York Teaching Hospital NHS Foundation Trust

RCB

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RCBP9	White Cross Court Rehabilitation Hospital		YO31 8FT
RCBAW	Archways Intermediate Care Unit		YO31 8HT
RCB05	St Monica's Community Hospital		YO61 3JD
RCBXD	New Selby War Memorial Hospital		YO8 9BX
RCBL8	Malton Community Hospital		YO17 7NG
RCBWH	Whitby Community Hospital		YO21 1EE

This report describes our judgement of the quality of care provided within this core service by York Teaching Hospital NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by York Teaching Hospital NHS Foundation Trust and these are brought together to inform our overall judgement of York Teaching Hospital NHS Foundation Trust

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

Overall rating for this core service Good

Overall we rated effective, caring, responsive and well-led as good. We rated safety as requiring improvement.

Medical cover was provided in different ways in each location, but no service had dedicated or immediately accessible medical support in the evenings, at night or over the weekend. On most wards, there were two qualified nurses on duty for day shifts and the numbers of healthcare assistants met the staffing needs for the time of day. However, wards were full, this meant that at night there was a qualified nurse-to-patient ratio of up to 1:24 and during the day up to 1:12 (one qualified nurse for 24 or 12 patients). Following the inspection, the trust told us they had approved a case for increasing nurse staffing at night from 1 to 2 RNs in all its community units and recruitment was underway at the time of inspection. The controlled drug registers were generally found to be accurate. We found that pharmacy support was inconsistent and that a pharmacy technician was available once a week or less in the units. Resuscitation trolleys were kept in good order, and all equipment and materials were found to be in good condition and in date.

There was little evidence that community hospitals benchmarked their outcomes or quality of care against national guidelines or standards for patient care. However, staff were encouraged to give feedback on patient care both informally and formally at handovers. Clinical audits were carried out regularly and generally good levels of compliance were recorded. Staff told us at times audits were suspended for up to six months due to staff shortages. Following the inspection, the trust commented that they were not aware of any occasions where audits were suspended for this reason. There were some inappropriate admissions to the community wards from acute services, especially A&E, but these were risk managed and redirected to acute care if patients were not medically stable. The level of involvement of patients in care-planning varied. There was good planning and communication with therapy staff, however patients repeatedly told us they had not been told about their nursing care and treatment plans.

We spoke to 44 patients and 13 visitors who all told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay. We observed staff speaking to patients in a sensitive and compassionate manner. Staff knocked on doors before entering private areas and used privacy screens where available. Staff were kind and compassionate but had little time for patients to discuss their feelings and anxieties or to support them to talk about problems.

Facilities and equipment were available to meet the needs of patients. For example, rehabilitation equipment was available at most locations and hoists were provided. Admission criteria and pathways were in place and patients were usually admitted appropriately for nursing care and/or therapy input. Staff felt that they provided a good link between acute services and the community and had good connections with the therapy teams that followed up patients' progress at home. Therapy staff supported patients from Monday to Friday. There was no therapy input at weekends and this often resulted in a break in the continuity of treatment and progress.

Staff understood the trust's overall vision but there was no clear vision or strategy for the future regarding community services. There had been several recent changes within community services and staff expected further changes in the future, especially in Ryedale district and Whitby Community Hospital. Nurses told us they were taking on increasingly complex responsibilities involved in prescribing and night-time cover. Concerns about staffing levels were expressed by both staff and managers. Managers supported staff to access additional nursing and healthcare assistant staff when clinical needs or new complex admissions required it. Staff told us that their managers were supportive.

Summary of findings

Background to the service

York Teaching Hospital NHS Foundation Trust provides a range of acute hospital and specialist healthcare services for approximately 530,000 people living in and around York, North Yorkshire, North East Yorkshire and Ryedale, an area covering 3,400 square miles. The trust provides community-based services in Selby, York, Scarborough, Whitby and Ryedale.

Community inpatients facilities were provided at White Cross Court Rehabilitation Unit, Archways Intermediate Care Unit, St Monica's Community Hospital, New Selby War Memorial Hospital, Malton Community Hospital and Whitby Community Hospital.

St Monica's Community Hospital provided 12 inpatient beds. This was a nurse-led unit where medical care was provided by local GPs. This unit was described as providing both a 'step up' and a 'step down' to and from acute beds, from community rehabilitation and prevented admission to an acute setting or enabled discharge from an acute setting. Palliative patients at the end of life were also cared for in the unit.

White Cross Court Rehabilitation Unit provided 23 inpatient beds as part of a geriatric medicine service. Patients were admitted to the facility following a full assessment by a multidisciplinary team (MDT). This was a consultant-led unit with admissions only taken from the acute hospital in York where care is continued at this site.

Archways Intermediate Care Unit provided 22 inpatient beds over two floors. The facility was described as providing a 'step up' and a 'step down'. The unit had a designated GP from Monday to Friday with cover provided out of hours. Patients were admitted to the unit who were registered with a York or Selby GP and who had a rehabilitation need.

New Selby War Memorial Hospital provided 24 inpatient beds for patients registered with Selby GPs. Medical cover was provided by the patient's GP with out-of-hours cover available from the GP on-call provider. The facility provided 'step up' and 'step down' facilities, rehabilitation and palliative care.

Malton Community Hospital provided 28 inpatient beds for rehabilitation and for 'step up' and 'step down' care. This was a nurse-led unit with medical cover provided by local GPs. GPs visited the unit daily, with out-of-hours cover available from the local GP on-call provider.

Whitby Community Hospital provided 35 inpatient beds in two wards. The wards had differing medical cover arrangements. Abbey Ward had medical cover provided by medical officers and GPs local to the area from Monday to Friday from 9am until 11pm; after that time, cover was available from the local GP out-of-hours provider. War Memorial Ward had medical cover provided by the patients' own GPs. On War Memorial Ward, five beds were identified for palliative care, but they were not left empty if other patients with rehabilitation needs required them.

Our inspection team

Our inspection team was led by:

Chair: Stephen Powis, Medical Director, Royal Free Hospital, London

Head of Hospital Inspections: Adam Brown, Care Quality Commission

The team included CQC inspectors and a variety of specialists including medical and surgical consultants, junior doctors, senior managers, nurses, palliative care nurse specialist, allied health professionals, and experts by experience who had experience of using services.

Summary of findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 17 and 20 March 2015. During the visit we spoke with a range of staff who worked within the service, including nurses, doctors and therapists. We spoke with 44 patients and 13 relatives of people who used the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed more than 15 care or treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences of the core service.

What people who use the provider say

We spoke to 44 patients and 13 visitors who all told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay.

All the patients we spoke to told us that staff strove to maintain their dignity at all times and especially when carrying out personal care by ensuring privacy and closing doors and curtains.

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

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust must ensure there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance, taking into account patients' dependency levels.

The trust must review the uptake and monitoring of training, and ensure that staff in community inpatient services are compliant with mandatory training requirements

The trust should ensure there is sufficient pharmacy support for community inpatient facilities

The trust should ensure patients are involved in nursing care planning and are fully informed of progress and discharge planning

York Teaching Hospital NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Incidents were reported, managed by local managers and investigated. There was evidence that learning had taken place and changes made as a result of incidents. Staff understood their personal and professional responsibilities and applied the principles of the Duty of Candour legislation as part of their working roles.

The rate of harm-free care from January to December 2014 ranged from 87% to 95% across all the community hospital inpatient wards.

Staff reported safeguarding concerns and alerts within the trust to the safeguarding lead, who investigated concerns on behalf of the trust. Compliance with safeguarding training was good and ranged between 93% and 100%.

The trust completed root cause analysis (RCA) investigations into serious incidents. Staff guidance and training, audit and discussions took place on how staff could escalate concerns in order to prevent similar incidents happening in the future.

The controlled drug registers were generally found to be accurate. We found that pharmacy support was inconsistent and that a pharmacy technician was available once a week or less in the units. Resuscitation trolleys were kept in good order, and all equipment and materials were found to be in good condition and in date.

We looked at 19 patient records, 11 medication charts and five 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. Most records were completed appropriately; however, we found some omissions on drug charts, which were highlighted to staff by CQC inspectors and managed appropriately by the Trust. We found two omissions in the controlled drugs registers.

Care plans were mostly individualised and we found evidence of goal setting and discharge planning.

Staff followed infection control principles and were seen to wash their hands and use hand gel appropriately. All staff were 'bare below the elbows' and they checked that the inspectors followed the same principles while working in clinical areas.

Ward managers reported that systems were in place for mandatory training. Data we received from the trust showed that 80% of appraisals and approximately 50% of

mandatory training had been completed but we found that local data showed 75% to 80% of mandatory training had been completed, as it could take up to six weeks for the data to show on the electronic system.

We found that nursing assessments and risk assessments were in place. Where risks had been identified, appropriate action plans were in place and reviewed regularly during inpatient stays.

Medical cover was provided in different ways in each location, but no service had dedicated or immediately accessible medical support in the evenings, at night or over the weekend.

On most wards, there were two qualified nurses on duty for day shifts and the numbers of healthcare assistants met the staffing needs for the time of day. However, wards were full, this meant that at night there was a qualified nurse-to-patient ratio of up to 1:24 and during the day up to 1:12 (one qualified nurse for 24 or 12 patients). This falls outside the recommended Royal College of Nursing (RCN) ratio of 1:8.

Incident reporting, learning and improvement

- Incidents were reported using the Datix system. All staff were trained in how to identify an incident or a near miss and in how to use the system. We found that qualified nursing staff in all locations were confident about reporting and recording incidents. Some junior staff preferred to report to their ward manager who would then record the event. The system required each ward manager to complete information on their actions for every incident and to record the level of harm caused.
- Staff gave examples of incidents they had reported and their outcomes. They told us that teams and the organisation as a whole learned from incidents and there was evidence of clear action planning following reviews.
- The trust completed RCA investigations into serious incidents. Staff guidance and training, audit and discussions took place on how staff could escalate concerns in order to prevent similar incidents happening in the future.
- Minutes from the most recent governance meeting were viewed, and we saw that they included details of serious incidents discussed by the team, RCAs and lessons learned.
- The rate of harm-free care for the previous calendar year ranged from 87% to 95% for all the community inpatient wards.

Falls

- Falls had been identified as a concern by the trust. A significant number of community inpatients were undergoing rehabilitation or were frail, elderly people who were known to be at risk of falls. Falls were registered as a risk in the community risk register with a score of 12 which is a moderate risk within a risk range of 0 to 25..
- A falls 'task and finish' group had been established and a new risk screening tool introduced.
- A new falls strategy was in the process of being launched; this was to be supported by training for all appropriate staff.

Archways Intermediate Care Unit

- Archways reported 65 incidents due to slips, trips and falls between April and December 2014.
- Archways had a mean number of four falls per 1,000 bed days resulting in harm.

Malton Community Hospital

- Malton reported 33 incidents due to slips, trips and falls between April and December 2014.
- Malton had a mean number of four falls per 1,000 bed days resulting in harm.

New Selby War Memorial Hospital

- Selby reported 38 incidents due to slips, trips and falls between April and December 2014.
- Selby had a mean number of three falls per 1,000 bed days resulting in harm.

St Monica's Community Hospital

- St Monica's reported 16 incidents due to slips, trips and falls between April and December 2014.
- St Monica's reported a mean number of three falls per 1,000 bed days resulting in harm.

Whitby Community Hospital

- Whitby reported 32 incidents as a result of slips, trips and falls between April and December 2014.
- Whitby had a mean number of 1. 5 falls per 1,000 bed days resulting in harm.

Requires improvement

Are services safe?

- We saw that sensor alerts were used with people at a high risk of falling.

Whitecross Court

- Whitecross Court reported 22 incidents as a result of slips, trips and falls between April and December 2014.
- We observed patients wearing anti-slip socks provided by the trust to prevent falls.

Duty of Candour

- All staff we met understood the term and its meaning in practice. We were told in every location we visited that the trust required all staff to display an open, honest and transparent culture and to communicate with patients and families when incidents occurred.

Safeguarding

- The trust's safeguarding policy was available to all staff via the intranet.
- Staff reported safeguarding concerns and alerts within the trust to the safeguarding lead, who investigated concerns on behalf of the trust.
- Staff were able to identify the different types of abuse and circumstances that would make it appropriate for them to make a report. They explained the role of the trust safeguarding lead, who would investigate any concerns raised.
- Most staff had received training in safeguarding adults. Staff received updates and, for those still to complete training, there were action plans in place to ensure that this was done before the end of March 2015.
- Compliance with safeguarding trainng was good, ranging between 93% and 100%

Medicines management

- We found that medicines were administered correctly and appropriately. The controlled drug registers were found to be completed accurately.
- Drugs fridge temperatures were checked daily and the results were within the acceptable parameters. No out-of-date drugs were found in the fridges.
- Significant numbers of drugs were found on the wards; this increased the associated risks by making monitoring and medicines management more difficult than necessary.
- Pharmacy support was available once a week to most units but less frequently in Whitby.

Whitby Community Hospital

Abbey Ward had pharmacy support only every three months. At this location, we found out-of-date drugs both in the store cupboard and on the medicine trolley. This was investigated immediately by the ward manager and we were reassured that no patients were currently taking the out-of-date medication. This and all other out-of-date drugs were removed immediately.

Safety of equipment

- Resuscitation trolleys were checked, and all equipment and materials were found to be in good condition and in date.
- Sufficient and appropriate equipment was available to meet patients' needs. This included hoists, stand aids, blood pressure machines and defibrillators. Staff reported no issues with access to appropriate equipment or supplies.
- Staff received training on medical devices and records were kept of staff competency checks, particularly for new equipment.
- Equipment was all well maintained, ready for use and cleaned. All service logs were complete and up to date.
- Medical devices training was organised and delivered to ward staff.

Records and management

- Records were stored appropriately and readily available when requested.
- We looked at 19 patient records, 11 medication charts and five DNA CPR forms. Most records were completed appropriately; however, we found some omissions on drug charts, which were highlighted to staff by CQC inspectors and managed appropriately by Trust staff.
- Documentation was usually completed in full and individualised for each patient. However, patients had little or no input into their nursing care plans.
- We were told by patients that they were 'very involved' in therapy care planning and goal setting. Therapy care plans were individualised and we found evidence of documented goal setting and discharge planning.
- In most cases, therapy and nursing notes were kept together at the end of patients' beds.
- Documentation audits were carried out, action plans were used to address compliance issues, and

improvements were made. However, we found that, when there were staff shortages, no audits were undertaken in some units for substantial periods of time.

Cleanliness, infection control and hygiene

- The clinical environment and equipment were checked regularly and we found all areas to be clean and equipment correctly labelled as such. Domestic staff had access to and used the correct colour-coded equipment for cleaning purposes such as mops, buckets, cleaning cloths.
- Staff followed infection control principles and were seen to wash their hands and use hand gel appropriately. All staff were 'bare below the elbows' and they checked that the inspectors followed the same principles while working in clinical areas.
- Personal protective equipment (PPE) was available and used appropriately.
- We found that dirty linen was managed appropriately. Sluice areas were clean and well organised.
- There had been no healthcare-acquired infections in the previous 12 months, with the exception of Clostridium difficile (C. difficile) at Archways Intermediate Care Unit. Also, there had been no cases of methicillin-resistant Staphylococcus aureus (MRSA) in the community hospitals.

Mandatory training

- Ward managers reported that all staff had completed mandatory training and annual updates either had been completed or were planned to take place before the end of March 2015.
- Training records were discussed with ward managers; it was noted that most community inpatient wards kept their own records. Where staff had not attended training, there was a reason recorded, such as maternity leave or long-term sickness.
- Staff were given sufficient time to attend training, which was included on off-duty rotas. However, training was often in York and some staff had to travel up to 40 miles each way to attend.

Whitby Community Hospital

Staff received 'train the trainer' sessions so that some mandatory training could be delivered locally. This was to prevent excessive travel constraints and to improve training rates.

Mortality reviews

- Mortality reviews were conducted by the York Teaching Hospital NHS Foundation Trust Medical Directorate, whether the patient was under the care of a consultant or a GP.
- Death rates at the hospitals were largely as expected, with two notable exceptions.

New Selby War Memorial Hospital

At the time of the inspection, three of the 24 beds were being used for patients near the end of their life. The hospital worked closely with the local hospice and palliative care specialist nurses. Some people made New Selby War Memorial Hospital their preferred place to die.

Malton Community Hospital

Again, people chose this hospital as a preferred place to die and the hospital had close working relationships with local palliative care nurse specialists and hospice providers.

Assessing and responding to patient risk

- We found that therapy and nursing assessments and risk assessments were in place. Where risks were identified, appropriate action plans were in place and reviewed regularly during inpatient stays.
- Staff understood and knew how to follow escalation processes when a patient's condition deteriorated. If medical cover was not available, staff had contact details for alternative support. If patients required an urgent transfer back into an acute setting, then the 999 ambulance service was used.

Staffing levels and caseloads

Medical cover

- Medical cover was inconsistent and provided in different ways in each location, but no service had dedicated or immediately accessible medical support for evenings, nights or weekends.

Nursing staff

- On most wards, there were two qualified nurses on duty for day shifts, but only one nurse on duty at night. The numbers of healthcare assistants met the staffing needs for the time of day. However, when wards were full, this meant that there was a qualified nurse-to-patient ratio of up to 1:24 at night or 1:12 during the day (one qualified nurse for 24 or 12 patients). Following the

inspection, the trust told us they had approved a case for increasing nurse staffing at night from 1 to 2 RN's in all its community units and recruitment was underway at the time of inspection.

- Staffing shortfalls were managed in advance by ward managers offering extra shifts to permanent staff. They could access the trust staff bank, staff from other community hospital wards or agency staff. We found that ward managers were not usually supernumerary to nurse staffing.
- We were told that staffing levels were historical and based on budgets, although there had been some changes to the skill mix by converting some posts into higher or lower grades within the same financial budget allocation.
- Most inpatient ward teams worked three shifts per day, but some staff preferred to work long shifts to fit in with their personal circumstances.
- Staff sickness rates were variable across the community hospitals.
- All inpatient areas we visited were busy but we found that there was a calm atmosphere. Staff told us that they were kept busy, and at times they had insufficient staff to provide good-quality patient care.

Therapy staff

- Therapy staff worked from Monday to Friday in all units.
- Students rated training in the units as excellent and were full and active team members.
- Therapists were managed in a separate line management structure and reported that they had excellent support from their line managers and professional leads.
- There was a skill mix of specialists among both physiotherapy and occupational therapy staff. Staffing levels for therapists were sufficient to meet patients' needs.

New Selby War Memorial Hospital

Overnight, only one trained nurse was on duty; this gave a ratio of 1:24. We were told that this was a concern for staff, who had raised this risk with management over several years. We found that the acuity of the patients on this unit was moderate to high for a community hospital. At the time of our inspection, three patients were being cared for at the end of their life. The unit had 2.8 whole-time equivalent (WTE) staff on long-term sick leave at the time of the inspection. However, the overall average sickness level reported in November 2014 was 2.9%, which was very close to the 3% average for community services. The use of agency staff was particularly high at this location, with an average of 5.82% agency staff use as of November 2014.

Malton Community Hospital

We were told of chronic staffing issues on this unit. Overnight, the unit had two trained nurses but no security cover; the staffing ratio was 1:14. We were told that staff were frequently taken from this unit to support other units, leaving lower staffing levels and increasing the use of agency staff. Average sickness levels at Malton in November 2014 were 4.2%, 1.2 percentage points above the average for community services.

Whitby Community Hospital

Services in Whitby and Ryedale were to be transferred to another provider in July 2015. Nursing staff had accepted the imminent change. Average sickness rates as of November 2014 were reported as 3.4%, slightly above the average for community services.

St Monica's Community Hospital

Sickness levels in this location were the highest of all at 4.8%, but, as the unit was the smallest in the district, this appeared to have little impact on staffing levels.

Managing anticipated risks

- All community inpatient services had regular fire checks and no risks had been identified by the fire officers. All services had plans for evacuation and processes were understood by staff. Contingency plans were in place where necessary: for example, in the case of a lift breakdown, an alternative lift had been identified and emergency services would be informed.
- We observed that one lift was out of action at Archways Intermediate Care Unit. We saw that evacuation chairs were stored on second floor and plans were now in place for fire officers to carry out planned evacuation procedures from the first- and second-floor wards, utilising mattresses and evacuation chairs.
- Security and access at night was limited in most community hospital locations.

Major incident awareness and training

- Major incident and business continuity plans were in place. A mobile telephone was available in case the

Requires improvement

Are services safe?

telephone lines failed and there was clearly labelled information and protocols to hand. Contact telephone numbers were available for managers and the acute site for when escalation actions were necessary.

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.

There was little evidence that community hospitals benchmarked their outcomes or quality of care against national guidelines or standards for patient care. However, staff were encouraged to give feedback on patient care both informally and formally at handovers.

Clinical audits were carried out regularly and generally good levels of compliance were recorded, but staff told us, at times audits were suspended for up to six months due to staff shortages. Following the inspection, the trust commented that they were not aware of any occasions where audits were suspended for this reason.

Mandatory training completion across all community hospital wards. The compliance rate for most training modules was 75% to 80%.

Discharge planning was integral to the care of patients and home visits were incorporated into patients' plans to help assess their mood, wellbeing, safety and mobility needs. This allowed sufficient time to identify any equipment required and to allow efficient ordering prior to a formal discharge. Delayed transfers of care throughout the trust were due to a range of causes. These delays included delays in obtaining equipment, and recruiting staff to support care packages.

There were some inappropriate admissions to the community wards from acute services, especially A&E, but these were risk managed and redirected to acute care if patients were not medically stable.

The level of involvement in care-planning varied. There was good planning and communication with therapy staff, however patients repeatedly told us they had not been told about their nursing care and treatment plans.

Evidence-based care and treatment

- Staff did not use a nursing dependency tool to calculate the number of staff required.
- Staff had easy access to policies and guidance on the trust intranet and internet. Current guidance was displayed on noticeboards.
- Patients were assessed using multidisciplinary tools devised by the Trust's clinical staff.
- NICE guidance was shared across teams and new information and guidance were cascaded down from trust level by community managers.
- Staff were encouraged to give feedback on patient care both informally and formally at handovers.
- We saw a discharge summary checklist that had been devised by a senior physiotherapist; this was included at the front of all patient notes together with an action sheet that provided greater accountability in terms who was doing what and by when.
- There were some inappropriate admissions to the community wards from acute services, especially A&E, but these were risk managed and redirected to acute care if patients were not medically stable.

Pain relief

- Patients were offered analgesia when they reported pain. Patients told us that their pain had been controlled very well and that this contrasted greatly with their experiences elsewhere.
- None of the patients we spoke with reported having any pain.

Nutrition and hydration

- All patients had their nutrition and hydration needs assessed and charts were completed competently. Malnutrition universal screening tool (MUST) scores were used and nutritional needs were catered for by staff. Units used the 'red tray' system to monitor the intake of patients at nutritional risk.
- Staff could access nutrition support by telephone and they could access a dietetics assessment on request.
- Patients were offered a good range of hot and cold meals to choose from depending on their preferences and appetite. Most patients told us that they enjoyed the food and that it was well presented and appetising.
- Staff were observed checking that food and drinks were within reach of patients; they adjusted furniture if necessary.
- Staff showed pride in serving meals and mealtimes.

Good

Are services effective?

- Patients were supported and encouraged to eat and drink. Respect and care were shown to patients and spills onto patients' clothing were avoided.

Uses of technology and telemedicine

- Community inpatient wards made use of specialist beds, floor mats and chair sensors, particularly during the first 24 to 48 hours after admission. This equipment was used with patients' consent to alert staff and to enable patients to learn when an activity might present a risk to their safety. Once patients had adjusted to the environment, they were reassessed and the sensors were removed if appropriate.

Monitoring quality and people's outcomes

- Staff used information from the ward-level dashboards to benchmark their patient outcomes against local guidelines and to check performance in comparison with the other community inpatient wards and with previous months.
- Results from the ward level dashboard were discussed at monthly governance and management meetings.
- There was very little evidence that community hospitals benchmarked their outcomes or quality of care against national guidelines or standards for patient care.

Outcomes of care and treatment

- Clinical audits were carried out and generally good levels of compliance were recorded.
- Evidence and outcomes of audits were displayed on ward noticeboards for staff, patients and visitors to view.
- We saw the results of a therapy outcome measures (TOM) work stream which showed that 80% of patients fully achieved their goals in both physiotherapy and occupational therapy. In the same work stream, 100% of therapy patients rated the service as good, very good or excellent. Clinical audits.
- Clinical audits were carried out regularly, except for a period of six months when routine audits were suspended at Whitby Community Hospital due to staff shortages.

Competent staff

- Staff competencies were assessed and recorded by senior ward staff and ward managers as part of the appraisal system.
- Staff appraisals were undertaken and we saw evidence that they were well planned. Staff competencies were linked to training needs and outcomes from their appraisals.
- Staff were supported to access and complete mandatory training, much of which was available via e-learning modules. However, face-to-face training was more difficult to access in a number of locations due to the distance between workplaces and training venues.
- We found that some senior nurses were nurse prescribers.
- There was evidence of a high standard of integrated working between physiotherapists and occupational therapists.
- Therapy staff were highly skilled and training was supported throughout the units.

Whitby Community Hospital

The therapy team was well staffed with high levels of expertise to meet complex needs. Specialists in this team included highly specialist neuro-therapists, hand therapists and specialist palliative care occupational therapists. Speech and language therapists attended weekly. In addition, nursing staff were trained in assessing the patients' ability to swallow.

Multidisciplinary working and coordination of care pathways

- Ward handovers took place at shift changes, with Whitby Community hospital giving written handover notes to the nurse on the following shift. Not all team members were included in all handovers; in some units, healthcare workers were not included but were expected to read a communication book.
- MDT meetings took place once a week and teams usually included a nurse, an occupational therapist, a physiotherapist, a social worker and a mental health practitioner.

Referral, transfer, discharge and transition

- The average length of stay varied depending on the service, but patients appeared to feel no pressure to leave the ward environment. Average lengths of stay varied from 15 days to 30 days depending on the unit.

Good

Are services effective?

- Delayed transfers of care throughout the trust were due to a range of causes. The most frequent reason for delayed discharges was the inability to provide complex care packages in the community due to difficulties in recruiting care staff.
- For planned discharges, the ward staff referred patients to the district nursing teams and 24-hour care services. Therapy services provided an outreach/in-reach model and a home assessment was performed as part of the discharge process. This model of therapy enabled continuity of care with hospital based therapists able to care for the person in their own home and for patients who already had therapy input in the home the therapy would continue the care in the hospital setting.
- Discharge planning was integral to the care of patients and home visits were incorporated into patients' plans to help assess their mood, wellbeing, safety and mobility needs. This allowed sufficient time to identify any equipment required and to allow efficient ordering prior to a formal discharge.
- Patient information packs included a range of contact details in case patients or families required support after discharge.
- Staff did not involve patients sufficiently in their care and patients repeatedly told us that they had not been told about their care and treatment plans.

Availability of information

- Patients were usually admitted with medical records from the acute site. If records did not arrive, this was reported as an incident.
- Patient information notices were displayed on all community inpatient wards.
- Staff had access to trust bulletins and the intranet and to wider information on clinical guidelines and pathways, policies and procedures via the internet.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff involved patients in their care and obtained verbal consent before carrying out any interventions.
- Documentation relating to deprivation of liberty safeguards was in place, with associated risks highlighted, and review plans were in place.
- 'Best interest' assessments were carried out and staff understood their responsibilities with regard to consent for patients who might lack mental capacity.
- We observed one 'best interest' meeting and found that it was conducted professionally and included both the individual and family members.
- Patients told us that staff informed them about what they needed to do and checked for verbal consent before continuing.

Good

Are services caring?

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

We spoke to 44 patients and 13 visitors who all told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay. We observed staff speaking to patients in a sensitive and compassionate manner. Staff knocked on doors before entering private areas and used privacy screens where available.

There was a good range of quality information leaflets for patients and families to read and keep.

Patients told us that they did not always know what was happening to them and that communication was often poor.

Staff were kind and compassionate but had little time for patients to discuss their feelings and anxieties or to support them to talk about problems.

Staff cared for most patients well.

Dignity, respect and compassionate care

- We spoke to 44 patients and 13 visitors who all told us that the care they received from all staff was excellent and that patients felt safe and cared for during their stay.
- All the patients we spoke to told us that staff strove to maintain their dignity at all times and especially when carrying out personal care by ensuring privacy and closing doors and curtains.
- Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered.
- We observed staff speaking to patients in a sensitive and compassionate manner. Staff knocked on doors before entering private areas and used privacy screens where available.
- We observed staff supporting patients to dining rooms and providing sufficient support and protection for them to eat their lunch safely and comfortably. Staff sat with patients so that they were at eye level when supporting their eating.

Patients' understanding and involvement

- Staff told us that they had access to interpreter services and took care to try to understand each patient's personal needs and cultural preferences.
- There was a good range of quality information leaflets for patients and families to read and keep.
- Some Patients told us that they had not been involved in the planning of nursing care and did not know the goals towards discharge. However, we were told that patients were clear about their therapy goals and were fully involved in Patients told us that they did not always know what was happening to them and that communication was often poor.

Emotional support

- Staff had little time for patients to discuss their feelings and anxieties. However, patients did tell us that they had been supported at their most difficult times.
- Chaplaincy support was available at most sites on a weekly basis but the chaplain would go to the wards if needed. The chaplain could access support for all faiths and denominations as required and supported patients, relatives and staff.

Promotion of self-care

- Staff cared for many patients well but we saw little evidence of independence being promoted in nursing plans. However, therapy staff were very proactive in the process of rehabilitation towards independence.
- Staff told us that the rehabilitation environment in the community hospital wards encouraged patients to become independent and more mobile. However, this meant that there was a risk of falls and similar incidents, which were discussed with patients. Any incidents and near misses were reported as an incident.

Good

Are services responsive to people's needs?

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

Facilities and equipment were available to meet the needs of patients. For example, rehabilitation equipment was available at most locations and hoists were provided.

Admission criteria and pathways were in place and patients were usually admitted appropriately for nursing care and/or therapy input.

All patients were treated as individuals and families were welcome in the ward environment.

Staff felt that they provided a good link between acute services and the community and had good connections with the therapy teams that followed up patients' progress at home.

Therapy staff supported patients from Monday to Friday. There was no therapy input at weekends and this often resulted in a break in the continuity of treatment and progress.

Planning and delivering services that meet people's needs

- Facilities and equipment were available to meet the needs of patients. For example, rehabilitation equipment was available at most locations and hoists were provided.
- Staff demonstrated a good understanding of the local population and the services available to patients from local authorities as well as voluntary organisations and hospice care.
- Staff gave examples of liaising with specialist workers including the community mental health team and Macmillan nurses.
- Admission criteria and pathways were in place and patients were usually admitted appropriately for nursing care and/or therapy input.
- Admission criteria were mostly adhered to in partnership with hospital consultants and local GPs to provide intermediate care to patients. This included patients who were transferred from the acute hospital following medical or surgical care and patients admitted from the community who required additional care but did not require acute hospital care.

Whitby Community Hospital

There were clear admission criteria at this hospital. A waiting list system was in operation and patients at home and deemed high priority were prioritised. Whitby Community Hospital also served as a step-down unit from Scarborough and James Cook hospitals.

Archways Intermediate Care Unit

The admission criteria for this unit were that the patient should be registered with a York or Selby GP and have a rehabilitation need fully supported by identified goals.

White Cross Court Rehabilitation Unit

Staff told us that, although patients were medically stable on admission, not all were suitable for rehabilitation.

Equality and diversity

- All patients were treated as individuals and families were welcome in the ward environment.
- Ward staff allowed flexible visiting times according to personal circumstances and patient needs. However, mealtimes were protected.
- Staff knew how to access interpreter services when required and had asked a family to help staff make flash cards in the past for a patient who did not speak English.
- Staff were aware that the trust catered for many different diets and cultural choices and knew that they could make requests for specialist foods for patients.

Meeting the needs of people in vulnerable circumstances

- Some wards made good use of dementia-friendly signage and colour coding on doors.
- Staff felt that they provided a good link between acute services and the community and had good connections with the therapy and community nursing teams that followed up patients' progress at home.
- Noticeboards displayed information about support available for carers.

Access to the right care at the right time

- Therapy staff supported patients from Monday to Friday. There was no therapy input at weekends and this often resulted in a break in the continuity of treatment and progress.

Good

Are services responsive to people's needs?

- Patients and staff told us that they were happy to be on a ward close to home and to their relatives.
- MDTs were present in all services and their efforts were evident throughout our visit.

Complaints handling and learning from feedback

- Patient feedback was encouraged on discharge from all community inpatient wards. Patients told us that they could ask questions or raise concerns with any member of staff at any time during their stay. However, the rate for formal feedback forms being successfully completed was low.
- In the previous six months there had been no formal complaints in community inpatient services and staff were unaware of any Patient Advice and Liaison Service enquiries.
- Staff felt that concerns at ward level were their responsibility and most problems were solved by listening and talking to patients or relatives about their concerns. They were aware of the complaints process to be followed when necessary.
- Information on how to raise a concern or make a complaint was displayed in ward areas and included in patient information leaflets.

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.

Staff understood the trust's overall vision but there was no clear vision or strategy for the future regarding community services. There had been several recent changes within community services and staff expected further changes in the future, especially in Ryedale district and Whitby Community Hospital.

Staff and management appeared unaware of the extent to which nurse staffing ratios fell outside the levels recommended by NICE guidance and of the fact that nurses were taking on increasingly complex responsibilities involved in prescribing and night-time cover. However, concerns about staffing levels were expressed by both staff and managers.

Managers supported staff to access additional nursing and healthcare assistant staff when clinical needs or new complex admissions required it. Staff told us that their managers were supportive.

Vision and strategy for this service

- Staff told us that patients were at the centre of all that they do and they understood their role in the organisation.
- Staff told us that they could influence services in their own area and that some staff had been involved in policy and practice development.
- We were told that the organisation was ambitious about providing services for the entire community.
- Staff understood the trust's overall vision but there was no clear vision or strategy for the future regarding community services.

Whitby Community Hospital

We were told that the clinical commissioning group (CCG) for Ryedale and Whitby had re-tendered community services and that another provider had been successful. The service was due to transfer to the new employer in July 2015. Staff told us that they had been kept well informed by the trust, and appropriate consultations had taken place jointly with the CCG and the trust. All staff would be transferred to the new employer, including the service manager. Staff told us that they felt supported in the process and understood that they would continue to provide NHS services. Ancillary staff told us that they felt less secure about their position.

Governance, risk management and quality measurement

- Staff and managers had raised concerns regarding staffing ratio's being exceeding national guidelines particularly overnight to Trust managers and executives and these had been recorded on the risk register.
- Each unit had access to its dashboard of risk and quality measures and this was maintained and reviewed regularly.
- Most staff felt able to raise issues relating to incidents and concerns at directorate level.
- Governance systems and processes were clear and each of the five locations had regular governance meetings.

Leadership of this service

- We observed good local leadership at ward level. There was a clear management structure with clear lines of accountability.
- Information was cascaded to front-line staff by a series of tiered meetings. These were documented and had clear action plans.
- Staff told us that they rarely saw board members.

Whitby Community Hospital

We saw good leadership and staff engagement at Whitby, although the service here was subject to future change. Management and staff were to transfer to the new employer and we were told that individual senior clinicians had risen to the challenge and had exhibited good leadership skills.

Culture within this service

- Staff we spoke to prided themselves in providing good-quality care to patients.
- Staff did not feel particularly empowered due to their workloads, but there was a good sense of team working and full awareness of the benefits of MDTs.

Good

Are services well-led?

- Some staff told us that they feared being honest but others had no problems with being open and transparent.
- We were told that staff had a 'can do' attitude and that they were willing to do things differently to improve patient experiences.
- A local GP told us that they felt that everything was moving in the right direction towards integration.

Fit and proper person requirement

Staff told us that they understood the 'fit and proper person' requirement of trust board members Staff told us that they understood that board members had to be judged to be trustworthy and open in character and had no legal convictions.

Public and staff engagement

- Patients and relatives were actively encouraged to complete Friends and Family Test surveys.
- Full and proper consultation had taken place with both the public and staff with regards to the service transfer of Whitby Community Hospital.
- We were told about volunteers who came in to help. Each volunteer had an induction, which included basic infection control measures on arrival, and there was appropriate debarring screening.

Innovation, improvement and sustainability

- The trust was piloting two community response teams funded by the Better Care Fund. The response teams would support multidisciplinary and joint working in order to meet individuals' needs in the community, thereby preventing unnecessary admissions to hospital.
- The service is piloting a workforce planning tool.
- We observed an excellent and highly professional allied health professional (AHP) team working at well-integrated levels with all other staff for the benefit of patients. Staff were encouraged to make suggestions and good links were reported with the university, further informing and stimulating AHP practice. Discharge pathways were clearly defined and there were attempts to resolve delays caused by social services working through referrals by ensuring that those patients likely to need long-term care were identified early following admission and the referral sent through at that point.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(2)(a) HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not have suitable arrangements in place in order to ensure that persons employed for the regulated activity are appropriately supported in relation to their responsibilities to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. This was in breach of Regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust must review the uptake and monitoring of training, and ensure that staff in community inpatient services are compliant with mandatory training requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) HSCA (RA) Regulations 2014 Staffing. How the regulation was not being met: The provider had not taken the appropriate steps to ensure that, at all times, there are sufficient numbers of suitably skilled, qualified and experienced persons employed for the purposes of carrying on the regulated activities. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The provider must ensure that there are at all times sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice taking into account patients' dependency levels within community inpatient services.