Sherwood Forest Hospitals NHS Foundation Trust

Community health inpatient services

Kings Mill Hospital
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Ratings

Overall rating for this service	Requires improvement
Are services safe?	**Good**
Are services effective?	**Requires improvement**

Summary of findings

Community health inpatient services

Requires improvement

Summary of this service

Our overall rating of this service stayed the same. We rated it as requires improvement because:

- There was a robust and open culture towards reporting of incidents and we saw evidence of staff learning from investigations, however there were some delays in reviewing incidents but a plan was in place to address this. Staff were aware of their responsibilities to safeguard patients from avoidable harm and suitably reported any concerns.
- Staffing levels were mostly maintained with the use of bank and agency staff, although there were occasions staff provision was affected as some patients required one to one care and it had not been possible to rota on extra staff.
- The wards and clinical areas were visibly clean and systems to monitor and manage the risk of the spread of infection were in place. Equipment was available and was serviced to ensure it was safe to use. Oxygen cylinders were not being stored in accordance with Health and Safety Executive (HSE) guidance.

Effectiveness of medical services was rated as requiring improvement because:

- There was minimal evidence available for demonstrating patient outcomes at this hospital which made it difficult to benchmark the effectiveness of the care given against other providers.
- At our last inspection of Mansfield Community Hospital in June 2015 we found staff did not always understand the requirements of the Mental Capacity Act 2005 in relation to their roles and responsibilities. At this inspection we found medical and nursing staff understood the principles and application of the Mental Capacity Act 2005, however, training was not extended to health care assistants who delivered care to patients.

Sherwood Forest Hospitals provides medical care (including older people's care) at Mansfield Community Hospital as part of the specialist medicine division. Mansfield Community Hospital has three medical wards; Oakham Ward and Lindhurst Ward with 24 beds each and Chatsworth Rehabilitation Ward with 16 beds.

Between January 2015 and December 2015 there were 45 admissions to the hospital. Most admissions were planned admissions for rehabilitation care and treatment.

This was a focused inspection following a comprehensive inspection that had taken place in June 2015. At that time, medical care at Mansfield Community Hospital was rated overall as requires improvement. As The effectiveness of the service was rated as inadequate with safety, responsiveness and well led rated as requires improvement with caring rated as good.

During our inspection of this hospital we spoke with 4 patients, and 13 staff. We looked at the medical and nursing records of six patients. We spoke with medical staff, junior and senior nursing staff, allied health professionals, healthcare workers, and housekeepers.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

Summary of findings

- There was a robust and open culture towards reporting of incidents and we saw evidence of staff learning from investigations, however there were some delays in reviewing incidents but a plan was in place to address this.
- There was a system in place to ensure bank and agency staff were inducted before working on wards, however, audits showed the induction process was not always robustly followed.
- The wards and clinical areas were visibly clean and systems to monitor and manage the risk of the spread of infection were in place.
- Staffing levels were mostly maintained with the use of bank and agency staff. Attempts to recruit to staff vacancies were in progress. However, on some occasions where patients required one to one care it had not been possible to rota extra staff on duty.
- Suitable equipment, including resuscitation equipment, was available, serviced and ready for patient use.

However, we also found:

- Some records were large files containing loose pages, these were at risk of being detached and lost from the patient's record.
- There was a system in place to ensure bank and agency staff were given an induction before working on wards, however audits showed the induction process was not always robustly followed. This meant bank and agency staff may not be oriented to their working environment and responsibilities.
- Oxygen cylinders were not being stored in accordance with Health and Safety Executive (HSE) guidance.

Is the service effective?

Requires improvement ↑

Our rating of effective improved. We rated it as requires improvement because:

- There was minimal data collected on patient outcomes at Mansfield Community Hospital which meant care could not be benchmarked against other providers.
- Therapy services were not provided seven days per week on the wards.
- Medical and nursing staff understood the principles and application of the Mental Capacity Act 2005, however, training was not extended to health care assistants who delivered care to patients.
- The average length of stay for patients was significantly worse than the trust average.
- Prescribed food supplement drinks were not securely stored.

However:

- All policies and procedures were based on evidence-based care and treatment and recommended best practice
- The nutritional and hydration needs of patients were assessed, monitored and met.
- Suitable systems and processes were in place to recognise, identify and treat patients who may have had sepsis.

Our rating of caring stayed the same. We rated it as good because:

Our rating of responsive stayed the same. We rated it as requires improvement because:

Detailed findings from this inspection

Is the service safe?

Incidents

- An incident reporting policy and procedure was available to all staff. Incidents were reported through the trust's electronic reporting system. Without exception all staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system.
- There were no never events in medical care services between May 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although a Never Event incident has the potential to cause serious patient harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- At Mansfield Community Hospital there had been 23 incidents between May 2015 and June 2016. The majority of these were related to medication errors and omissions. One incident was graded as there being low harm to the patient as medical intervention and increased observations were required due to the patient experiencing confusion. The remaining 22 incidents did not result in harm to the patient and there were no identifiable themes and trends. The reviews of incidents did not consider if the staff involved had received training and competency assessments in the management of medicines.
- Root cause analysis (RCA) investigations were completed on all serious incidents. However at Mansfield Community Hospital no serious incidents had occurred in the past 12 months.
- On Oakham Ward there was backlog of incidents that had not been closed, these dated back to January 2016. This had resulted from a change in ward management. The current manager was working through the incident processes and the number of incidents was reducing.
- Learning from incidents was cascaded to staff in a number of ways, through a ward communication book, emails, and safety bulletins which were displayed on wards.
- Ward managers and staff we spoke with recognised the importance of being open with patients, and were familiar with the principles of the duty of candour and knew where to find the trust policy and procedure.
- There was a Duty of Candour (Being Open) policy available on the intranet for staff to access. This had been reviewed and ratified in December 2015 so was in date with next review in 2018.
- There had not been any incidents at Mansfield Community Hospital in the past year which had triggered the duty of candour process. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify and apologise to patients (or other relevant persons) if there have been mistakes in their care that have led to moderate or significant harm.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas such as pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- Safety thermometer data was publicly displayed on most of the wards and clinical areas we visited. This meant patients and the public could see how the ward was performing in relation to patient safety

Detailed findings from this inspection

- Between June 2015 and May 2016 there had not been any reported hospital acquired pressure ulcers at the three wards at Mansfield Community Hospital.
- Lindhurst and Oakham had no reported harms for the period December 2015 – May 2016 so harm free care data showed improvements were being made. For Chatsworth Rehabilitation Ward the number of new harms was consistent at between nil to two for each month for the same period.

Cleanliness, infection control and hygiene

- All areas we visited during our inspection were visibly clean.
- Mansfield Community Hospital participated in 'Patient-Led Assessments of the Care Environment' (PLACE). PLACE are a self-assessment of non-clinical services, which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare in assessing providers. The most recent patient led assessment of the care environment (PLACE) data demonstrated a high compliance rate of cleanliness in the ward areas of 99.1% which is above the national average of 97.5%.
- The cleaning audits for cleaning, nursing and estate for the Mansfield Community Hospital wards for April 2016 ranged from 93% - to 100%. The audits clearly highlighted to ward staff where the deficits were identified.
- In May 2016 data showed infection prevention and control and hand hygiene training completion rates were between 90% – 91% for each of the three wards.
- Hand cleansing gel was available at the entrance to the hospital and each ward as well as patient bedsides. There were supplies of personal protective equipment such as gloves in a range of sizes and aprons available for staff to use.
- We observed staff adhered to bare below elbow principles to ensure that effective hand cleansing could take place.
- Hand hygiene audits for healthcare assistant staff for July 2015 – July 2016 showed 100% compliance.
- After being cleaned equipment was labelled with dated, green stickers to indicate it was clean and suitable for patient use.
- Some privacy curtains between bed spaces did not have recorded dates to indicate when they were put up. This meant that staff would not know when they were due to be replaced.
- Each ward had a link nurse for infection prevention and control. There was a handbook available which detailed the role and responsibility of the infection control link nurse. This included resources and key information.
- There was a provision of side rooms on all wards, which staff prioritised for known or suspected infectious patients. We saw signs were placed on the doors to indicate there were actual or suspected infections. Personal protective equipment, gloves and aprons were outside the rooms and we observed staff using these before entering.
- All admissions to the hospital were from King's Mill Hospital, where Methicillin-resistant Staphylococcus aureus (MRSA) screening took place for all patients. MRSA is a bacterium responsible for several difficult-to-treat infections. This screening reduced the risk of the spread of infection.
- Between July 2015 and June 2016, there had no reported cases of MRSA bacteraemia or Clostridium difficile infections at Mansfield Community Hospital.
- Rescreening of patients took place every 21 days and ward performance of this was monitored. Between May 2015 and May 2016 there had been four occasions where re-screening had exceeded the 21-day timescale.

Environment and equipment

Detailed findings from this inspection

- Staff reported that space for equipment storage was an issue and we observed some corridors had equipment stored on them. In some circumstances, this prevented patients from using the handrails.
- Each ward had a sealed and pre-packed resuscitation trolley that had a standard range of equipment. We checked the resuscitation equipment on two ward areas. The resuscitation equipment on the wards was clean. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence, on most wards that the equipment had been checked daily by staff and was safe and ready for use in an emergency.
- When resuscitation equipment had been used or when seals were broken there was a system in place to replace the trolley with another pre-packed trolley. A spare trolley was on site to ensure equipment was always available and a replacement for the used trolley could be accessed quickly.
- On Oakham Ward we saw oxygen cylinders stored on the floor on the ward corridor. Health and Safety Executive (HSE) guidance states oxygen cylinders should be stored in a purpose-built trolley in a well-ventilated storage area, with cylinders being chained, or clamped to prevent them from falling over.
- Some equipment was available for bariatric (heavier) patients such as chairs and wheelchairs. Where specialised equipment was required but not available this was hired. Staff told us these items could be obtained quickly.

Medicines

- There were secure and suitable storage arrangements in place for medicines and suitably trained staff held the keys to medicines.
- Temperatures of fridges and treatment rooms were monitored regularly to ensure that medicines were suitably stored. Fridge temperatures were within acceptable maximum and minimum limits. During our visit weather conditions were hot resulting in the temperature of one treatment room being recorded as 31°c, so exceeding the recommended 25°c for medicines. Staff had escalated this to the estates department, however no actions had been taken at the time of our visit.
- A pharmacist technician and pharmacist visited all wards each weekday and an on-call service was available out of hours. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. Medicines interventions by a pharmacist were recorded on the medicine administration records to help guide staff in the safe administration of medicines.
- Some commonly used stock medications were held on site to avoid delays in patients receiving their prescribed medicines. For non-stock items these could be accessed from Kings Mill Hospital. Staff told us they were delivered quickly if required.
- As part of the induction programme for staff their competency in managing and administering medicines was assessed prior to them undertaking this role.
- Data for June 2016 showed medicines management training for staff was: Chatsworth Rehabilitation Ward 88%, Lindhurst Ward 65%, Oakham Ward 78%. For Oakham Ward this showed a 10% fall form the data provided for May 2016. This was against a trust target of 80%, so Lindhurst Ward had not met the trust target. The majority of incidents reported related to a range of medicines management, however incidents reviews did not consider if the training and competency of staff had been a significant factor.
- We observed staff administering medications. This was mostly done in a safe and caring manner in accordance with trust policies and procedures. Staff wore red ‘do not disturb’ tabards while completing medication rounds. This stopped any unnecessary interruptions which could affect safety.
- In the treatment room the pill crusher was dirty with residual medication in it, this increased the risk of cross contamination should staff reuse this without cleaning it.

Detailed findings from this inspection

- Patients told us they received their medications in a timely manner. We observed one patient on Oakham Ward where their medications had been left with them and no staff were in the vicinity. The patient told us staff did check later that they had taken the medicines. However, this did not follow the administration practice for the trust.
- Discharges from the hospital were planned in advance, this meant patients' medicines were prepared and ready for them when they left.
- Some prescription only food supplement drinks were stored in cupboards in the kitchen. There was a facility to lock the cupboards however, keys were left in the lock. This meant they were accessible to patients who weren't prescribed them.

Records

- During our inspection we reviewed six medical and nursing care records. Records were paper-based, apart from observations records, and were held at the patient's bedside and, in notes trolleys in the main ward corridors. Although confidentiality was maintained for the medical notes, the same could not be assured for the notes which were kept at the end of the bed.
- Some records were large files with some pages and information not secured. This increased the risk of them being lost or not being stored in a manner which meant relevant information was chronological and in the correct place.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored, managed and recorded on a day-to-day basis using nationally recognised risk assessment tools.
- Patient records were multidisciplinary and we saw where entries had been made by nurses, doctors and allied health professionals including physiotherapists, occupational therapists, speech and language therapists and, dietetics staff.

Safeguarding

- Staff were aware of their responsibilities to report safeguarding concerns and gave us examples of where referrals had been made. Staff told us that they were aware some safeguarding meetings were held but they were not always informed of the outcomes of the safeguarding referrals. Where a safeguarding referral had been made there was a divider placed in the patient's medical records to alert staff of the referral. We saw examples of this system in use.
- Safeguarding alerts were recorded on the electronic reporting system. The safeguarding lead nurse was well known to staff and it was reported they were accessible and willing to provide advice.
- Safeguarding training was included as part of the annual mandatory training programme. All staff told us they had received this in the past year and figures provided by the trust showed above 80% compliance which was the trust target.

Mandatory training

- Staff received training in mandatory topics such as infection control, fire safety, basic life support, medical devices, slips, trips and falls, medicines management, patient safety and emergency planning, blood transfusion, tissue viability, alcohol and drugs, information governance, manual handling, health and safety, safeguarding adults, mental capacity act, conflict resolution, safeguarding children (level one, two and three) and equality and diversity.
- There were role specific mandatory training modules set to ensure that staff received training appropriate to their role.
- Training rates were not reported by site so it was not possible to assess the compliance with mandatory training for staff at the Mansfield Community Hospital site.

Detailed findings from this inspection

- The trust target for compliance with mandatory training was 80%. Information received after our inspection showed as of June 2016 mandatory training compliance within medical care services, trustwide, exceeded the trust target for nursing staff (86%), medical staff (84%) and allied health professional staff (89%).
- Sepsis training was considered mandatory at this trust. As of 31 March 2016 training compliance (trust wide) in sepsis was; consultant 99%, nursing staff 90% and junior doctors 100%.
- Staff we spoke with told us their mandatory training was up to date. Managers coordinated the booking of mandatory training and monitored staff attendance.

Assessing and responding to patient risk

- Mansfield Community Hospital provided care for patients who were considered to be medically stable and entering a rehabilitation phase of their treatment. The hospital did not therefore have a full range of acute care provision.
- The discharge team at King's Mill Hospital determined which patient was suitable for discharge to Mansfield Community Hospital. There was criteria to ensure that only those patients who were suitably stable were transferred.
- Where there were medical emergencies or a significant deterioration in the patient's condition transfer by ambulance was arranged to the nearby acute trust.
- Staff completed an electronic national early warning system (NEWS) assessment to identify if a patient's condition was changing or deteriorating. The NEWS system was designed to enable staff to recognise and respond to acute illness, clinical deterioration and to seek appropriate medical assistance. The electronic system automatically changed the frequency of the frequency that observations were required.
- Between June 2015 and April 2016, the percentage of observations that were overdue ranged from 0.3% to 2.7% for the three wards.
- Nurses had hand held devices which showed alerts if observations were overdue.
- The electronic NEWS system did not allow for changes in parameters where some medical conditions affected the scoring of the NEWS. This could raise the score falsely indicating the patient was deteriorating. Where the parameters for escalation were raised due to medical conditions this was documented.
- A protocol was in place for the management of patients with suspected sepsis, however this did not describe the process to be followed at the trust's community sites and did not consider that medical staff may not be readily available. Each ward had a sepsis box which contained the equipment and medications required for the emergency treatment of suspected sepsis. Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs.
- Where patients experienced delays in their transfer and treatment, we saw these were reported. One delay reported in May 2016, was currently being investigated.
- Where diagnostic testing was urgently required, for example blood tests, there were systems in place to use taxi's to transport samples to the local acute trust for testing.
- A 'Reducing Harms Team' based on the Emergency Assessment Unit (EAU) at King's Mill Hospital could be accessed by ward staff through the duty nurse manager. This team was available to support wards where enhanced observation of an individual patient was required, sometimes accessing staff form this team was challenging due to the high demand across the trust.

Nursing staffing

Detailed findings from this inspection

- There is no nationally established guidance for community inpatient services staffing ratios. In order to ensure patients received safe care and treatment at all times staffing levels and skill mix were regularly reviewed. Patient acuity and dependency data was collected through the use of a nationally recognised 'Safer Nursing Care Tool'. Each ward had planned staffing levels with a minimum of one nurse on duty to each eight patients for all wards on day shifts, at nights there was at least one nurse to 12 patients.
- Gaps on the staffing rota were filled by staff doing extra shifts, or bank and agency staff being used. Planned staffing levels were mostly achieved but on occasions affected by short notice sickness or agency staff not arriving for planned shifts.
- The acuity of patients (acuity is the measurement of the level of nursing care required by a patient), had on occasions affected the number of staff on duty; this was usually where patients required enhanced observations to keep them safe and it had not been possible to get extra staff in to cover these shifts.
- Incident reports had been completed where staffing levels had fallen below planned levels and attempts to find staff had failed. Extra staff were put on shifts where this was anticipated. There was also access to the 'Reducing Harms' team who provided staff to wards on an ad hoc basis to work with particular patients. During our visit we saw that additional staff were on duty to maintain patient observations.
- All three wards at Mansfield Community Hospital had registered nurse vacancies. Rolling adverts to recruit staff were ongoing. Some appointments had been made and some new staff had start dates.
- Nursing staff completed accountability handovers, where staff leaving the shift handed over to oncoming staff and both staff signed to verify information had been handed over. The records identified any interventions or tasks that required completing.
- Actual vs established staffing levels were displayed on a notice board so that patients could see if staffing levels were being met.
- Additional to the nurse staffing numbers on Oakham Ward there was an advanced nurse practitioner who worked three days each week.
- An induction checklist was in place for bank and agency staff. We saw completed copies of these. Following an induction bank and agency staff were issued with a green card, which expired after three months. This provided evidence of their induction being completed. The induction was renewed after each three-month period. There was a system in place to monitor if bank and agency staff had green induction cards. For May 2016, 14 staff across the three wards had not been inducted, 11 of these were on Chatsworth Rehabilitation Ward. This meant bank and agency staff may not be oriented to their working environment and responsibilities.

Medical staffing

- Consultant led medical care was provided on wards. Day to day medical cover was provided by staff grade doctors or advanced nurse practitioners. Consultant led ward rounds/multi-disciplinary meetings were held twice weekly.
- At weekends and out of hours, medical cover was provided by the on call GP service and there was no direct access to medical consultants.

Major incident awareness and training

- Staff had access to a 24/7 helpline number for estates advice and support for emergency situations. We were given an example recently where the water supply had been cut off for a while and staff had accessed the helpline to ensure the issue was rectified as quickly as possible.
- Business continuity plans were available on the trust intranet and readily accessible to staff.

- A major incident plan with action cards was available on the intranet for staff to access. The role of Mansfield Community Hospital in the event of a major emergency was to take patient transfers to King's Mill Hospital to create capacity at the acute hospital site.

Is the service effective?

Evidence-based care and treatment

- Staff accessed information on guidance and best practice on the trust's intranet, staff reported it was easy to locate documents they were looking for. All policies and procedures were based on evidence-based care and treatment and recommended best practice
- Staff worked towards National Institute for Health and Care Excellence (NICE) guidelines for the assessment and treatment of pressure ulcers. We saw risk assessments in patient's records and where risks were identified pressure ulcer prevention plans (PUPPs), were in place.
- The Sepsis Clinical Lead for the trust was aware of the latest National Institute for Health and Care Excellence (NICE) guidelines (NG51); Sepsis: recognition, diagnosis and early management and told us there were plans to review the current sepsis policy in line with these guidelines.
- Records indicated that sepsis screening was undertaken if the patient's physiological observations indicated there was deterioration in their condition. Staff had access to a sepsis treatment box and could describe the assessment process, however they were reliant on medical or advanced nurse practitioners being available to prescribe the antibiotics. If they were not available staff regarded this as a medical emergency and arranged immediate transfer to the local acute trust. We were given recent examples where this had been taken place.
- A falls proforma was in place which staff completed after patients had fallen. This was based on evidence-based guidance. We saw completed examples but noted that lying and standing blood pressure readings were not always completed as prompted on the form.
- Core care plans were based on best practice, There was space to personalise the plan in relation to patients' individual needs; most care plans had some personalisation recorded to ensure they were individual to each patient.
- Following patients experiencing fractures we saw treatments were considered that would protect and prevent patients from further fractures.
- Multi-disciplinary meetings and the input from social workers showed that (NICE Guideline NG22), Older people with social care needs and multiple long-term conditions was considered. Records documented patient's' living circumstances and social situations. Discharge planning considered the needs of carers and involved relevant agencies to address all of the person's needs, including their medical, psychological, emotional, social and personal, needs.

Pain relief

- The electronic observational recording system recorded patients' reported pain levels. This was used in conjunction with other observations to calculate the risk of patients deteriorating.
- Patients told us staff regularly asked if they were experiencing pain and if they required pain relieving medication this was given promptly.
- Nursing metrics (performance monitoring reports) for both Oakham and Lindhurst Wards showed in May 2016, 97 % of their patients were given good care in response to pain management. Data for Chatsworth Rehabilitation Ward was not submitted for May 2016.

Detailed findings from this inspection

Nutrition and hydration

- All inpatient wards we visited used and completed the malnutrition universal screening tool (MUST) to assess patients' nutritional needs. The MUST tool is a five-step screening tool which is used to identify patients who are malnourished, at risk of malnutrition or are classed as obese. We reviewed patients' records and saw patients were weighed as a minimum weekly, or more frequently if there were concerns on the MUST.
- Patients mostly ate in the dining room but could choose to eat by their bedside. There was a system of using red jug lids and trays to alert staff if a patient had been identified as being nutritionally at risk. We saw these in use in ward bays and in the dining room.
- Drinks were readily available to patients and were within their reach on side tables. Staff were aware of the hot weather conditions during our visit and ensured patients drank sufficient fluids.
- Ward kitchens were well stocked with a range of foods, from cereals, sandwiches, bread, soup and microwave meals. This meant patients could access food at any time outside of set mealtimes.
- The hospital performed better than the England average on the PLACE assessment for food. The hospital scored 97.4% for their overall provision of food compared to the national average score of 87.2%.
- Percutaneous endoscopic gastrostomy (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. We looked at one patient record where the patient received nutrition by tube feeding. All the risk assessments and charts associated with the PEG were fully completed and updated.

Patient outcomes

- The trust had one open mortality outlier alert. This is when there have been a higher number of deaths than expected for a defined condition. The trust received notification from Dr Foster Intelligence that they had shown a higher than expected hospital standardised mortality ratio (HSMR) in the area of 'fluid and electrolyte disorders'. There were 13 deaths whose primary diagnosis of admission was coded under fluid and electrolyte disorders, against a calculated expected number of 9.05. The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect.
- The medical and nursing notes for all thirteen patients were reviewed, along with their pathology and radiology results and their observation charts. Each case had been reviewed to see whether the primary diagnosis (in this case fluid and electrolyte disorders) was appropriate and to look at the care of those patients and their cause of death.
- Results of the review were discussed at the trust mortality group (TMG) in July 2015. At that point all the patient notes had been reviewed and the outcomes identified. The final report was presented at the TMG on 10th November 2015. The review indicated all cases were unavoidable deaths and where an electrolyte imbalance had been identified there was a significant underlying cause. We were therefore, assured the trust had appropriately investigated and addressed this outlier and were satisfied this case could be closed.
- The trust had a clinical audit plan however this targeted at acute care activity and no data was provided specific to Mansfield Community Hospital.
- The number of admissions to Mansfield Community Hospital between July 2015 and June 2016 accounted for 0.2% of the trust medical admission activity.
- From the period of December 2014 to November 2015 medical patients at this hospital had a worse than expected risk of readmission for elective admissions for the rehabilitation service. For the same period, the hospital had a worse than expected risk of readmission for non-elective patients in gastroenterology and rehabilitation.

- Some patients were considered as being fit for discharge but were waiting for community care packages or care home placements; where discharges were delayed these were monitored. In June 2016 data showed that there were 20 delayed discharges across the three wards at Mansfield Community Hospital, the majority of the delays were on Lindhurst Ward. The length of delay varied significantly from between two and 67 days.
- There were 76 patients readmitted to acute care within 28 days of discharge from Mansfield Community Hospital over the last 6 months (three were elective admissions).
- The Elderly Mobility Scale (EMS) was used to set goals and measure patients' progress. 'Smart' (specific, measurable, achievable, realistic and time based); goals were used to monitor patients' progress. Progress against these goals was considered at multi-disciplinary meetings.
- We requested information for the trust on patient outcomes. The trust provided a range of assessment tools which were in use but did not provide evidence of how patient outcomes were monitored. The trust should ensure patient outcomes are monitored and reviewed to ensure the medical services are meeting the needs of the patient.

Competent staff

- Some wards had some health care assistants who were trained in specific extended roles such as venepuncture (taking blood), catheterisation, cannulisation and Electrocardiograms (CCGs).
- Data for May 2016 showed that appraisal rates for Chatsworth Rehabilitation Ward were 100% and for Lindhurst Ward were 93%. Oakham Ward rates were at 64%, this ward had recently had a change of manager. The current manager was aware that some appraisals were overdue and a plan was in place to address this. The trust target for appraisal completion was 98%.
- Staff we spoke with were aware of the Nursing and Midwifery revalidation process and information was displayed on a staff notice board.
- One newly qualified staff nurse spoke of their induction and preceptorship as being a positive experience. They had spent three weeks working supernumerary and a schedule of training was being completed.
- The trust had a staff clinical supervision policy but did not allocate time on rotas for supervision. We asked the trust how many staff accessed clinical supervision, however the trust were unable to provide figures for this.
- Staff completed acute illness management training (AIMS). The data provided showed that between 63% and 79% of nurses had competed this and between 67% and 92% of health care assistants had competed this.

Multidisciplinary working

- Access to speech and language therapists and dietitians was on a referral basis dependent on assessed patient needs.
- Chatsworth Rehabilitation Ward, a neuro rehab ward, had a dedicated psychologist to support patients with the psychological impacts of experiencing neuro related illnesses/injuries.
- We observed one multi-disciplinary meeting. There was respectfulness and consideration given to each disciplines input into the care the patient received. It was evident that discharge planning was focused upon. All aspects of the patient's care needs were discussed, including social and psychological needs as well as the patient's physical health. The meetings considered patient goals and their progress, taking into account their social circumstances and capabilities prior to their current illness.
- Board rounds were held each weekday morning, at these medical staff, nursing staff, and allied health professionals (for example physiotherapists and occupational therapists), discussed each patient's progress and the plan for the day.

- Therapy staff were well integrated into the ward teams and worked closely with nursing staff on agreed goals and discharge plans.
- Speech and Language therapists (SALT) were employed under a service level agreement (SLA) with a nearby trust. An SLA is a contract between a service provider and the end user that defines the level of service expected from the service provider. SALT services were provided between 8am to 4pm Monday to Friday. There was no SALT provision out of hours.

Seven-day services

- Therapy services such as physiotherapy, speech and language therapists, and occupational therapy operated Monday to Friday 9am to either 4pm or 5pm.
- There was no access to a medical consultant out of hours and medical care was provided by an external on call GP service.
- Phlebotomy services were available Monday to Friday 9.00am to 5.00pm. At other times medical and nursing staff were able to take blood and suitable arrangements were in place to transport samples for testing.

Access to information

- Patients' nursing and medical records were transferred with them when they were admitted from the acute trust. This meant full information regarding their care and condition was available.
- Yellow stickers were placed in medical notes with significant transfer information; these were fully completed in the records we looked at. A ward manager told us these were being audited however, findings were not yet available.
- Diagnostic and imaging test results were available on electronic systems. This ensured they were accessible to staff in a timely manner. Staff we spoke with confirmed test results were returned quickly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical and nursing staff we spoke with demonstrated an awareness of the Mental Capacity Act 2005 (MCA) and its application.
- Monitoring of MCA was recorded at trust wide division level. The data for the medicine showed that 85% of medical staff and 99% nursing staff had completed MCA training.
- Training on the MCA was provided only to medical and qualified nursing staff. As health care assistants (HCAs) also delivered care to patients, the lack of training would not ensure they understood about capacity and informed consent. Some HCAs were trained to undertake some medical procedures such as venepuncture and catheterisation, which is invasive care and treatment. The lack of training for HCAs increased the risk of care and treatment not being delivered in accordance with the law.
- Two sets of patient notes we reviewed showed appropriate consultations and recording regarding decision-making processes. One patient did not have capacity and records showed appropriate consultations and decisions had been made in the patient's best interests. The second set of records showed the patient had been actively involved in decision making regarding their care.
- A Deprivation of Liberty Safeguards (DoLS) policy (for adults 18 years and over) was available to all staff at the trust. The purpose of the guidance was to inform staff about the procedural arrangements for working with patients with impaired mental capacity who were 18 years and older and for whom care or treatment was given in circumstances that might amount to Deprivation of Liberty.
- Nursing staff knew how to make a Deprivation of Liberty Safeguarding referral where it was suspected that the patient was being deprived of their liberty. On one ward there were two patients where DoLs referrals had been made.

Detailed findings from this inspection

- Trustwide, for or the year 1st August 2015 - 31st July 2016 there had been 113 DoLs applications, of these 28 had been assessed and approved.
- Therapy staff required the consent and cooperation of patients to work towards rehabilitation goals, this was typically recorded as verbal consent being given by the patient.

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure trust induction procedures are robustly followed at Mansfield Community Hospital so staff are oriented to their role and environment.
- Ensure oxygen cylinders are stored in a purpose-built trolley in a well-ventilated storage area and cylinders are chained or clamped to prevent them from falling over in accordance with Health and Safety Executive (HSE) guidance.
- Ensure the protocol for the management of patients with suspected sepsis includes a description of how staff in community hospital settings manage suspected sepsis.
- Ensure patient outcomes are monitored and reviewed to ensure the medical services are meeting the needs of the patient.
- Ensure prescribed food supplements are stored safely and securely.
- Ensure patient record files are sufficiently robust and secure to ensure loose pages are not lost.
- Ensure Mental Capacity Act 2005 training is delivered to health care assistants (HCAs). The lack of training for HCAs increases the risk of care and treatment not being delivered in accordance with the law.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

Inspection Manager : Helen Vine, Care Quality Commission

The team included CQC inspectors, inspection managers, clinical fellows, a paramedic operations officer, nurse practitioner, a geriatrician, a junior doctor, a head of nursing and midwifery, an associate director, a non-executive director, a director of nursing and a mental health act reviewer.