were able to access the test results online.
- Patients that required an X-ray could have arrangements made to attend an appointment at either Surbiton Health Centre, if they were able to sit in a wheelchair or at Kingston Hospital if they needed a stretcher. Results were faxed through within 24 hours and sometimes sooner if requested urgently. For patients that had an MRI or CT scan, the results were provided within a week.
- Permanent and bank members of staff were able to access emails, electronic files and the trust intranet. The one regular member of agency staff that worked in the unit was also provided with full access.
- Discharge information from Cedars Unit was posted to the patient's GP as well as a copy given to the patient. All paper records would be scanned and uploaded to a patient's electronic record after discharge.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The provider's consent and mental capacity policy had been reviewed in October 2016 and was available to staff on the intranet.
- It was clearly stated on the bedrail assessment form that use of bedrails was a form of restraint and within the policy the risk assessment was a mandatory requirement before bed rails could be applied to bed. The assessment document provided clear guidance to staff using a red, amber and green coding system of what bed rail recommendation was made and was completed on admission for all patients.
- A bed rail audit was completed in March 2016, assessing the compliance of completing of the bed rail assessment tool and found that seven out of 15 patients had not had risk assessments completed for use of bed rails. Although a re-audit had not been carried out, all bed rail assessment forms for six patients that we reviewed had been completed appropriately.
- Staff had received training on the Mental Capacity Act (2005) (MCA) in relation to seeking patient consent prior to specific decisions. Data for the organisation showed that 68% of Your Healthcare staff had received MCA training; however there was no specific data for unit staff. Two therapy staff that we spoke with had limited knowledge of the MCA and stated that nurses would do a basic capacity assessment on admission. Nurses that we spoke with had more knowledge of the MCA principles.
- We observed patients being asked for their consent to care and treatment.
- The Deprivation of Liberty Safeguards is part of the Mental Capacity Act 2005. It aims to make sure that people in care homes, hospitals and supported living were looked after in a way that does not inappropriately restrict their freedom. There were no patients on the unit at the time of our inspection that were under a Deprivation of Liberty Safeguards. However, when we asked staff about these they were able to explain the process that they would follow, such as a referral being made to the local authority for assessment.
- The unit did not have a framework for discussion of do not attempt cardio-pulmonary resuscitation instructions (DNACPR) that was taken from the national best practice guidelines. Staff told us that if the patient was not for cardio-pulmonary resuscitation, the form was completed by the hospital and kept with the patient's notes. The information was then included on the daily bed state, so all staff were aware. We were told there was due to be a meeting with the senior nurses and the GPs about DNACPR and reviewing the process for it to happen on the unit.
- During our inspection, there was one patient on the unit not for cardio-pulmonary resuscitation. We reviewed this patient's DNACPR records and found that the completion of the record met best practice guidance.

Good

Are services caring?

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

Summary

We rated caring as 'good' because:

- Patients were generally positive about the care and support they received.
- People were treated with dignity and respect and relationships with staff were positive.
- People valued the rehabilitation activities they took part in.

However:

- Confidentiality was not always maintained when undertaking handovers on Elm Ward.
- Activities for patients on the wards were extremely limited.
- Walking frames were removed from some patient's beds at night, meaning that they were not being encouraged to be independent.

Compassionate care

- We observed patients received compassionate care which was centred on them. Patients were mostly positive about their care and treatment.
- We saw one patient who had been discharged in August, but still visited Elm Ward each week to greet the staff. They told us that their care on the ward had been excellent.
- Patients told us the staff were 'kind and gentle' and a relative told us 'all have been helpful and kind, I feel Mum is safe here and will recover.' Comments received from cards included 'The standard of nursing care is second to none; the staff treat you as a human being and not as a number.' 'I felt very well taken care of' and 'I have nothing but praise for the excellent treatment received from a most friendly team'.
- Care was provided in five, six bedded bays and single rooms. Each bay was single sex accommodation in accordance with national guidance.
- We saw staff closing curtains and doors when providing personal care to protect patient's privacy and dignity. However, the proximity of the bays meant that discussions of professionals with the patient could be heard by others within the bay.
- The morning handover we observed in Elm Ward was conducted at the nurse's station at the end of one of the bays. We were told that it was sometimes held there and other times in a separate room. Due to the proximity of the nurse's station to some beds in the bay, there was a possibility that patients could hear discussions about other patients.
- The provider requested feedback from patients in a service user engagement survey over the period January to October 2016. This incorporated the NHS England friends and family test (FFT) questions. The response rate for both wards was extremely low, with only eight responses for Chestnut Ward and six for Elm Ward. The results showed all of the respondents would be extremely likely or likely to recommend the unit.
- In the Patient-Led Assessments of the Care Environment PLACE survey 2016 for Cedars Unit, the average score for privacy, dignity and wellbeing was 84% which was the same as the national average.
- All patients on admission were asked to sign a consent form for agreement of staff members of the opposite sex to assist them with personal care. We saw these completed for in all 10 records that we checked.
- We saw many examples of cards that had been given to the staff on the unit complimenting them about the care that they had received. Data provided to us showed that the inpatient services had received 51 compliments in the year 2015/16.
- Staff we spoke with were committed to the care and treatment they provided and we saw positive interaction with patients on both wards.
- Staff told us there was a volunteer who visited Cedars Unit with a dog which patients enjoyed, although this had not happened in recent weeks as the volunteer had been unable to come. They also told us of times when they had encouraged relatives to bring in a patient's cat which was appreciated by the patient.
- Most patients said there were limited activities to engage in on the unit. Although one patient reported that they had been provided with puzzles, six others stated there was little to do saying 'we sit here like lemons' and 'bored, nothing to do here'. There was a television in each bay, side room and also in the day room on Chestnut Ward. However one patient reported that it was kept on late in the night in one bay in

Good

Are services caring?

Chestnut Ward and this was disturbing. Staff told us that the lack of therapeutic activities on the unit had been identified as an issue, and provision of an activity co-ordinator discussed, however funding was not available.

- In a rehabilitation ward, it is important that patients are encouraged to dress in their own clothes in order to encourage independence and recovery and prepare them for discharge home. On the first day of our inspection we noted that all the patients in Elm Ward were in hospital pyjamas during the day rather than their own clothes. However on subsequent days we visited, they were dressed in their own clothes. On our unannounced visit during the afternoon, there were three patients in hospital pyjamas. The patients on Chestnut Ward were mainly in their own clothes throughout our inspection.
- Patients told us that arrangements could be made for a hairdresser to come to the unit if they requested it and a mobile shop came into the unit twice a week. One patient told us that a member of staff had cut their hair which they had appreciated.

Understanding and involvement of patients and those close to them

- Most patients on both wards told us they were involved in their care and kept informed by staff. Many patients told us they were pleased with the progress they were making. One patient told us 'staff keep us well informed' and a comment card said 'above all you understand what is happening to you.' However one patient said there was 'not a lot of communication' and another 'I feel in the dark about going home, worried, and I am not happy about that.'
- One relative reported that they and their family were being given advice and being included on options for change of a patient's residency after discharge, which included signposting to the relevant people.
- The service user survey results found that all of the respondents from Chestnut Ward felt sufficiently involved in planning their care and treatment but two of the six respondents for Elm Ward did not. In addition, in answer to the question 'Did you understand everything the staff member told you, one respondent on each of the wards answered no, however the remainder stated they had.
- We observed a discussion between a patient and occupational therapist and noted that there was a discussion for follow up plans and the patient given opportunity to outline her own aims.
- Patients were positive about the therapy input that they received. One said that the physiotherapy classes 'were wonderful as they make them fun.' However we learned from staff that although this class was meant to run weekly it had been cancelled on a number of occasions due to staffing issues.
- We were told network meetings would be organised for some patients with complex needs where required for discharge planning. The patient and their family would attend these meetings to set out what their aims and aspirations were. We saw records of two meetings that demonstrated this patient involvement.
- Staff told us about previous years, where a patient's spouse was at home alone on Christmas day, they would arrange for extra lunch to be provided so that couples could spend Christmas together.
- Level of independence charts were completed on the board behind each patient's bed.
- However, we observed that walking frames were removed from all patients' beds in Elm Ward and some in Chestnut during an evening visit. One patient also told us that walking frames were put out of reach of another patient. Staff told us that this was because they were at risk of falling and that they wanted patients to call if they wished to leave their beds. However, this meant that patient's independence was not being encouraged.
- The unit had undertaken a repeat of the '15 Step Challenge' audit in February 2016 that had last been undertaken in 2013. The purpose of this was to aid staff in observing and measuring the first impressions of the wards. This had been published in June 2016 with two recommendations: displaying of more compliments for staff and visitors to see and use of a picture board to help patients and visitors identify staff. However, on our inspection which was nine months after the inspection, we found that none of these recommendations had been acted upon.

Good

Are services caring?

Emotional support

- On Cedars Unit, we observed that staff had developed strong therapeutic relationships. Psychological and psychiatric support was available, if a patient was referred for this by the GP. This could be done with a form or by phone for a more urgent referral.
- On both wards, we observed staff talking sensitively with patients, taking into account their emotional needs.
- Visiting times were restricted on the unit, however relatives told us that they were able to call and speak to patients at other times of the day and we observed this happening. Staff also told us that they would vary visiting times if required for patients who would benefit from family support.
- There was not a routine chaplain visit to the unit; however senior nurses told us that they could contact a local chaplain if it was required.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Care for patients requiring neuro-rehabilitation was directed by a specialist team.
- There was consideration for the needs of patients living with dementia and reasonable adjustments had been made on the unit that were suitable for these individuals.
- There had been a low number of complaints and the responses provided to those received had been appropriate.
- Average waits for patients to access the unit were low.

However:

- The provision of care for patients with a higher dependency meant that delivering services could be more challenging for staff.
- Some staff reported using family members to translate instead of interpreter services which is poor practice.

Planning and delivering services which meet people's needs

- Staff told us patients with more challenging needs were being admitted and it was difficult to meet their needs and protect the emotional wellbeing of other patients. This was also raised by a patient who reported that two nights in the previous week; nurses had to deal with a challenging patient, leaving the rest of the ward with little support.
- All the staff we asked were aware that part of their role was to encourage independence of the patients in order to aid their rehabilitation. We observed a number of episodes of care where staff were seen encouraging patients rather than doing activities for them.
- There was an activities for daily living (ADL) specialist kitchen on the ground floor beneath the unit within the outpatients department that could be used by therapists while working with patients. However, this was reported to not be used often as it was a long way from the unit and the environment was not similar to a patient's house and so it had limited benefit.
- Four beds were allocated for patients who required neuro-rehabilitation. The care for these patients was led by the Community Neuro Rehabilitation Team (CNRT) and this was available between 8am and 4pm, six days per week. The waiting times for the team could be from three to five days for stroke patients and eight to ten weeks for the CNRT. As the beds were not always full they were used for other patient conditions and then they may not be available for neuro rehabilitation when such patient needed admission.
- One patient on Elm Ward previously attended a local day centre prior to their admission to hospital. The ward had arranged with the day centre that they collected the patient whilst he was at the unit so that he could continue his normal activities.
- Staff told us that they tried to be flexible in their approach in order to respond to the needs of the local community.
- There was an agreed admission criteria. Senior staff told us that this was adhered to. A senior nurse would visit a patient within the acute hospital if necessary to assess their suitability for rehabilitation on Cedars Unit.

Equality and diversity

- There were appropriate facilities including safe and level access for patients and visitors with limited mobility, although the lifts were somewhat dated. These included designated parking and toilet facilities to accommodate patients and visitors in wheelchairs.
- There was no multi-faith room within the unit. Staff told us patients were able to use a room within another part of Tolworth Hospital if this was requested, however this room was in another accommodation block and patients would need support from staff to access this.
- Staff were aware of different dietary needs of patients and ensured they were provided. There were a number of menu choices available for patient's dietary preferences and nutritional needs including; halal, kosher, vegan and puree diet. Most patient's reported that they were happy with the food options, however one patient stated that the food did not suit their needs as a diabetic and a comment card stated 'restricted food choices as on puree diet'.
- Staff had access to telephone translation services and interpreters if patients requested this. There were also a number of staff on the unit that spoke a second language and would assist when it was suitable for

them to do so. However, some staff reported that they would often use family if interpretation was needed which is poor practice. The unit had a menu that contained photographs of food choices that could be used for patients who may not be able to read English.

Meeting the needs of people in vulnerable circumstances

- The unit used a 'forget me not' sticker to identify patients living with dementia. There was a plan to introduce a dementia passport on the unit that would help staff to better understand the needs of patient's living with dementia. There had been some effort to make the unit a dementia friendly environment such as the use of pictures and word signs on toilets. In addition, there were clocks in order to orientate patients to the time.
- We were shown an activity box for patients living with dementia by a member of staff. This had puzzles and sensory balls that could be used by this group of patients while they were staying on the unit.
- In the PLACE survey 2016 for Cedars Unit, the average score for the care of patients living with dementia was 92% compared with the national average of 75% and for catering for patients with a disability was 86% compared to a national average of 79%.
- One patient reported that they had been given an old fashioned school bell to use as there was no buzzer in the day room. They said that they understood this and found it reassuring. We also observed another patient with a bell in the day room.
- On both wards patients ate all their meals next to their bed as there was no provision made for shared dining facilities.
- A red tray system was used to identify patients who needed help and support from staff with meals.

Access to the right care at the right time

- At the time of our announced inspection, there had been 17 delayed discharges on Cedars Unit between March 2016 and August 2016, all of which had been due to social issues, such as delays waiting for admission to residential care homes.
- Physiotherapists were only available on the unit between Monday and Friday. They did provide explanation sheets with pictures for patients of the exercises they were given. Patients were encouraged to do their exercises with care staff at weekends, although therapy staff said that 'this was not very successful.' Patients were also provided with a general exercise booklet to take home with them on discharge, although it was only available in English.
- The average wait for patients to access the unit between October 2015 and August 2016 was three days for Chestnut Ward and four days for Elm Ward.
- The average bed occupancy within the community inpatients between April and October 2016 was 79% which was lower than the national average of 89%. This was also lower than the level of 85% at which it was generally accepted that it could start to affect the quality of care provided to patients.

Learning from complaints and concerns

- Nurse managers told us that if a concern was reported, they would arrange a face to face meeting with the family and patient as soon as possible in order to see if they could respond to the concern directly. If patients or relatives were not happy with this response, then it would be passed to the complaints department.
- The unit had a low number of complaints received. Only three between September 2015 and August 2016. We saw documented actions that had taken place following those complaints. In addition, we saw letters written to patients following incidents that had happened on the unit. These were detailed and included a written apology.
- Patients we spoke with said they felt confident to make a complaint and believed it would be taken seriously.
- We saw leaflets advising patients about raising a concern or making a complaint available on both wards.

Good

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

We rated well-led as good because:

- Staff on the unit were positive about their local leadership and the support that was provided to them.
- The risk register reflected the issues that the unit faced.
- Staff engagement was high and staff had been asked for their feedback into planning for new facilities in the unit.

However:

- There were no team meetings for nursing staff and therefore the process for cascading information was not robust.
- Staff sickness rates were significantly higher than the England average.
- There were extremely low response rates to the service user engagement survey.

Service vision and strategy

- Senior medical and nursing staff responsible for Cedars Unit told us that there were plans to demolish the hospital site where the unit was located by 2019. Their vision was for a new fit for purpose unit to be built, which would better accommodate the growing variety of patient's needs.

Governance, risk management and quality measurement

- An adult governance group was held every two months and attended by one of the unit managers. Issues raised here would go to the integrated governance board. This group reviewed the risk register, discussed training and infection control as well as ratifying new and updates to policies.
- A front line services meeting was also held each fortnight and attended by one of the clinical lead nurses. This meeting provided updates on recruitment, training and current issues.
- There were no team meetings held on the unit. We were told this was difficult to arrange due to the staff on different shifts and therefore information would be discussed in the sisters meeting and relied on the ward sisters to pass on information to staff. There was no method of monitoring what information staff had been informed of, such as changes to policies or processes.
- The occupational therapy team met twice a month and reviewed governance, service training, staffing and caseloads.
- The GPs who attended the unit did not link into the governance structure, as they were provided under a service level agreement and were not part of Your Healthcare. They told us that they would pass any issues to the lead nurse to raise on their behalf.
- An organisation risk register and a risk register for adult governance were kept. The organisation risk register had a new risk added in April 2016 which was about consideration of options for the future provision of inpatient beds. This was currently recorded as a low risk. The directorate risk register contained risks that had been highlighted to us by staff during our inspection such as nursing vacancies.

Leadership of this service

- On Cedars Unit, staff spoke positively of the leadership of the unit and that they received good support from the senior nurses and managers on the unit. Although the managing director did not visit the unit, it was reported that the board lead for foundation was visible and approachable. Senior staff said that they would be comfortable raising concerns to the board lead for foundation.

Culture within this service

- Staff felt valued by their peers and by the ward sisters and ward managers. Staff had a strong focus on providing compassionate care. One member of staff told us how they had been encouraged to apply and complete their nurse training in order to progress in their career.
- For community inpatients nursing staff, the sickness rates between September 2015 and August 2016 was 10% which was significantly higher than the England average between March, April and May 2016 of 4.02%.

Good

Are services well-led?

Turnover of staff was also high with seven physiotherapists leaving from the service and six inpatient nurses between September 2015 and August 2016.

- Some staff did say that they felt the 'voice' of the Cedars Unit was not heard within Your Healthcare, as they were a small part of the services provided. However, others said that they felt empowered to lead more change at the ward level.
- Nursing staff told us they would raise any concerns about the quality of care with senior staff.

Public engagement

- The provider asked for feedback on the unit through a service user engagement survey. We saw this leaflet available on both wards. There had been an extremely low number of results received for Cedars Unit with only 14 responses between January and October 2016. This meant that the opportunities to learn and improve from patient feedback were limited.
- The provider asked people living within the community served by Your Healthcare to join as a member and provide their views on services. A membership council was held four times a year and fed into the main board.

Staff engagement

- Staff had taken part in the providers staff survey and 52% of staff had responded which was an increase of the previous year of 36%. The results were positive with 89% engagement indicator shown. No action plans had yet been arranged to look at areas for improvement identified in the survey, although it had been carried out in January 2016. We saw an action plan from the 2015 staff survey; however it was not clear if all the actions had been completed.
- The ward sisters and managers reported that they were being asked for their views on the vision for the new location of the unit and two staff we spoke with told us that all staff had been asked to contribute their thoughts on this prior to meetings being held with managers. One told us they were hoping for more space in a new building so that a separate dining area could be provided as they felt that patients spent too much time next to the beds.

Innovation, improvement and sustainability

- The unit had recently bought a new piece of equipment called the 'Hover Jack'. This allowed the nursing staff to safely lift patients from the floor whilst keeping them flat so that they could then be transferred to a bed. This reduced manual handling for staff and a better patient experience.
- The management told us that they had recently invested in a bariatric training suit for manual handling training. This allowed staff to better understand the problems of mobility and routine activity associated with bariatric patients.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The provider did not ensure compliance with this regulation because:** **1. All deaths on The Cedars Unit were not notified to the Care Quality Commission.**