Derby Hospitals NHS Foundation Trust

RTG

Community health inpatient services

Quality Report

London Road Community Hospital
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This report describes our judgement of the quality of care provided within this core service by Derby Hospitals 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 <Derby Hospitals NHS Foundation Trust> and these are brought together to inform our overall judgement of Derby Hospitals NHS Foundation Trust

Summary of findings

Ratings

Overall rating for community health inpatient services	Good
Are community health inpatient services safe?	Good
Are community health inpatient services effective?	Requires Improvement
Are community health inpatient services caring?	Good
Are community health inpatient services responsive?	Good
Are community health inpatient services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

The London Road Community Hospital is a community hospital located in Derby city centre. It had four inpatient wards with a total of 101 beds, providing 'step down' care for people leaving acute hospital care. The trust provided an additional 16 beds at Perth House, a Derby City Council care home. During the inspection, we visited both sites and spoke with 39 patients and 11 relatives. We observed interactions between patients and staff and we reviewed 10 sets of care records. We also spoke with 67 staff, including nurses, occupational therapists, physiotherapists, pharmacy technicians, hotel services staff, admin and clerical support staff, GPs and visiting clinical staff.

There were clear processes for the prevention and control of infection and maintaining safe equipment. Staffing levels were under pressure but were supported through reducing bed numbers and employing temporary staff. There were processes in place to ensure continuity of care with bank and agency staff as much as possible.

There were arrangements to minimise risks to patients, with measures to prevent falls and pressure ulcers. We saw elements of good practice including the use of safety dashboards, clean clinical areas and good infection prevention and control practice. However, ward staff were not consistent in reporting patient safety incidents.

Care was provided in line with national policies, with good multidisciplinary working to meet people's needs. Most staff had attended suitable training. There was a lack of consistency in how people's mental capacity to make decisions was assessed and not all decision-making was informed by or in line with best practice guidance and legislation.

Across all staff groups we observed a commitment to a timely, but safe and person-centred discharge for each patient. There were delays relating to the discharge process for some patients, and staff worked with other agencies to find solutions.

Staff treated patients with dignity and respect, although some patients did not feel sufficiently informed about discharge arrangements. Patients' concerns and complaints were dealt with by senior staff at ward level and learning from feedback was shared at ward meetings.

Community inpatient staff were aware of the trust's values and said they tried to put these into action as part of their daily work. There was still uncertainty about the future direction of the hospital. Staff felt well supported by their line managers and were proud of the service they worked in.

Summary of findings

Background to the service

The London Road Community Hospital, part of Derby Hospitals NHS Foundation Trust, is a community hospital located in Derby city centre. It provides rehabilitation and intermediate care, inpatient facilities and some outpatient services.

The community inpatient service provides rehabilitation services from a multidisciplinary team to patients transferred from the Royal Derby Hospital. This is to ensure they are fit and able to be discharged home or to a care home.

The intermediate care service at a local authority care home, Perth House, provides 16 beds for people who require some rehabilitation following illness before returning to their homes usually with home care package. People can be admitted to Perth House from the hospital or GP referral.

Care was delivered by nurses, support staff and allied health professionals and was overseen by GPs and hospital consultants. At night and weekends, emergency care and support was provided by NHS 111, 999 and the out-of-hours service.

During the inspection, we spoke with 67 staff, including nurses, occupational therapists, physiotherapists, pharmacy technicians, hotel services staff, admin and clerical support staff, GPs and visiting clinical staff. We also spoke with 39 patients and 11 relatives. We observed interactions between patients and staff and we reviewed 10 sets of care records.

Our inspection team

Our inspection team was led by:

Chair: Jan Ditheridge, Chief Executive, Shropshire Community Health NHS Trust.

Team Leader: Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included a CQC manager, three CQC inspectors, two specialist nurses, an occupational therapist and an expert by experience who was a carer of someone using community services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive 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 on 9 and 10 December 2014. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We also spoke with staff individually. In all we spoke with 67 staff, including nurses, occupational therapists, physiotherapists, pharmacy technicians, hotel services staff, administrative and clerical support staff, GPs, an

Summary of findings

advanced nurse practitioner and visiting clinical staff. We also spoke with 39 patients and 12 relatives. We observed how patients were being cared for. We also reviewed patients' care or treatment records. We carried out an unannounced visit on 22 December 2014.

What people who use the provider say

Patients and relatives told us staff were kind and caring. They said there was a good choice of food that met their needs and that they were supported to eat and drink enough.

A small number of patients felt that there were not enough staff to deal with the needs of the patients, especially at night. Others told us their discharge arrangements were not always planned with them.

Some of the comments received included:

- "Staff are very patient"
- "The cleaning staff are very friendly and the place is always spotless"
- "If I ring for assistance they come very quickly during the day, but at night I usually have to wait quite a long time for staff to answer the call bell"

Good practice

Our inspection team highlighted the following areas of good practice:

- There was good multidisciplinary and integrated working taking place on the wards and intermediate care unit, which clearly placed the patient at the centre of care.
- Leadership on the wards was visible and effective.
- We found that staff took pride in caring. They were passionate about their work and the difference it made to patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that all ward staff are able to support patients who do not have the capacity to give consent to care and treatment, and contribute to making decisions in their best interests in line with the Mental Capacity Act 2005.
- The provider should support ward staff in reporting patient safety incidents appropriately.
- The provider should review the arrangements at London Road Community Hospital for obtaining medication outside the designated delivery times.
- The provider should continue to monitor the discharge processes for patients, to ensure patients are kept fully informed and that delays to discharge are minimised, including from intermediate care beds.
- The provider should ensure that care records and observation charts are completed accurately and kept up to date.
- The provider should improve the medical staffing levels.
- The provider should monitor use of interpreter services so as to ensure patients' individual needs are being addressed.

Derby Hospitals NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are community health inpatient services safe?

By safe, we mean that people are protected from abuse

Summary

Arrangements to minimise risks to patients were in place with measures to prevent falls and pressure ulcers. We saw elements of good practice including the use of safety dashboards; clean clinical areas and good infection prevention and control practice. Ward staff were not consistent in reporting patient safety incidents.

There were clear processes for the prevention and control of infection and maintaining safe equipment. Staffing levels were under pressure but were supported through reducing bed numbers and employing temporary staff. There were processes in place to ensure continuity of care with bank and agency staff as much as possible. Arrangements for out-of-hour's medical cover were in place and staff told us these generally worked well.

Incident reporting, learning and improvement

- Staff reported incidents on the trust-wide electronic reporting system. This was available in all ward areas via the trust intranet. Staff told us this was relatively simple to do, and many we spoke with had reported incidents. We saw examples in which incidents had been reported and a full investigation was carried out, including looking at the root cause of why the incident happened in the first place.
- We found that not all staff were aware of the importance of reporting patient safety incidents correctly, or escalating them to senior managers. For example, during our visit we found that prescribed medication was not available for two patients. Another incident involved an agitated patient being physically restrained by staff. Ward staff had not reported these incidents.
- There was evidence, in staff meeting minutes, of incident reports being shared. These meetings occurred at monthly intervals.

- Between 1 April 2013 and 31 March 2014, there were 46 serious incidents reported in the community services. Information seen demonstrated that only four of these incidents related to the inpatient service and resulted in no harm to the patient.
- A safety dashboard was on display on all four wards. This meant patients and the public could see how the ward was performing in relation to patient safety. The dashboard included the number of days since a fall with harm, hospital acquired pressure damage, hospital acquired infections and ward staffing levels. For example, we saw on Ward 5 that it had been 357 days since a patient was identified as having a hospital acquired pressure ulcer and 115 days since a patient suffered a fall with harm.

Duty of Candour

- Staff we spoke with were comfortable about reporting incidents and were familiar with the concepts of openness and transparency. Senior staff confirmed they had received training regarding this regulation. They said they were cascading the requirements of the newly introduced Duty of Candour regulations to all staff.
- We were told that the electronic incident reporting system provided a prompt for staff to inform relatives of any incidents.

Safeguarding

- Staff received training in protecting vulnerable people as part of the mandatory training programme. Staff updated this training every three years. Training rates for adult safeguarding across the four wards for the period May 2013 to October 2014 ranged from 100% on two wards to 94%.
- The trust had a dedicated safeguarding team, which included clinical nursing staff. The team were able to support staff across both hospital sites, keep them informed on safeguarding issues and provide training across the trust.
- The safeguarding team trained individual ward nurses at London Road Community Hospital to be safeguarding link nurses within their own clinical area. These link nurses acted as an additional resource for their colleagues and were able to assist with training.
- Staff we spoke with demonstrated an understanding of the principles of safeguarding and could describe the steps they would take if they had concerns or suspected abuse. We saw that information including contact numbers to report concerns was prominently displayed in ward areas.
- All the patients we spoke with told us they felt safe in the hospital. However, one patient described an incident where he was restrained by members of staff against his will. We reported this to the ward manager who arranged a meeting with the patient and their family to discuss their concerns.

Medicines management

- Overall, we found there were adequate systems in place for the safe supply, storage, administration and disposal of patients' medications, although we found some issues that required improvement.
- Medicines were stored securely in locked cabinets or trolleys on all wards. Prescription pads were stored within locked cabinets and access to all medication keys was controlled by the nurse in charge.
- We observed medicines administration and saw practice was in line with Nursing and Midwifery Council guidance. We checked administration records and found they were complete with no unexplained omissions.
- The pharmacist visited the hospital three times a week and pharmacy technicians were available on the ward Monday to Friday. Pharmacy technicians ensured that stock levels were maintained and provided advice regarding medicines management to both staff and patients. This meant that community in-patient services had access to a comprehensive pharmacy service.
- Although the supply of medications was usually prompt staff reported issues with obtaining pharmacy supplies from Royal Derby Hospital, especially when a patient was being discharged. Occasionally, this had resulted in the patient leaving the hospital without their prescribed medication.
- We found that oral cytotoxic medication was not available for two patients. Cytotoxic medication is primarily used to treat cancer, often called chemotherapy. We discussed this with the GP in the hospital who explained that these medications could only be prescribed by an oncologist. The ward staff told us this had happened before and took staff a lot of time to organise the correct prescription. One of the patients received their prescribed medication that evening, but the second patient did not have their medication until

the following day. The oncologist confirmed that the patients' medical condition would not deteriorate as a result of receiving their medication late. We raised this with the trusts Chief Nurse who took action to ensure this was addressed.

Safety of equipment

- All portable electrical appliances had been tested as per guidance and a rolling programme was evident. Any equipment that was not safe was repaired or replaced as necessary. Staff kept records and we saw these were up to date.
- Emergency resuscitation equipment was available and checked daily. We saw evidence that emergency equipment had been serviced.
- There were arrangements for sharing national safety alerts with staff. Staff we spoke with were aware of the system and we saw minutes of team meetings where safety alerts had been discussed. We saw records of safety alerts retained in ward areas
- There were arrangements for checking mattresses to ensure they remained fit for purpose and did not increase the risk of cross infection or pressure damage to patients. We saw checklists that showed mattresses were checked regularly.
- Systems were in place to remove broken, or faulty equipment. Staff told us that equipment would be removed from service as soon as a problem was identified and the equipment had been reviewed by the medical engineers. We saw evidence that maintenance issues were documented and any updates were recorded. Equipment was serviced according to the manufacturer's instructions.

Records and management

- Records were stored appropriately and were readily available when requested.
- We looked at 10 sets of care records. Most records were appropriately completed. However we identified gaps in some records, particularly in the food and fluid balance records and personal care round records. For example, we saw an example of hydration and food charts that contained no indication of the amount consumed and drunk by the patient. This meant that they did not always contain all the information required to support the delivery of safe care.
- Therapy records were well maintained and we found that patients' therapy goals were recorded and agreed with the individual.
- The hospital used a combination of computerised and paper records. Staff told us that there was a great deal of duplication due to trying to ensure both systems were up to date and vital patient information was not lost. Staff told us computer records were to be further developed.

Cleanliness, infection control and hygiene

- The areas we visited were clean. Hand-washing facilities were readily available and we observed staff adhering to the trust's 'bare below the elbow' policy.
- We observed staff on the wards washing their hands in accordance with the guidance published in the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- Hand hygiene audits undertaken in September and October 2014 showed that all staff demonstrated good hand hygiene.
- Equipment was regularly cleaned and labelled as clean and ready for use. Each ward had its own system for cleaning equipment daily and this was checked by the ward housekeeper. We saw records of cleaning audits undertaken by the facilities manager.
- The trust employed a team of specialist infection control nurses who were appropriately trained. Ward staff told us they knew how to contact these staff and that they visited regularly and attended team meetings.
- There were procedures for the management, storage and disposal of clinical waste. We observed that clinical waste was segregated and 'sharps' waste was handled appropriately in line with recent guidance from the Health and Safety Executive.

Mandatory training

- We looked at the training records for the hospital and they showed that all staff were either up to date with their training or had training days scheduled.
- The staff we spoke with all confirmed that they were up to date with their mandatory training.

Assessing and responding to patient risk

- The hospital used a scoring system referred to as National Early Warning Score (NEWS) to identify

deteriorating adult patients. Routine physiological observations such as blood pressure, temperature and heart rate were recorded to monitor a patient's clinical condition, and certain scores would raise an alert.

- Care records we reviewed demonstrated that risk assessments including falls, pressure ulcers, and MUST (Malnutrition Universal Screening Tool) had been appropriately completed. We saw evidence of actions as a result of risk assessments.
- We saw falls were monitored, audited and themes were highlighted that led to changes in care. For example, we saw that the incidence of falls had decreased and none had been reported since July 2014. The matron explained that a falls pro-forma had been developed at Royal Derby Hospital and this was introduced to the community hospital. One of the ward sisters had the lead on falls prevention and was cascading training and information on how to reduce falls to all staff.
- Staff we spoke with told us they received information on anticipated admissions, which meant they could access appropriate equipment, if necessary, prior to the patient arriving in the hospital.

Staffing levels and caseload

- Each hospital ward displayed a board at the entrance, which showed the number of nursing staff and healthcare assistants that should be on duty and the number there actually were. The number of therapists was not highlighted to visitors or patients. We saw the established staffing and the actual staffing levels were the same or greater on all wards, except one, during the inspection and also during the unannounced inspection. This meant that there were sufficient staff on duty to meet patients' identified health needs.
- Trust figures for May to October 2014 showed the average fill rate, i.e. the percentage of hours when planned staffing levels were met, for day time nursing staff was just over 88% and for care assistants was just over 94%. The averages for night time were 94% and 114% respectively. Staffing levels were reviewed regularly.
- Staff felt there were sometimes insufficient staff, but that patient care was not compromised. At the time of our inspection, the wards were busy; however, patients' call bells were answered within a few minutes. Staffing levels were being maintained by the use of bank and agency staff. Where possible regular bank and agency staff were used to promote continuity of care and minimise risk. New agency staff received a short induction to orientate them to the service before starting work.
- One nurse and two healthcare assistants had recently been recruited to one of the wards, and another ward was also in the process of increasing staff numbers. The matron explained that a recognised tool called the Northwick Park Dependency Tool (NPDT) had been used to calculate staffing requirements. The NPDT assessed the care needs of patients and estimated care hours and suggested care arrangements. As a result, the Board agreed funding to recruit more staff to two of the wards. Bed numbers had been reduced as an interim measure on two wards
- There were eight whole time equivalent medical posts, but only three were filled. Locums were employed to cover in the interim. Medical support was available in the hospital five days a week, with support from a GP available for four hours at the weekend.
- All staff were aware of how to access medical support both in day-time hours and in the evenings and at weekends. When medical cover was not available on the wards, staff telephoned the out of hours GP service for support.
- Therapy staff told us they felt the staffing establishment was satisfactory when there were no absences. They provided a five day service at the hospital. When they were short staffed the 'at home team' would try to provide some support.

Managing anticipated risks

- There were local risk registers and we noted that these were current and complete. Staff told us that they felt confident in raising concerns or risks with their managers.
- The matron told us that staff were offered the influenza vaccination and reported a high take up of this vaccination. This meant that there would be less likelihood of disruption to staffing levels because of illness.
- Staff had been trained in basic life support, and nursing staff had been trained in advanced life support. Staff also informed us that if a patient had a cardiac arrest at the community hospital, they would commence resuscitation and call the emergency services through 999.

Major incident awareness and training

- The matron and ward managers were aware of the major incident and business continuity policy and understood their roles and responsibilities in the case of a major incident.

Requires Improvement

Are community health inpatient services effective?

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

Summary

There was a lack of consistency in how people's mental capacity to make decisions was assessed and not all decision-making was informed by, or was in line with, best practice guidance and legislation.

Care was provided in line with national policies, with good multidisciplinary working to meet people's needs. We observed some staff handovers. These were effective and comprehensive in ensuring staff had information on patient's needs. Nursing staff described close working relationships with occupational and physiotherapists. Most staff had attended suitable training.

Across all staff groups we observed a commitment to facilitating a timely, but safe and person-centred discharge for the patient. There were delays relating to the discharge process for some patients, and staff worked with other agencies to find solutions.

Evidence based care and treatment

- Policies and procedures were developed in line with national guidance and were available for staff on the hospital intranet site.
- Patients were assessed and received treatment in line with evidence based practice.
- We saw evidence that the National Institute for Health and Care Excellence (NICE) guidance, such as the clinical guidance on the prevention and management of pressure ulcers, was followed.
- Patients were assessed using recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow score, a nationally recognised tool.
- Patients were assessed using recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow Score, a nationally recognised tool.
- We saw other examples of national guidance being implemented. For example, in the area of nutrition, we saw that guidance from NICE was in place ('Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition'), relating to screening for malnutrition.
- On one ward, we saw that a stroke pathway was in use and when we reviewed a patient's records, we saw how multidisciplinary teams had been involved, including therapists, a stroke nurse, and discharge coordinators.
- Patients had a care and rehabilitation plan devised to meet their needs. Therapy goals and milestones had been identified, with review dates documented.
- On all of the wards, patients were supported to develop social links and take part in activities. We saw that there were many different activities for patients and relatives to attend if they wished. We saw evidence of patients being supported to take part in activities such as art, reminiscence, pampering and music. During our visit, we saw that a music therapy session was being enjoyed by patients. We also saw that a Christmas party had been arranged and, on one ward, patients had access to an interactive computer system supplied by My Dementia Improvement Network. This is a computer system designed to improve the mood and wellbeing of patients living with dementia.
- A senior ward sister confirmed that funding had recently been confirmed for an activities coordinator for 13 hours per week. The dining areas on the wards also doubled up as an activity area for occupational therapists to work with patients.
- On one of the wards, a reminiscence lounge had been created with photographs of 'old Derby' on the walls. In this way, staff told us that they were "looking at small innovations with a big impact". We were told that patients had also assisted with making the Christmas decorations currently on the ward.

Pain relief

- Patients told us that their pain was adequately controlled. They told us that pain relief was offered and given immediately it was requested.
- The hospital wards received daily visits (Monday to Friday) by GPs, who were able to adjust prescriptions for analgesia, as required.

Requires Improvement

Are community health inpatient services effective?

- A recognised pain assessment tool was used and documented as part of the care pathway.

Nutrition and hydration

- We reviewed 11 care records and found that nutrition and hydration assessments were completed on all appropriate patients. These assessments were detailed and used the Malnutrition Universal Screening Tool (MUST). We saw that appropriate follow up actions were taken when a risk was identified, so as to ensure patients received sufficient nutrition and fluid to promote their recovery
- We looked at food and fluid records and found these were, in the main, complete, accurate and current.
- Protected meal times took place on all the wards we visited. This allowed patients to eat without being interrupted by non-urgent medical treatment and meant staff were available to offer assistance where required.
- Patients told us that the food was of good quality and that they had plenty to eat and drink throughout the day.
- Ward staff had access to advice from dieticians and speech and language therapists (SLT). Dieticians and the SLT visited the hospital once a week and were also available to give telephone advice.

Approach to monitoring quality and people's outcomes

- Individual patient outcomes were monitored. Therapists used recognised outcome monitoring scores such as the Berg Balance Scale, a widely used clinical test of a person's balance abilities and the modified Barthel Index, used to measure performance in activities of daily living. This allowed physiotherapists and occupational therapists to monitor the effectiveness of their treatments and to support patients in regaining independence.
- Performance information, including staffing levels, patient safety incidents and patient feedback was displayed on all the wards.
- The hospital participated in the national patient NHS National Patient Safety Thermometer scheme, and this demonstrated that the patient outcomes measured were in line with national averages.
- At Perth House, where the trust provides 16 intermediate care beds, we reviewed the care records of two out of the eight patients there at the time of the inspection. . Outcome measures used by occupational therapists and physiotherapists showed evidence of progress. For example, patients had improved in performing personal and domestic activities of daily living which were assessed and recorded by staff on a daily basis.
- Information provided showed the average length of stay for patients at London Road Community Hospital was 20 days, compared with the national average of 28 days.

Competent staff

- New staff received a trust induction for one week and were supernumerary on the unit for the first two weeks. A recently employed staff member told us they were very satisfied with the induction and level of support they received.
- We saw training records which demonstrated that between 87% and 96% of staff across the four wards had participated in an annual appraisal in the year up to March 2014. The trust's target for staff appraisal was 88%.
- Staff told us they were supported by their managers to attend training days and to complete online training. Staff said the training they had received was appropriate and relevant to their roles. One senior nurse told us about the dementia awareness course that all her staff were attending to support them in caring better for many of their patients living with dementia.
- Nursing sisters had attended a leadership skills course. We were told that this course was now being offered to staff nurses. Others had qualified as nurse prescribers.

Multi-disciplinary working and coordination of care pathways

- There was a strong commitment to multi-disciplinary working. Each ward area had a multi-disciplinary team meeting on at least a weekly basis to plan the needs of patients. We saw documentary evidence of a multi-disciplinary approach to discharge planning.
- Patients had timetables detailing when each therapist would be treating them each week. This ensured that patients, their families and nursing staff were aware of the planned therapy sessions and had more insight into the rehabilitation programme.
- At Perth House teams worked well together, ensuring individual patient needs were at the centre of care and treatment. Health care assistants based at the care centre supported therapy and nursing staff.

Requires Improvement

Are community health inpatient services effective?

- We observed a weekly multi-disciplinary meeting attended by the ward manager, social worker, occupational therapist and physiotherapist. We saw good team working, clear decision making and that each team member's opinions were valued.

Referral, transfer, discharge and transition

- Admission criteria and pathways were in place and patients were, in the main, appropriately admitted to the facilities. A 'flow co-ordinator' based at the acute hospital assessed and screened patients who might be suitable for discharge to London Road Community Hospital. Occasionally, patients were admitted from the acute hospital, the Royal Derby Hospital, but were medically unsuitable for discharge to the community hospital and had to be readmitted back to the acute hospital.
- Perth House provided 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. One hundred and seventy patients had been supported at Perth House since April 2014. The average length of stay to support discharge from acute care was in line with targets, but for preventing admissions it was 14 days instead of eight. Bed occupancy was consistently lower than capacity and during our inspection only half of the available beds were occupied.
- There were often delays in patient discharges from the community wards. One of the wards at the hospital was a designated delays to discharge ward. This meant some patients remained in hospital longer than was required to meet their healthcare needs. These delays often took place when patients lived in remote rural areas without support services, or outside of Derbyshire. There were also challenges in setting up complex care packages.
- There were weekly multidisciplinary review meetings involving social services and the NHS continuing healthcare team. There were also daily 'delays to discharge' meetings, in which each ward was contacted to discuss discharges. A social worker from the local authority visited the hospital for two hours on weekdays to assist with discharge.
- Home assessments were conducted with the patient and carers by a member of the multidisciplinary team before discharge. This ensured equipment or further community support was provided once the patient was discharged home.
- Patients were referred to appropriate community services to ensure their needs continued to be met in their own homes after discharge. This included referral to community rehabilitation teams to ensure patients were supported to achieve their full rehabilitation potential.

Availability of information

- Patient records accompanied the patient on arrival from the Royal Derby Hospital. Staff told us if the records had not been received, they could be requested and delivered quickly. We spoke with a doctor who confirmed they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients.
- We reviewed the discharge summaries produced for patients including those sent electronically to GPs. We found they contained all the required information about the patient's care and treatment, as well as therapy needs, which would allow treatment to continue in the community setting. We spoke with a visiting GP who confirmed that their practice always received appropriately completed discharge summaries from the community hospital. .

Consent

- Staff involved patients in their care and we observed on a number of occasions that they obtained verbal consent before carrying out any personal care or treatment.
- Many of the patients were living with dementia or suffering confusion due to temporary infections or illness. There were a number of patients who did not have capacity to consent to their care and treatment. However, when we looked at the records of four of these patients we found only one completed mental capacity assessment. This meant that staff were making decisions about people's care which may not have been in their best interests. Staff were acting without due regard for trust policy, or the legal requirements of the Mental Capacity Act 2005.
- We discussed the mental capacity of a particular patient with the matron. She agreed that there was no evidence

in the person's file that an assessment had been undertaken. She advised that she would ask the ward manager to look into this matter immediately and ensure the patient's capacity to consent to treatment was assessed as soon as possible.

- Sometimes, hospital staff need to apply to the local authority for authorisation to keep someone in hospital, so that they receive the care and treatment they need. This applies to people who do not have the mental capacity to consent to their treatment. These authorisations are called Deprivation of Liberty Safeguards. Nursing staff we spoke with understood the concept of these safeguards and could give examples of when they would be considered. The matron told us that the safeguarding team, based at Royal Derby Hospital, maintained a database of all patients who were subject to Deprivation of Liberty Safeguards. They told us they reviewed each of these patients each week, to ensure the safeguards were still valid.
- We observed a 'best interest' meeting on one of the wards and saw that the patient's family members, the social worker and the ward manager had met to discuss the best interests of the patient in line with the Mental Capacity Act 2005. However, other relatives told us they were not involved and had not been kept informed about treatment decisions and how these should be arrived at.

Good

Are community health inpatient services caring?

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

Summary

Staff treated patients with dignity and respect. Staff communicated well with patients and relatives and attempted to support them to regain their independence. Some patients did not feel sufficiently informed about discharge arrangements and others would have preferred more rehabilitation therapy before being discharged.

Dignity, respect and compassionate care

- Patients were treated with dignity and respect. Staff knocked on doors before entering rooms and closed curtains around beds to provide privacy for patients during personal care and treatment.
- We observed staff speak with patients in a compassionate and sensitive way in a variety of situations. For example, we saw staff members respond with kindness and sensitivity to a particularly distressed patient.
- When we were speaking with one patient, they advised us that they wanted to be made more comfortable in their bed and we saw staff assist the patient with their wishes.
- Patients were cared for in accordance with national same sex accommodation guidelines.
- The NHS Friends and Family Test was undertaken on all four wards. Results from November 2014 were positive.
- Recent patient-led assessments of the care environment (PLACE) found patients were treated with dignity and respect.

Patient understanding and involvement

- Six of the patients we spoke with were positive about the support they had been offered by all the multidisciplinary team. We saw evidence in the care records of three of the patients which showed communication had been ongoing with the patient and their relative throughout their care.
- Some of the patients we spoke with were not clear about the plans for their discharge and they and their relatives felt they had not been kept informed. In one case the relative was extremely anxious.
- One patient told us how they were involved and fully informed regarding their discharge arrangements. However, two patients we spoke with, despite having been in the hospital for several days, did not know their predicted date of discharge. This was also confirmed by a visiting family member we spoke with who commented that they had "never heard of a discharge plan."
- There were good supplies of patient information leaflets, which covered a wide range of relevant topics available for patients and their relatives. Information displays were well maintained, showing how the ward was performing across a range of indicators. For example, details about how many falls had been on the ward and the results of infection control audits.
- Senior ward sisters were visible on all wards, which meant that relatives and patients could speak with them if they had any questions about their care. Ward information boards identified who was in charge of wards for each shift and who to contact if there were any problems.

Emotional support

- We spent time on one of the wards observing interactions between staff and patients. Staff were seen comforting patients and relatives in a supportive manner.
- Chaplaincy services could be arranged if required. Staff also described being able to access support for those of other religious denominations.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Promotion of self-care

- Most patients were admitted to the wards for rehabilitation. Therapy staff treated patients on the ward and patients were supported to self-care. Three patients and a family member told us that assistance was given when required, but that patients were encouraged to help themselves when appropriate. On one ward the nursing sister told us patients were supported to make their own breakfast.
- We observed lunch time on two of the wards. Patients had been encouraged to attend the dining room in order to eat lunch. Lunch was being supervised by three

Good

Are community health inpatient services caring?

or four healthcare assistants. We spent time observing how staff interacted with patients. We saw patients were encouraged to eat their meal in a sensitive and caring manner by staff.

- Therapists we spoke with confirmed that some patients told them that they did not feel as though they had received enough rehabilitation and wanted further physiotherapy before discharge. This was also confirmed by a former patient who wrote to us before the inspection and by two family members who spoke with us during our inspection. This meant some patients did not feel there was sufficient rehabilitation input before being discharged home.

Good

Are community health inpatient services responsive to people's needs?

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

Summary

Community inpatient services provided facilities for patients to recover and rehabilitate following an acute episode of illness and in some cases to prevent them being admitted to hospital. Services were flexible and catered for people's different needs. Patients' concerns and complaints were dealt with by senior staff at ward level and learning from feedback was shared at ward meetings.

Planning and delivering services which meet people's needs

- London Road Community Hospital provided 101 'step down' beds across four wards for patients who were well enough to be discharged from the Royal Derby Hospital, but needed more care and rehabilitation before returning home or to residential care.
- The intermediate care beds at Perth House also provided this facility as well as 'step up' beds to help prevent people from being admitted into hospital. These services helped reduce the length of patient stays in an acute hospital. They supported patients effectively without acute hospital care, promoting their independence. Patients received ongoing assessment, planning, treatment, evaluation and timely reviews of programmes.
- There were links between both hospitals to ensure effective transfers and ensure a 'pull' approach to acute discharges.
- Staff were able to request additional nursing staff when it had been identified that a patient required enhanced support. For example, on one ward a patient was receiving continual one to one care while they were waiting to be discharged to a care home.

Equality and diversity

- Staff received training in equality and diversity as part of the mandatory training programme, although the uptake of refresher training by staff was less than 50%.
- Staff informed us that interpreter services were available and requested when needed, although they admitted that they mostly relied on the family of patients to interpret for them, as necessary. During our visit we met a patient who spoke limited English. They explained that a relative attended to interpret for them, as they did not want anyone other than family members to support them. Senior managers told us interpreting services were frequently used but they did not monitor or keep track of their use.
- We were told by ward staff that food that met people's special cultural and religious needs was available if required.

Meeting the needs of people in vulnerable services

- Each ward had a nurse and care support worker who were dementia champions. They raised awareness amongst staff and were given dedicated time for training and support.
- For people living with dementia, staff used a 'This is me' form to provide a picture of people's preferred routines, preferences and choices. Documentation we reviewed on all four wards included information of the patient's likes and dislikes.
- We reviewed the care records of one patient who was living with dementia. We noted they had specific dietary needs and saw how these were fully met at lunchtime by the nurse who was providing one-to-one care.
- On one ward a number of staff had formed a dementia team. They had created a board displaying previous occupations that patients might have, with suggested meaningful activities. For example, some of the gentlemen were engaged with the task of assembling bird boxes while others loved planting and potting flowers or vegetables.
- We were told that there were few patients with learning disabilities who used the community hospital. The clinical director told us there was no specific system to flag people with a learning disability and ensure care approaches were reasonably adjusted to meet their health needs. There were no audits relating to this area. However, there was a specialist learning disability nurse at Royal Derby Hospital who would be able to support staff and patients with a learning disability should the need arise. Staff were aware of the lead for learning disabilities in the trust and knew how to contact them.

Access to the right care at the right time

- Staff told us the hospital provided daily reviews of all patients by a doctor. However, medical cover was only

Good

Are community health inpatient services responsive to people's needs?

available for four hours over the weekend. Access to medical support overnight was dependent on contacting the local out-of-hours service, or, in an emergency, 999 services would be contacted.

- Therapy services provided by physiotherapists and occupational therapists were available Monday through to Friday. Speech and language therapist (SALT) services were available on request, but the therapists usually attended the hospital once a week. We were told that a number of nurses had undertaken specialist training on the assessment of swallowing.
- We discussed discharge planning with a discharge coordinator and staff on the wards. They advised us that discharge planning started on the day of arrival for the patient.
- Pharmacy services were provided Monday through to Friday and included pharmacy technician support. The pharmacy technician we spoke with told us that, generally, medications were available on discharge and in a format suitable for the patient. We were told, however, of instances when patients had been discharged without their medication, as it had not been delivered to the hospital in time. Staff had previously had to send medicines to the patient's home by taxi service. We were told that they adhered to the medicines code. For example, any cytotoxic medication or antibiotics would not be delivered to a patient by taxi.
- The concern about late delivery of medication to the community hospital had been escalated to the chief pharmacist at the trust and there had not been any recent late deliveries of medication.

Complaints handling and learning from feedback

- We saw the complaints policy was clearly displayed on each ward. Nursing staff were able to describe the complaints process and explain how they would advise patients to raise a complaint.
- The wards also had leaflets explaining how to access the Patient Advice and Liaison Service (PALS) based at Royal Derby Hospital, if patients or their relatives wanted support in raising concerns.
- Patients received an information booklet on admission to the hospital. However, five out of six patients we spoke with on one of the wards were not aware of how they could raise a complaint. One person said they would speak with their relative if they were concerned and ask them to raise a concern on their behalf.
- The matron told us that ten formal complaints had been received about the hospital wards in the past six months. We saw evidence showing that these had been thoroughly investigated, or were in the process of investigation.
- Each ward had a complaints log. We saw that complaints were positively resolved at a local level at the earliest opportunity. Most staff said they would refer the patient to the ward sister in the first instance, if a patient was not happy with their care.
- Senior ward staff told us complaints relating to their service were shared amongst the teams during team meetings and in staff newsletters. Learning was also shared within matron's meetings and the monthly head of department meetings. There was evidence of feedback, learning and changes to practice as the result of complaints made.

Good

Are community health inpatient services well-led?

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

Summary

Community inpatient staff were aware of the trust's values and said they tried to put these into action as part of their daily work. There was still uncertainty about the future direction of the hospital. Staff described an open and learning culture. They felt able to raise issues with managers, if required. Senior managers from the trust visited the hospital regularly. Staff felt well supported by their line managers and were proud of the service they worked in.

Service vision and strategy

- There had been a great deal of change over the last few years. Before acute care services transferred to the Royal Derby Hospital site in 2009, London Road Community Hospital was the main acute hospital. Some services, including two of the inpatient wards, stayed at the community hospital and the other two wards were transferred from a small rehabilitation unit.
- The general manager told us that staff from the two wards that had not transferred with the other acute services felt "left here" and that, for many years, there had not been a clear plan for the hospital. He told us there was now a clear vision, but he was not in a position to share this with staff yet. Informing staff would be managed by the trust communications team.
- The trust had a clear vision statement, to take pride in caring, which was displayed around London Road Community Hospital and on the staff intranet. This formed the basis of the staff development review and appraisal process.
- Most staff we spoke with were aware of the trust's vision, values and objectives and showed commitment to caring through their individual and team behaviours. One staff member commented, "Taking pride in caring is what we have always done, this is definitely a value we can all relate to."

Governance, risk management and quality measurement

- Across all inpatient services, the ward sisters demonstrated a good awareness of governance arrangements. They described the actions taken to monitor patient safety and risk. This included incident reporting, keeping a risk register and undertaking audits.
- We saw minutes of ward meetings that covered areas such as risks, incidents, complaints and audits. Clear actions were described and previous actions were evaluated.
- We were also told about the quality review meetings, which ensured that quality and safety matters received due consideration and that actions were agreed and progress monitored. For example, we looked at the review of one of the wards and saw that it included staff training figures, complaints and the number of falls.
- We also saw minutes of the monthly matron's reports for escalation. These were very detailed and reported on areas such as staffing, patient complexity, staff sickness levels, and clinical risks.
- Quality measures such as the NHS Safety Thermometer data, hand-hygiene audit results and the results of the NHS Friends and Family Test were posted on noticeboards on each ward. This meant staff, patients and visitors were able to see how well the ward was performing in these areas.
- There were monthly community hospital senior management meetings, attended by medical consultants, nursing matrons and senior therapists. These discussed referral processes, clinical pathways, staffing, clinical audits and bed management. The meeting in November 2014 introduced sharing complaints and learning from serious incidents.

Leadership of this service

- In July 2014 poor leadership and concerns raised by patients about staffing on one ward led to an intensive support programme. This focused on improving incident reviews, audits, ward assurance data and staff engagement.
- The safe staffing board report for July to September 2014 showed that a community ward was one of eleven across the trust with low staffing levels. Two of the

Good

Are community health inpatient services well-led?

community wards had reduced their bed numbers as a response to low staffing available. Funding had been approved to employ extra healthcare assistants as part of the winter plan.

- Ward staff on all four wards told us that they felt supported by their direct line management. Ward sisters had an open door policy and staff found them to be approachable.
- Nursing and care staff told us that the ward managers and the matron provided strong leadership that focused on the needs of patients in the hospital. They said that the matron had a visible presence on the wards each day.
- We saw evidence of a programme of leadership training for middle grade staff to attend.
- Some members of staff told us that the chief executive regularly held meetings with staff at the hospital, and that she attended staff induction sessions to welcome new starters.

Culture within this service

- All staff that we spoke with advised us that they understood the trust's whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed on the wards advising staff of the whistleblowing procedure.
- The NHS Staff Survey 2013 saw the percentage of staff recommending the trust as a place to work or receive treatment was within expectations when compared with other trusts.
- Sickness absence was high particularly on one ward, where there were two health care assistants, two registered nurses and a receptionist on long term sick leave.

Public and staff engagement

- The trust operated an initiative called "Pride of Derby awards" where patients, relatives or staff were able to nominate staff members. These awards were signed by the chief executive and displayed on ward notice boards to acknowledge the work of staff.
- We saw patients were asked for their views about the care they received, or make a comment about the ward. A flip chart had been set up at the entrance to each ward where visitors or patients could write comments. The comments were reviewed each day by the ward sister and action taken to address them. We were told it was a similar, but simpler system of 'You said, we did.'

Innovation, improvement and sustainability

- A change in visiting times was currently being trialled with visitors now able to visit between 11am to 6pm. Previously, visiting times were from 2pm to 4pm and 4pm to 6pm, which had resulted in nursing staff being busy with visitors' queries, as family members understandably wanted to discuss their relative's progress.
- A staff training passport application was available to all staff on their mobile phones, ensuring they had access to their training records whenever they wanted, with reminders of when their training needed to be updated. One staff member showed us her 'passport' and told us they found it very useful.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not have suitable arrangements for establishing and acting in accordance with the best interests of patients without the capacity to give consent to care and treatment, in line with the requirements of the Mental Capacity Act 2005.** **Regulation 18 (1)(b) & (2)**