Rotherham Doncaster and South Humber NHS Foundation Trust

RXE

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)
RXE00	Trust Headquarters - Doncaster		

This report describes our judgement of the quality of care provided within this core service by Rotherham Doncaster and South Humber 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 Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber 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 we rated this service as good.

Staff reported incidents and there was evidence of learning from incidents in the service. The service had implemented a FallSafe bundle and a multidisciplinary falls risk assessment tool in line with recommendations from NICE (CG161). Care records were comprehensive, individualised and up to date. Wards were clean and tidy and equipment was available for staff to use.

People's care and treatment was planned and delivered mostly in line with current evidence based guidance and there was participation in local and national audits. Patient outcomes were better than or in line with the national average. There was evidence of internal and external multidisciplinary working.

Staff were caring, they respected patients' privacy and dignity. Patients were involved in decisions made about their care and treatment. The service met the needs of vulnerable patients. Senior staff held weekly clinics on the wards for patients and relatives to discuss their care.

The service actively worked with stakeholders to ensure that patients' needs were met through the way services were organised and delivered.

Governance in the service was effective. Risks were identified and managed at ward level. Nursing leadership was good with an open and honest culture where the benefit of raising concerns was valued. Managers engaged with staff and the public and supported improvement and innovation.

Venous thromboembolism was not in line with NICE guidance (CG92) and posed a clinical risk to patients' care. The service was not assured from the records held that staff had completed the appropriate training and that patients were not put at risk.

There was limited evidence of how the service's strategy aligned to the trust's strategic objectives.

Summary of findings

Our inspection team

Our Inspection Team was led by:

Chair: Philip Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Cathy Winn, Care Quality Commission

The team that inspected community inpatient services included: a CQC inspector, a registered senior nurse and a registered senior allied health professional.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed a range of information we hold about these services and asked other organisations to share what they knew.

During the inspection visit, the inspection team spoke with five patients, one relative and 26 members of staff. We observed care being delivered on the wards, looked at 30 pieces of patient documentation such as care records and risk assessments. We reviewed 39 medication charts. We observed mealtimes, nursing handovers and a multidisciplinary meeting. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who contacted us directly to tell us about their experiences.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The service must complete VTE risk assessments on all patients admitted (Reg 12:2a).
- The service must monitor VTE as part of the safety thermometer (Reg 12:2a).

Action the provider SHOULD take to improve

- The service should develop a consistent and accurate record of mandatory training
- The service should ensure the vision and strategy are clearly documented and linked to the trust's strategic objectives.
- The service should review the process of recording risk.

Rotherham Doncaster and South Humber 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

Summary

We rated safety as requires improvement.

There was no risk assessment for venous thromboembolism (VTE) on patients admitted to Hawthorn and Hazel wards. This was not in line with NICE guidance (CG92) and posed a clinical risk to patients' care. During our inspection we identified a patient who was high risk for VTE and had not undergone a risk assessment. The wards did not display VTE as part of the safety thermometer. The provider could not confirm that patients were receiving appropriate interventions to keep them safe.

There was inconsistent recording of mandatory training. The service was not assured from the records held that staff had completed the appropriate training and that patients were not put at risk.

Staff reported incidents and there was evidence of learning from incidents in the service. The service had implemented a FallSafe bundle and the multidisciplinary falls risk assessment tool was in line with recommendations from NICE (CG161).

Safety performance

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers (PUs), falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- The wards reported zero VTE risk assessments as part of the national safety thermometer data.
- The wards did not display safety thermometer performance information.

Requires improvement

Are services safe?

- The service reported four falls with harm, 12 new PUs and six CUTIs between June 2014 and June 2015. Falls and PUs both peaked in February 2015.
- Hawthorn and Hazel wards did not complete VTE assessments. This was not in line with NICE guidance (CG92) that covers the care and treatment of all adults (aged 18 and over) who are admitted to hospital as inpatients. We reviewed the records of two patients admitted to Hawthorn ward during our inspection. The referral forms did not document any entries under "anti-embolic therapy". Both patients had an increased risk of VTE according to NICE guidance. One patient was receiving VTE prophylaxis commenced by the acute trust, the other patient had no prophylaxis. This posed a clinical risk to patient care. We discussed this with the matron and ward sister who said they would review the process and take immediate action.
- Medical staff completed VTE assessments on Magnolia ward.
- The service participated in the trust's sign up to safety campaign, the pledge was to reduce the number of avoidable falls, reduce avoidable pressure sores and introduce intentional rounding.

Incident reporting, learning and improvement

- There were no never events and four serious incidents reported between February 2014 and March 2015, two grade three PU and two falls. The trust investigated serious incidents using a root cause analysis process. We reviewed three investigations. Two contained recommendations and an action plan. During our inspection we saw evidence of the recommendations in practice, for example, up to date documentation of pressure area care and mobility and falls care goals set.
- Incidents were reported on an electronic system. Staff of different grades and disciplines were aware of how to report an incident.
- The service reported 531 incidents between May 2014 and April 2015, 155 on Hawthorn, 182 on Hazel and 194 on Magnolia. Ward managers and staff told us medicines and falls were the main themes from incidents.
- Staff received feedback and lessons learnt from incidents through ward meetings, newsletters and emails. Staff gave us examples of changes made following incidents. For example, changes to the environment and supervision of patients on Magnolia and the introduction of pendant alarms and intentional rounding to reduce falls in the service.
- Staff completed incident forms when there was a lack or shortage of staffing. The staffing review group reviewed these incidents. There did not appear to be a trend in incidents of other types when staffing was low.

Duty of Candour

- The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate or significant harm.Staff showed a limited understanding of Duty of Candour at ward level. They were aware of the principles of open and honest care but not the specific requirements associated with Duty of Candour.
- Senior staff demonstrated an understanding of the Duty of Candour. The incident form included a reference to the duty.

Safeguarding

- The service had staff trained in safeguarding adults' level three and four.
- On average 85% of staff in the service had completed safeguarding adults' level one and 54% had completed level two training.
- On average 89% of staff in the service had completed safeguarding children level one and 56% had completed level two training.
- The trust's target for training compliance was 90% by September 2015.
- Staff showed a good understanding of safeguarding and explained the process they would follow to raise any concerns.
- The safeguarding team's contact details and process was on display on all wards.

Medicines

- Medicines were well-managed overall on all three wards. We observed one medication round and reviewed 39 medication administration records (MAR). Five (13%) of the 39 MARs had omissions of medications.

Requires improvement

Are services safe?

The pharmacy team checked all drug charts on a regular basis. The pharmacist 10 point plan is a series of additional checks done by the ward pharmacist as part of the validation process of patients' drug charts. The number of issues found with drug cards had reduced since the introduction of this process.

- The trust selected medication errors as one of the five key focus areas as part of the Sign Up to Safety campaign.
- Nursing staff completed a medicines competency. Rehabilitation assistants completed a competency to check controlled drugs with a registered nurse. Pharmacists trained nurses in patient group directions to allow the supply and administration of prescription only medicines.
- Records we inspected showed daily checks of the medicines refrigerator temperatures took place on all three wards. The refrigerators were clean, the recorded temperatures were within normal range of between 4 – 8°C and there were no out of date items stored in them.
- We checked controlled drugs on the three wards. The book was correct, stored appropriately and contained no anomalies. A ward manager was aware of one incident where a controlled drug had been omitted, an incident form was completed. A ward manager from another ward would investigate the incident.
- Senior staff used the edmet tool for medication incidents. This is an objective tool to ensure consistent scoring of medication errors and fair action across all staff.
- No patients were receiving oxygen during our inspection. Staff told us that they prescribed oxygen to patients that required it.
- Data submitted by the trust showed that, of 196 medicines incidents in the trust between April and June 2015, 45 (23%) occurred within the business division. We were unable to identify how many of these incidents took place in this service.
- The trust's 2015 medicines reconciliation audit showed that medicines reconciliation occurred within 72 hours of admission 80% of the time on Hawthorn ward and 100% of the time on Hazel and Magnolia wards.
- Patients on Magnolia ward self-medicated in preparation for discharge. Staff explained the three levels of self-medication assessment and support they used. Senior staff on Hazel ward planned to introduce self-medication onto the ward, but no action plan or timescale was available for this at the time of our inspection.
- Pharmacists placed stickers on the MAR when they had reviewed medication as part of the FallSafe care bundle.

Environment and equipment

- Resuscitation equipment was available on all wards and records of the checks from the previous 10 weeks were all complete.
- Oxygen was stored in a designated area in the locked clinical room. It was not secured to the wall.
- The clinical room on Hawthorn ward where medications and medication trolleys were stored was cluttered due to pieces of equipment also being stored in the room.
- Equipment we observed was labelled with up to date portable appliance testing (PAT).
- Clean equipment was inconsistently labelled. Walking aids appeared clean and staff explained the process of cleaning the equipment before moving it to the storage area. However, they were not labelled. This meant staff lacked assurance that the equipment had been cleaned in line with trust policy.
- Each ward had a day room that was equipped with a quiet room, bookshelf, television, emergency buzzers, flowers, and clock. There was also an information board that informed patients of the date, weather and the day's activities.
- The garden on Magnolia ward was not accessible to all. Staff found the ward environment difficult when managing patients with challenging behaviour. Senior staff were due to submit a capital bid to upgrade the environment

Quality of records

- Documentation was completed on an electronic patient record called SystmOne.

Requires improvement

Are services safe?

- We reviewed care plans for four patients. These were individualised, comprehensive with goals updated on a weekly basis and evaluation of care undertaken as patients' condition changed or when the review date dictated.
- We found an example of individualised care planning, with one record containing a catheter management chart. Staff had completed this fully.
- The care plans included personal exercise programmes. This meant staff had access to rehabilitation plans to complete with patients.
- The service recently introduced intentional rounding. We reviewed two documents; staff had completed both hourly.
- The mandatory training programme included information governance training. The trust target was 90% by September 2015. Training compliance in the service ranged between 50-83% with an average of 66% of staff trained. A third of staff were not up to date with training.

Cleanliness, infection control and hygiene

- The environment on all three wards was visibly clean, including bed spaces and communal areas. The trust employed housekeeping staff to maintain a clean environment. The sluices, toilets and showers on all three wards were clean and equipment was stored appropriately.
- The wards displayed infection control information that was visible to patients and visitors.
- Staff adhered to the trust policies of hand hygiene and bare below the elbows. Staff had access to personal protective equipment (PPE) such as aprons and gloves. We observed staff using these in an isolation room on one of the wards.
- One patient was nursed in isolation during our inspection. An isolation sign was visible and we saw trust policies and procedures were been adhered to with regards to infection control and the nursing of a patient in isolation. Staff and visitors had access to PPE, hand gel and cleaning wipes.
- The trust target for infection prevention and control training was 90% by September 2015. Training compliance in the service ranged between 42-75% with an average of 57% of staff trained. This meant that staff were not up to date with training in infection control.
- Audit information submitted by the trust showed that staff completed the last audit of infection and prevention on Hawthorn ward in October 2014.

Mandatory training

- The trust target for mandatory training by September 2015 was 90%.
- Senior staff spoke to us about the challenges they faced releasing staff for mandatory training and also in obtaining accurate records of completed training.
- The trust submitted data on overall mandatory training compliance. The figures in this document differed to the figures provided by the business division. We viewed records on site, kept locally on the wards, these contained different figures again. The service was not assured from the records that staff had completed the appropriate training and that patients were not at risk.
- Figures provided by the business division showed overall mandatory training compliance to be 61% on Hawthorn ward, 66% on Hazel ward and 65% on Magnolia ward. Between 59-70% of staff were up to date with fire training, 60-75% with moving and handling training and 72-85% with life support training. Staff may put patients at risk as they may not have had the appropriate training.
- A member of administration staff or the clinical educator kept the local training records updated; both these posts were vacant at the time of our inspection.

Assessing and responding to patient risk

- The service used a recognised early warning tool called EWS. Rehabilitation assistants completed competencies to measure patient observations. They reported abnormalities with the EWS to a registered nurse. We reviewed nine EWS chart; all were complete. There were EWS abnormalities on two of the charts and staff had acted on both appropriately.

Requires improvement

Are services safe?

- The service employed Advance Nurse Practitioners (ANP) who had completed a competency framework and were nurse prescribers. The ANPs reviewed patients at the request of the ward staff.
- Hawthorn and Hazel ward contacted the community out of hours team or 999 if a patient deteriorated out of ANP hours. Staff on Magnolia contacted the acute medical unit at the acute trust or 999 if they had concerns about a patient out of ANP hours.
- We reviewed three sets of patient risk assessments; all were completed fully.
- The multidisciplinary falls risk assessment tool was in line with recommendations from NICE (CG161 assessment and prevention of falls in older people). Two rehabilitation assistants explained the actions they would take if a patient fell. The service had implemented a fall safe bundle, all patients wore pendant alarms and the wards displayed safety information prompting patients to use their call buzzer. Wards used falls sensors and low beds with patients consent for patients at high risk of falls.
- We heard six patient call buzzers whilst on the ward. Staff answered all of them in less than two minutes. This meant staff were able to meet patients' needs in a timely manner.
- The boards above patients' beds displayed the mobility level, walking aid, distance and supervision a patient required when walking. This meant staff on the ward had access to safety information at a glance.
- We observed two handovers. These were inclusive; therapists and rehabilitation assistants attended. Staff outlined key safety aspects, dietary needs, infection control issues, mobility and discharge plans. Handovers used 'patient status at a glance' information. The service introduced this following learning from falls investigations and this ensured that all staff had access to patient information.

Staffing levels and caseload

- The intermediate care service was redesigned in September 2014. Staffing was based on historical figures. Managers reviewed the service using the Shelford Safer Nursing Care Tool and patient dependency and found the establishment was not sufficient to meet the patient caseload. The sisters on Hazel and Hawthorn wards and matron adapted the complexity tool in use in the trust's community nursing service to use in an intermediate care setting to assess the complexity and dependency of patients. The service planned to pilot this tool to plan staffing for three months.
- Hawthorn and Hazel wards' establishment was 21.4 WTE registered nurses and 37.2 WTE nursing assistants. Information submitted by the trust showed that 769 shifts on the wards were filled by bank or agency staff between January and March 2015.
- Information submitted by the trust showed 6.3 WTE nursing assistant posts were vacant on Hazel and Hawthorn wards. Senior staff told us vacancies had been recruited to. New staff were waiting for start dates.
- Magnolia ward used the UK rehabilitation outcomes collaborative dependency tool to plan staffing. The use of the dependency tool was given as the reason Magnolia's bed occupancy was normally around 67%. The ward manager reviewed the patient dependency weekly.
- Magnolia ward's establishment was 11.2 WTE registered nurses and 13.6 WTE nursing assistants. Information submitted by the trust showed that 140 shifts on the ward were filled by bank or agency staff between January and March 2015.
- Information submitted by the trust showed 3 WTE registered nurse posts and 0.2 WTE nursing assistant posts were vacant on Magnolia ward.
- All the wards reported fill rates of greater than 90% for registered nurses and nursing assistants for all shifts between April and June 2015.
- A member of staff told us the ward manager arranged additional staff when it was needed. The bank and agency staff who worked on the ward were regular staff familiar with the ward.The permanent staff completed the tasks they had competencies for, for example, checking patients' observations and the bank and agency staff would complete other tasks. This mitigated the risk of potential incidents that may occur from the use of non-permanent staff.
- The wards in the service worked as a cluster overnight; four registered nurses worked across the three wards.

Requires improvement

Are services safe?

Two nurses were based on Hawthorn ward due to it being the admission ward where activity and acuity was higher. Staff carried an alarm that linked the three wards to request assistance.

- Staff told us of a four week period where one of the two nurses on Hawthorn ward overnight worked a twilight shift and finished at 3am. This meant that for four hours the cluster of wards did not have a second nurse for support. Managers were clear this was a business continuity arrangement to cover a staffing shortage. We viewed subsequent rotas from September to November 2015 where all night shifts on Hawthorn ward had two nurses planned as cover.
- The service had a clear out of hours escalation procedure.All staff we spoke to told us they contacted the senior manager on call with any concern or if they required advice.
- We reviewed the service's induction process for bank and agency staff.
- Wards displayed planned and actual staffing figures visible to patients and visitors.
- A consultant in rehabilitation medicine was in post on Magnolia ward.
- Therapy staff establishment was 5.6 WTE across the wards; two WTE therapy posts were vacant on Magnolia.

A locum therapist filled one vacancy. Therapists from the neurological outreach team were providing cover to Magnolia ward for the other vacancy. Recruitment to these posts was underway.

Managing anticipated risks

- Following a serious incident, Magnolia ward introduced a standard operating procedure that staff would follow in a situation where safety was at risk. Staff on Magnolia carried a fob to request assistance and access all areas on the ward.
- Magnolia had recruited a two registered mental health nurses to the ward to improve the skill mix of staff when managing patients with challenging behaviour.
- Staff on Magnolia ward participated in an annual bespoke training course with the managing work related violence team. This was combined with annual simulation training with the reducing restrictive intervention team.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- Staff on all three wards knew about the business continuity plan and where it was stored.
- Hazel ward displayed information about the business continuity plan on the wall for patients, visitors and staff to see.

Good

Are services effective?

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

Summary

The effectiveness of this service was good. Patients had good outcomes because they received effective care and treatment that met their needs.

Patient outcomes were better than or in line with the national average. The service participated in the National Intermediate Care Audit and UK Rehabilitative Outcomes Collaborative.

There was evidence of internal and external multidisciplinary (MDT) working. Wards held a weekly MDT meeting with clear, timely discharge planning.

Patients signed personalised rehabilitation plans to indicate consent. Staff showed evidence of understanding and the application of the Mental Capacity Act and deprivation of liberty safeguards.

Evidence based care and treatment

- We reviewed the case notes for a patient who had been admitted from home. There was a well-coordinated assessment, management and rehabilitation plan. The notes showed evidence of good care planning, appropriate sharing of information, access to orthopaedic consultants and evidence of considered discharge planning. The patient had two long term conditions which staff managed in line with national guidance; osteoporosis (NICE CG146) and osteoarthritis (NICE QS87).
- Therapists set person centred goals with patients during their initial assessment.
- Staff planned and delivered activities and exercise groups in line with recommendations from national guidance, for example NICE CG161 assessment and prevention of falls in older people.
- Planned rehabilitation on Magnolia ward was in line with best practice guidance and included memory, perceptual and vocational work to restore patients' independence.
- Hawthorn and Hazel wards management of VTE was not in line with NICE guidance (CG92).

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- Staff used an evidence based pain score (McGill) to assess patients' pain.
- We observed a member of staff addressing a patient's pain relief. They discussed with the patient and the MDT and agreed an appropriate management plan that was documented in the patient's record.
- Two patients told us staff kept their pain under control. Staff gave regular and as required painkillers.
- The service supported a patient with chronic pain to attend their regular clinic appointments during their inpatient stay.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- Staff carried out a nutritional assessment on patients and this included the use of the Malnutrition Universal Screening Tool (MUST). We inspected three MUST charts, 10 food and 12 fluid charts and found they had been completed fully.
- Nutritional information, menus, special diets and a menu key was displayed in the dining room visible to patients and visitors.
- Staff offered patients a choice of meals and drinks. We observed that drinks were placed within patients reach and staff offered drinks regularly.
- We observed lunchtime. Staff demonstrated knowledge about patients' dietary requirements. Patients interacted with staff and each other. It appeared to be a social experience.
- We observed a therapy breakfast on two wards where there was an enabling approach, for example, teapots on the table, cereals and toast on the table. Staff supported patients to regain their independence in preparation for discharge.

Good

Are services effective?

Patient outcomes

- The service participated in the National Intermediate Care Audit. The service achieved 75% or above on most standards in the 2014 results. The results for eight out of 10 standards had improved from the 2013 results. Examples of the standards included in the audit were; quality standard one "have the views of patients and their carers on current services and any plans for future service development been actively sought?" the service achieved 95.8%. Quality standard 5 "is a responsible team member (or key worker) identified to ensure the care plan is carried out?" the service achieved 96.3%. The two standards where compliance had not improved in 2014 were related to mandatory training. The audit lead had completed an action plan with a timescale. During our inspection we saw evidence of the service working towards the action plan. This included introducing dependency tools and informing patients of support that was available on discharge.
- Magnolia ward registered performance data with the UK rehabilitation outcomes collaborative.
- Staff recorded recognised outcome measures, for example, Tinetti, Functional Independence Measure, Functional Assessment Measure and Modified Barthel Index. Staff had not evaluated the outcome measures or benchmarked the service. This meant the service was not using the available information to inform improvements in quality.
- The ANPs reviewed readmissions monthly and were setting up a database of effectiveness to include delayed discharges, length of stay, and readmission back to the acute trust.
- Medical staff in the service were involved in research at local acute trusts.
- Seventy five percent of patients returned to their own home from Hazel and Hawthorne wards.
- The trust submitted evidence of the clinical audit schedule. This included a re-audit of pressure ulcers, use of antibiotics on inpatient wards reaudit, reaudit of care planning – patient care and experience and guidelines to staff on do not attempt cardiopulmonary resuscitation orders. The final reports and action plans from these audits were not yet available.

Competent staff

- Evidence submitted by the trust showed the rate of up to date appraisals in the service was between 43-87%.
- Wards had a clinical supervision tree in place. This consisted of three contact supervision sessions. For example, one to one or group supervision were held and three other sessions, including, ward meetings, or time out sessions a year. We saw evidence of recent ward meeting minutes and time out sessions.
- Rehabilitation assistants completed therapy competencies and training was in the early stages on all wards. The vision of senior staff was to integrate groups of rehabilitation assistants with the competencies into the team to embed rehabilitation in the workforce.
- We found inconsistency across different professions in the service in terms of the duration and frequency of supervision.
- A long term agency member of staff on Magnolia ward did not have specialist neurological rehabilitation skills. Permanent staff who had moved into the service from another speciality told us they received the training they required.
- The service supported a rehabilitation assistant to complete the care certificate.
- Therapy
- Senior staff received support from managers and human resources with absence and performance management.

Multi-disciplinary working and coordinated care pathways

- The wards held weekly MDT meetings. We observed an MDT meeting where there was evidence of effective pathway tracking, MDT working, sharing of information with the acute trust, timely and effective discharge planning, and monitoring of delayed discharges.
- Wards held individual case conferences according to patients' needs.
- Staff told us there were good working relationships within the MDT. We saw evidence of effective and integrated MDT working.

Good

Are services effective?

- Physiotherapists and Occupational therapists worked on Hazel and Hawthorn wards from 7am-7pm Monday to Saturday. They worked on Magnolia ward Monday to Friday. Advanced Nurse Practitioners (ANPs) worked Monday to Friday.
- All the wards had access to support from a dietician, speech and language therapist and a tissue viability nurse. The service had access to a part time pharmacist and full time pharmacy technician.
- Hazel and Hawthorn wards had a social worker attached to the wards who attended the weekly MDT meeting. Magnolia ward referred patients to social services on a case by case basis. The service tried to access the same social worker, but it was possible a different social worker could be involved with different patients on the ward. Patients with a neurological impairment can have complex needs and the lack of a specialist/dedicated social worker could affect the ability to plan and deliver holistic care.
- Staff told us they had good access to mental health services for patients. They thought this was because the services were part of the same organisation.
- The service had seven day access to the equipment provider.
- The service was building strong links with the MDT at the local acute trust. Service leads from the trust, social care and acute trust attended a strategic forum and ward managers from the trust and acute trust attended an operational forum, both held monthly.

Referral, transfer, discharge and transition

- The intermediate care service was redesigned in December 2014. Hawthorn ward became an admission and short stay ward. The service transferred patients who required longer term rehabilitation to Hazel ward.
- The integrated discharge team at the acute trust referred 'step down' patients into the service. The intermediate care service and integrated discharge team developed a referral form that was used by staff in the acute trust and staff on Hawthorn ward to triage and accept referrals.
- Staff in the community, for example, GP, community matrons, and the community intermediate care team referred 'step up' patients into the service.
- Hazel and Hawthorn wards admitted to and discharged from the service over the weekends. Admissions were accepted 24 hours a day.
- Staff completed a handover document that highlighted any risks to accompany the patients when they were transferred from Hawthorn to Hazel ward.
- Data submitted by the trust showed Hawthorn ward had 51 delayed discharges between October 2014 and July 2015, a total of 627 days. Hazel ward had 63 delayed discharges in the same period, a total of 712 days.
- We saw evidence of working with community services in discharge planning. Staff made onward referrals to the local authority enablement team, therapists completed home visits and social workers had completed carers' assessments.
- Magnolia ward received referrals from a range of service providers. An MDT referral meeting took place three times a week and patients were assessed within two working days of the meeting.
- Magnolia ward admitted to and discharged from the service between Monday and Friday.
- The service encouraged early referral to Magnolia ward. Patients would be part of an in reach and a transition caseload as they entered and left the service. This meant staff on the ward supported patients that required complex rehabilitation and the people/staff caring for them whilst they were waiting to be transferred and once they had been discharged from the service.
- Data submitted by the trust showed Magnolia ward had 24 delayed discharges between October 2014 and July 2015, a total of 340 days.
- Staff on all wards told us that delays in social care were the main reason for delayed discharges. Leads in the service and in social care discussed the delays at the monthly strategic forum.

Access to information

- The trust used multiple electronic records. Staff completed patient records on SystmOne, bed management was completed on Silverlink and some patient information and data remained paper based. Staff expressed frustration that the systems did not link with each other.

Good

Are services effective?

- Medical staff were piloting electronic notes on Magnolia ward.
- The service had access to contemporaneous information in the acute trust. Staff looked up patients' clinic appointments and information on the Patient Administration System (PAS) during the MDT meeting.
- The service displayed useful information at the nurse's station, for example, contact details for the acute trust, community services, emergency care practitioner's guidance, and in and out of hour's pharmacy information.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Staff demonstrated an understanding of consent, MCA and decision making.
- Data submitted by the trust showed between 93.3-100% compliance with MCA and DoLS training.
- Staff completed a cognitive screening tool on admission. Staff then followed this up with an assessment of capacity if indicated.
- A member of the MDT on Magnolia ward was a best interest's assessor.
- DoLS provide a legal framework to ensure that patients are only deprived of their liberty when there is no other way to care for them or safely provide treatment and to ensure that patient's human rights are protected.
- Two DoLS applications were in progress during our inspection, the documentation for these DOLS authorisations was of a good standard. Staff demonstrated an understanding of DoLS and told us which patients had DoLS in place or progress. This showed us the service was aware of their responsibilities to protect patients using this legislation.
- Staff on Magnolia accessed additional external training on MCA and DoLS as nursing staff would assess complex capacity on a regular basis.

Patients signed the paper copy of their care plan to agree it had been discussed with them and they consented to it.

Good

Are services caring?

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

Summary

We rated the service as good for caring.

There was evidence patients were involved in their care, they explained the treatment they had received and their discharge plan to our inspection team.

We saw that staff respected privacy and dignity at all times.

The service introduced a monthly carer's café to support patients, relatives and carers.

Compassionate care

- The NHS Friends and Family Test response rate was similar to the England average. Eighty seven percent of patients would recommend the service to their family or friends. Seventy seven percent of staff would recommend the service as a place to be cared for.
- The service scored better than the national average in the Patient Reported Experience Measures section of the 2014 National Intermediate Care Audit.
- We observed patients being treated with privacy and dignity. All staff spoke to the patients compassionately, informed them of their treatment and discharge plan.
- We witnessed staff speaking to patients at their height when sitting in the day room and dining room.
- We observed caring interactions on all the wards. Staff demonstrated an individualised care approach to patients and spoke to them in a respectful manner.
- On Hazel ward the named nurse and named therapist was displayed above patients' beds.

Understanding and involvement of patients and those close to them

- The patients we spoke to were complimentary regarding the care they received and knew when their planned discharge date was.
- There was evidence in the care plans on SystmOne of comprehensive discharge planning and involvement of relatives and carers in decision making.
- A patient and relative said they both felt involved in the care. They said the staff were caring and aware of individual patient preferences. They would do anything for you.
- Wards displayed patient and carer information. Examples of this included information on Age UK, dementia, carer's café, Headway and benefits and housing support.
- Results of a survey displayed on Magnolia ward showed 71% of patients and 50% of carers felt they were given enough information about the service.

Emotional support

- There was a range of clinical nurse specialists and case managers at the trust who supported patients with complex or long term conditions, for example, in neurological conditions, palliative care and tissue viability. Wards had the contact details for these services.
- Staff engaged patients discussing and recording on a board their favourite childhood memories during breakfast.
- A post discharge visit two weeks after discharge was arranged from Magnolia. Patients on Magnolia underwent a graduated discharge process spending one night at home, then a weekend at home prior to discharge. Staff visited patients at home two weeks following their discharge.
- Hazel ward had an independent living suite to promote to promote patient independence in readiness for discharge.

Good

Are services responsive to people's needs?

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

Summary

The responsiveness of this service was good. People's needs were met through the way services were organised and delivered.

The service actively worked with stakeholders and was involved in the clinical commissioning group's review of intermediate care and neurology services.

The service met the needs of vulnerable patients and those who required reasonable adjustments. Adaptations to the environment had been made to make the garden accessible and the wards supportive to those with dementia.

People knew how to raise concerns. Senior staff held weekly clinics on the wards for patients and relatives to discuss their care.

Planning and delivering services which meet people's needs

- The service had clear admission criteria and referral pathways for the intermediate care wards and the neurorehabilitation ward.
- The service engaged with commissioners, the acute trust, social care and other stakeholders in two Doncaster wide reviews of intermediate care and neurology services considering the holistic patient pathway.
- The service worked with geriatricians from the acute trust. Managers were working with the acute trust to formalise the pathway following recommendations from a falls serious incident investigation.
- There was evidence of good partnership working with GPs, the local authority and telehealth

Equality and diversity

- The service displayed information for patients developed by the trust. This was available in other languages, large print, braille and audio tape.
- The gardens on Hazel and Hawthorn wards were accessible; low flower beds had been created and there was a variety of seating available.
- During our inspection we observed staff communicating with a patient whose first language was not English. The patient's relative was present and staff were involving them appropriately in the patient's care.We asked staff about translation services and they demonstrated knowledge of the trust's interpreter policy.

Meeting the needs of people in vulnerable circumstances

- Staff screened patients for a cognitive impairment using an evidence based tool from the trust's memory clinic, the abbreviated mental test score.
- The environment on Hawthorn ward had been updated using a capital bid to make it dementia friendly. All wards had signage that was accessible to patients suffering from dementia.
- Staff identified and made an onward referral to the district nurses on discharge for a patient who had a progressive illness.
- A younger patient was on the ward during our inspection. Staff were using diversional therapy with them and trying to promote independence.

Access to the right care at the right time

- The average bed occupancy between October 2014 and July 2015 was 96% on Hawthorn ward, 99% on Hazel ward and 71% on Magnolia ward. This was above the national average and above the 85% occupancy level where regular bed shortages and an increased number of health care associated infections can occur (National Audit Office).
- Patients moved from Hawthorn to Hazel as part of the intermediate care pathway but there was no evidence of further regular bed moves during the patients' admission.
- Hawthorn ward's average length of stay was 9.4 days between April and June 2015. Hazel ward's length of stay was 27 days between April and June 2015. This was lower than the national average for 2014 which had been audited at 28 days.

Good

Are services responsive to people's needs?

- Staff in the MDT meeting regularly reviewed treatment and actively managed the flow of patients through the service. This helped to ensure patients' needs were being met and in the right environment.
- The multidisciplinary team on Magnolia ward completed the Health of the Nation Outcome Scales for Acquired Brain Injury to assess the suitability of the patient and if the unit could meet the patients' needs. The ward signposted the referrer to other services if they could not to accept the patient.
- Magnolia ward's average length of stay was 85.3 days between April and June 2015.

Learning from complaints and concerns

- The wards displayed information for patients and relatives about how to make a complaint and provide feedback about the service.
- Information submitted by the trust showed the service received two formal complaints between November 2013 and April 2015. One of these concerned staff attitude and was upheld.
- Senior staff demonstrated learning from complaints and explained the support available to them in the trust when managing staff.
- The wards displayed comments and feedback from complaints and your opinion counts forms that were visible to patients, visitors and staff. Some examples of these were involving family in a patients care, allowing private time with visitors and there being clutter on the corridor.
- Senior staff did not keep a log of informal complaints or your opinion counts forms. Staff addressed concerns and documented them in the patients' record.

Good

Are services well-led?

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

Summary

The leadership of this service was good. The leadership, governance and culture promote the delivery of high quality person-centred care.

Staff were aware of the service's vision. Nursing leadership was good with an open and honest culture where the benefit of raising concerns was valued. Improvement and innovation was supported. Managers engaged with staff and the public.

The levels of governance within the service functioned effectively. Risks were identified and managed at ward level.

There were gaps in the systematic recording of risks at business unit level. There was limited evidence of how the service's strategy this aligned to the trust's strategic objectives.

Service vision and strategy

- The trust had a vision and a set of values and staff we spoke to knew what these were.
- The business division had a five year strategic plan. The plan included an options appraisal and considered priorities and risks. The management team explained the strategic plan to us. The service's initial focus was on the clinical commissioning group's reviews of intermediate care and neurology services across Doncaster. There was limited documented evidence of how this local strategy linked to trust's strategic objectives.
- Senior staff had a vision for the ward nurses to work with the ANPs to improve their clinical assessment skills become nurse prescribers.

Governance, risk management and quality measurement

- The service held monthly governance meetings chaired by the matron and attended by members of the MDT. Minutes of the meetings included discussions around incident reviews and actions, staffing, your opinion counts forms and competencies.
- The business division stored governance and performance information on a live computer portal. We reviewed this and found individual audit action plans and meeting minutes. The service did not have an action plan to give an overview or evidence of task and finish groups to achieve actions or change.
- Senior staff shared information from the governance meetings through team meetings, emails and a news flash put up in the staff changing room and on the information board.
- Ward sisters completed weekly ward checks and audits, for example, patient dependency, staffing and completion of admission documentation. The gave feedback to staff weekly by putting information in staff drawers and on the wall in the MDT room
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current risk rating. Controls in place and actions to mitigate the risk were identified and monthly updates were recorded. The business division identified the risks in the service to be recruitment of nurses and mandatory training.
- Risks were identified, mitigated and managed at ward level. For example, night time nurse staffing and the storage of equipment. There were gaps in the systematic recording of risks at business division level.
- The management team told us they were on a journey to provide evidence of governance and performance and thought the business division was recognised at trust board level. The business support unit had begun to work with the management team to provide performance data

Leadership of this service

- Managers felt supported by the trust. Non-executive directors and the director of nursing had visited the service.

Good

Are services well-led?

- All the senior staff had attended the trust's leadership training "fit for the future" and spoke positively of this training.
- All staff told us they felt senior staff and managers were visible, approachable and supportive. Therapists received support from their professional leads as well as line managers.
- Matrons attended a monthly meeting for peer support. The introduction of ANPs in the team included another senior member of staff with a strategic view of the service.
- The three wards had strong nursing leadership. Therapy leadership within the service was weaker. Managers recognised this and were looking at ways to empower Allied Health Professional staff following the business division's redesign. The service and AHP professional leads reviewed the skill mix and vacancies were being advertised at different grades.

Culture within this service

- All members of staff we spoke to were proud to work in the trust and felt part of the team they worked in.
- All staff conveyed a strong open and honest culture.
- Staff told us they felt supported to report incidents and raise concerns to their line managers. Ward managers sought their views when implementing change.
- Staff told us they did not feel under pressure from managers to work additional shifts or types of shift patterns even during periods of staff shortages.
- Senior staff told us trust policies were relevant physical health as well as mental health.

Public engagement

- The service provided evidence of public engagement; every ward displayed the 15 step challenge toolkit designed to improve quality of services by patient, carers and the public.
- Wards displayed thank you cards, and patient and carer feedback through your opinion counts.
- Hazel ward displayed "Stan's story," a patient journey, so patients and staff had an understanding of a patients experience of using the service
- The trust participated in a "tweet us" campaign. Wards displayed the information and patients received a response on a Monday to Friday between 9am and 5pm.
- The service ran a carers café, a weekly patient and relative clinic where a member of the senior team met to discuss about patients or carers experiences on the ward.

Staff engagement

- All staff we spoke to felt that communication within the trust was good.
- Staff received a newsletter circulated from the executive team.
- The wards displayed "you said, we did" information on the ward a scheme where the executive team sought the views of staff and responded to them.
- Staff meetings took place all the wards. We reviewed minutes of these meetings, staff told us they received copies of the minutes by email so they were kept informed in they were unable to attend the meeting.
- Managers took a positive approach to competency management. They involved staff in a table top exercise to reduce errors from transcribing medication.
- Therapists attended AHP network meetings.

Innovation, improvement and sustainability

- The intermediate care service was redesigned in December 2014. Managers expected further changes to the intermediate care and neurological services following the outcome of the CCG review.
- Introduction of the governance portal brought all the wards individual action plans together in one place. This gave senior staff the opportunity to review and combine numerous pressure ulcer and falls action plans and felt this had improved patient safety and reduced serious incidents.
- The service launched FallSafe, an evidence based patient safety project supported by the Royal College of Physicians to reduce the incidence of falls on inpatient wards by up to 25%.
- Magnolia ward were working with the neurological outreach team to develop a pathway to improve access to inpatient care for patients with multiple sclerosis.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not assessed or protected against the risks of venous thromboembolism. Regulation 12 (2) (a).