

North East London NHS Foundation Trust

RATW3

# Community health inpatient services

## Quality Report

Trust Head Office,  
Goodmayes Hospital,  
Barley Lane,  
Ilford,  
Essex IG3 8XJ  
Tel: 0300 555 1200  
Website:

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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)
RATFG	Foxglove Ward	Foxglove Ward	
	Japonica Ward	Japonica Ward	
RATDK	Mayflower Community Hospital	Mayflower Community Hospital	
RATY2	Ainslie Rehabilitation Unit, Waltham Forest Rehabilitation Services	Ainslie Rehabilitation Unit, Waltham Forest Rehabilitation Services	
RATX4	Alistair Farquharson Centre, Thurrock Community Hospital	Alistair Farquharson Centre, Thurrock Community Hospital	







This report describes our judgement of the quality of care provided within this core service by North East London 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 North East London NHS Foundation Trust and these are brought together to inform our overall judgement of North East London 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.
- This was because we found a good culture for the timely reporting of incidents and the trust were able to identify themes and trends among community inpatient services. Safeguarding processes had a level of profile that enabled the identification of possible abuse and encouraged reporting. Processes for the safe administration of medication were in place and the overall standard of documentation was good. Wards were clean and staff were trained in infection prevention and control. Premises and equipment were largely well maintained and managed. However, we also found that equipment had not been serviced and space available for meaningful therapeutic activity compromised the service provided to patients.
- Community inpatient services were operating with a substantial nurse vacancy rate and on the whole we found this had been largely well managed. However, we found a number of examples where rehabilitation therapy staffing and facilities had led to a basic provision of rehabilitation service. Patients received timely pain relief and received adequate assistance to eat and drink. Staff were also able to access key skills training appropriate to their role. We found good examples of integrated and multidisciplinary working. Patient discharge was appropriately planned and managed.
- Staff understood their roles with consent and capacity. We also observed staff to be caring in their interactions. All patients we spoke with told us that staff were kind and treated them with respect. We did not come across any examples where this was not the case. Patients and relatives felt involved and included in care and treatment. Services were meeting the needs of vulnerable people. Assessments for wound management were completed and reviewed in accordance with the stated frequency. Community therapy assessments had taken place and case notes showed updates on preparation for discharge. Patients reported to us that their care and treatment needs were being met.
- Staff reported to us that they had confidence in their leadership, who they found responsive. There was a governance structure that enabled managers and senior managers to appropriately monitor and review the quality of the service.

# Summary of findings

## Background to the service

North East London NHS Foundation Trust's community inpatient services for adults were provided in both North East London and South West Essex from a number of locations. Foxglove and Japonica rehabilitation wards were 24 and 28 bed units located at King George's Hospital near Ilford. Mayflower Community Hospital was a 22 bed unit located in Billericay. The Ainslie Rehabilitation Unit was a 32 bed unit located in Chingford and the Alistair Farquharson Centre was a 28 bed unit located at Thurrock Community Hospital in Grays. Services were also provided from Thorndon ward at Brentwood Community Hospital and Grays Court Community Hospital.

Patients were admitted from home and from local acute hospitals. Referrals for admission came from individuals, neighbouring acute hospitals, GPs and community health services. Rehabilitation and continuing care were provided to people, including for those living with dementia. The average length of stay was 21 days in which time people were provided with rehabilitation and had care packages organised to enable them to return home. Longer stays were possible for people who needed longer periods of rehabilitation.

## Our inspection team

Our inspection team included CQC inspectors and a variety of specialists including specialist nurse practitioners, an occupational therapist and a pharmacist.

## Why we carried out this inspection

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

## How we carried out this inspection

As part of this inspection we visited five of the seven community inpatient locations: Foxglove, Japonica, Ainslie, Mayflower and Alistair Farquarson. At each location we spoke with patients and relatives. We also spoke with staff from a variety of professional backgrounds and grades. In total we spoke with 18

patients and relatives and 37 members of staff including physiotherapists, occupational therapists, nurses, doctors, administrators, senior managers, practice development leads and cleaners. We also reviewed a range of information about the core service that was supplied before and during this inspection.

## What people who use the provider say

- Patients were overall positive about the treatment and care they received. A patient on Foxglove told us "the staff are very kind and treat you with respect". "What they do is admirable. It's not easy. They are trying to do a difficult job and on the whole they are

succeeding". A relative told us "I think she is being treated really well here. She is cleaned and well fed. All the staff have been very patient. They are kind and doing their job well." One patient on Foxglove told us they had been admitted that morning. "They

# Summary of findings

have been wonderful in helping us settle in". a relative on Foxglove told us they had not come across one patient who was not happy to be here. On Mayflower a patient told us "they are good. I've been here quite a while and I have no problems with the nurses. In fact it is the only hospital where I can have a laugh with them." On Ainslie a patient told us "I am receiving first class care", "very happy" and "the hairdresser comes on Tuesday".

- One patient told us: "medication is regular. If the doctor changes anything he will tell you why. Like he told me why he stopped my diabetic tablets." Another said "my meds come regularly at the same time. They tell you what it's for". Patients told us they were asked routinely about pain. "They do ask you if you want to take some medication like pain killers". Another told us "They ask you if you want paracetamol. It's provided when I need it". "I had a lot of pain. When I talked to them they gave me a codeine. An hour later I got another one and asked to see the doctor. It took an hour to see him".
- On the subject of staffing, one patient on Japonica told us "there are enough staff. Sometimes they are a bit short but not often. They are overwhelmed sometimes. They deal with one person before moving to the next. I can't fault the treatment". Another said "I wrote on a matron report- you can't get better nurses, matron or cleaners". On Mayflower we were told "they do work hard. I might have to wait a bit; 10 to 15 minutes but they do catch up. They do give me a wash everyday". "At night they don't take much notice". Patients also told us: "staff are

fantastic but there is too much pressure on professionals", and "another stranger doing the medicines today" and said there were a lot of agency staff who didn't work as hard as the staff nurse.

- On Mayflower one patient told us "the bed is broken, missing a spring. This is the third day since it was reported. I asked a nurse this morning and she said they are waiting for a man. This means nothing to me".
- On the subject of food patients were reasonably positive. On Japonica we were told "the food is very good, with choices, you get a menu. I've gone vegetarian to help with my issues. It's never hot enough but it's never been cold". Another said "the food always looks the same every day. I have never been asked about halal food which I would like but the food is hot and tastes nice". "Food is not too bad. Sometimes you don't get what you ordered. I've never had it cold. For breakfast you can have cereal, brown or white toast." A relative told us "they gave me a plastic apron to use on my mother, which the other ward (local acute hospital) would not give me". On Mayflower we were told "I get lactose free milk in my tea. Five times a day. Food has never been cold or burnt" and "the food is not bad. It's not what I was expecting but it is edible. I've told them what I can't eat. They provide me with water all day". On Foxglove we were told "food is excellent. Nice and warm with a good selection of main courses and cold stuff, salads and a sweet dish". Another relative said: "my mum has not been eating, so a nurse put mash in to her soup to help her eat more".

## Good practice

- A good culture for the timely reporting of incidents and identification of themes across the inpatient services.
- Patients received timely pain relief.
- We found good examples of integrated and multidisciplinary working.
- Patient discharge was appropriately planned and managed.
- The butterfly scheme training had been delivered in all inpatient wards. Inpatients were screened for dementia on admission, the trust had a dementia group. A frailty assessment scale had been implemented.
- The trust had a falls strategic group and membership included community & inpatient falls champions. The trust had distributed patient safety magnets, having enabled community inpatients to easily identify those at risk of falls or who need assistance at meal times.

# Summary of findings

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the provider **MUST** take to improve

- The trust must ensure that equipment at the Alistair Farquharson Centre is appropriately stored and therapy equipment properly maintained.
- The trust must ensure that equipment such as blood pressure machines, beds and bed pan macerators were are properly maintained.
- The trust must ensure that there are suitably qualified staff to meet the needs of the rehabilitation service at Mayflower Hospital and the Alistair Farquharson Centre.

### Action the provider **SHOULD** take to improve

- The trust should consider whether the layout of the premises and the environment of the Alistair Farquharson Centre is suitable for modern needs.
- The trust should ensure that the staff rota on Alistair Farquharson reflects the actual time staff started work. For instance, staff were starting their shifts at 7.15am when the rota said 8.15am.
- The trust should ensure that at Mayflower Hospital there are sufficient groups such as exercise groups and activities of daily living groups.

North East London 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 safe as requires improvement. This was because
- We found a number of examples where therapy staffing and facilities had led a basic provision of rehabilitation service. Alistair Farquarson,
- Community inpatient services covered a wide geographical area. There were many different services provided in many different places. This meant there were a variety of different arrangements in place for managing premises which were largely well maintained and well managed. The recent reconfiguration of some inpatient services had meant movement of equipment, which had also been well managed. However, we found instances, where equipment had not been serviced and essential items had not been checked. There were other items awaiting repair for periods of time. This included blood pressure machines, beds and bed pan macerators. We also found that at the Alistair Farquarson Centre equipment storage space and space available for meaningful therapeutic activity compromised the service provided to patients.
- We also found a lot of safe care and treatment. There was a good culture for the timely reporting of incidents including all serious incidents (SIs) which were appropriately responded to and learnt from at ward level and managerial level. The trust were able to identify themes and trends among community inpatient services.
- Safeguarding processes had a level of profile that enabled the identification of possible abuse and encouraged reporting.
- Processes for the administration of medication meant that patients received their medication in a timely manner interacted with staff over medication changes and the need for pain relief, however, the reliance on bank and agency nurses compromised this in one instance we found.

# Are services safe?

- The overall standard of documentation was good. We found that risk assessments were fully completed for each patient, these included skin integrity, nutrition, pain assessments and falls risks. Overall records we reviewed were up to date, written legibly, dated and signed.
- Wards were clean and staff were trained in infection prevention and control (IPC).
- Community inpatient services were operating with a substantial nurse vacancy rate. Bank and agency staff were used to fill large gaps in rotas and the trust had taken steps to minimise the disruption this may cause by including agency staff as part of the team by allowing block bookings, making them part of the teams and involving them in staff training. On the whole we found this had been largely well managed.

## Safety performance

- Safety thermometer results were discussed at team meetings and displayed on staff notice boards at Japonica, Foxglove and Ainslie.
- The patient whiteboard on Japonica highlighted red or green days on a falls calendar and pressure ulcers calendar to show days on which they were harm free. Falls had been recorded on two of the nine days of the month so far. The same patient pressure ulcer calendar was all clear.
- The information collected from the safety thermometer meant the Alistair Farquharson Centre were able to identify they had had a high rate of patients with urinary catheters. They worked with referring acute hospitals to reduce the number of patients admitted with a catheter. There was also a falls strategic group where an action was to place fall sensors into patient bedrooms where the falls risk assessment identified high risk of falls. The safety thermometer recording was missed in January. Ward staff told us this was due to a lack of communication from the previous manager. Departmental Patient and Quality Safety Group (DPQSG) minutes show this had also been discussed and reviewed at leadership level.

## Incident reporting, learning & improvement

- Trusts are required to report serious incidents to STEIS (Strategic Executive Information System). These include 'never events' (serious patient safety incidents that are

wholly preventable). Out of 358 serious incidents reported between 1 November 2014 and 31 October 2015, 37 related to this core service. None of these were never events. 25 were inherited pressure ulcers. The trust has also provided information on 255 grade 3 pressure ulcers reported as serious incidents between 1 November 2014 and 31 October 2015. There were ten shown for this core service.

- Incidents were reported using the online 'Datix' system which was accessible through the trust intranet and allowed for an audit trail to be formed in which staff could look and learn from incidents.
- The person responsible for assessing and responding to the Datix recorded incident depended on the level of risk and the incident that had been identified. The trust department that handled serious incidents (SIs) shared their findings with senior and ward managers. There was an expectation that the lessons learned were shared with staff in team meetings and handovers. The incident themes were shared with managers through their monthly Departmental Patient and Quality Safety Group (DPQSG) which looked at an overall geographical area within the trust and disseminated information to each department. Recent incident issues for community inpatients were falls, medication errors and staffing issues.
- Senior managers told us they had a target for all serious Incident (SIs) to be reported within 24 hours and staff were encouraged to sign off incident reports on a weekly basis.
- The matron's view on Japonica was to encourage staff to report and staff had received training on incident reporting. Incidents were standing agenda items in team meetings and staff received automatic email alerts about incident learning. Inherited pressure ulcers were reported through Datix and referring acute partners were alerted when this occurred. Senior staff told us there hadn't been any SIs on Japonica for two years.
- On Alistair Farquarson, Datix showed that in the last 3 months they had recorded two SIs; one where a patient's family reported a patient discharge with grade 3 pressure ulcers acquired on the unit. The other SI,

## Are services safe?

related to a fractured neck of femur,(FNOF) where a patient was found outside of their room on the floor. There was a total of 269 incidents reported over the same period, indicating a good reporting culture.

- On Mayflower we found all staff were trained in incident reporting. Evidence was seen, showing the process and actions taken in relation to a recent SI; in January a grade 4 pressure ulcer had occurred and arrangements were made for pressure relieving mattresses to be rented as needed. The learning from the incident was to ensure that staff are utilising pressure relieving mattresses.
- Datix prompted staff to record whether Duty of Candour (DoC) requirements had been fulfilled. If there was an SI, staff were required to support the patient and their family. An example of working with DoC from September 2015 was found. A patient who had a grade 2 pressure ulcer had become a grade 3. The trust accepted responsibility and a matron visited the patient and their family at home to feedback the outcome of the investigation. A SI alert had been completed within the target 24 hours and a root cause analysis (RCA) had been completed within the 72 hour target with action to complete pressure care training. The matron told us a new pressure ulcer care policy had been introduced last year that met DoC requirements and staff received updated pressure care and management training. On Foxglove we spoke with two members of ward staff who were both able to clearly explain being open and honest and sharing information in relation to DoC.

### Safeguarding

- There was a safeguarding duty desk at the trust for staff to contact the safeguarding team with any queries for both children and adults. There was also complex case support from the team. There were monthly safeguarding meetings within each directorate. Inpatient services had a matron who was a safeguarding specialist, who went to units to assist with training. Staff were aware of safeguarding processes and completing Datix.
- Members of the trust safeguarding team visited inpatient units a couple of times a month for familiarity and visibility. We spoke with two safeguarding leads who took responsibility for covering different inpatient units. We were told staff had a reasonable view of what

safeguarding was and made use of the safeguarding advice desk. The safeguarding team held an overview of safeguarding issues and categorised them in to ten types of abuse.

- There was online safeguarding training and ward based training was also carried out by the safeguarding team on an ad hoc and 'as required' basis. Agency staff received the same safeguarding training as permanent staff and ad hoc training was also provided by safeguarding as and when required. There was a lot of information available to staff on the intranet.
- On Japonica, the safeguarding information board contained a 'six principles of safeguarding adults from harm' that included the contact details of the trust safeguarding team, including out of hours contact. The safeguarding board meeting had taken place on Japonica as a joint initiative. Safeguarding leads told us there was not a high volume of safeguarding cases on Japonica who they felt had a good reporting culture.
- There were no safeguarding alerts or concerns received into CQC from 1 January 2015 to 18 February 2016 relevant to this core service.

### Medicines

- A pharmacy inspector visited Foxglove as part of our inspection to sample inpatient medicines management:
- Access to the treatment room was secured with a key pad and cupboards within the room were locked.
- The pharmacy team at the trust carried out quarterly audits to make sure that medicines were managed safely on the ward. There were no actions arising from the last audit in November 2015. Members of the pharmacy team at the trust visited the ward every weekday. There was an emergency cupboard to provide access to medicines out of hours.
- The pharmacy technician told us that they spoke with patients when they arrived on the ward to take a detailed medication history and check that the list of medicines prescribed was complete and correct. She said she would include family members in the discussion if they were involved in helping their relative manage their medicines. Members of the pharmacy team at the trust were involved in planning for

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discharge. The trust provided information sheets for people to explain their medicines, as well as medicine record sheets for use by patients, relatives or care workers.

- We saw that there was a process in place to support patients to take their own medicines to help maintain their independence and get them ready to manage at home. However at the time of our visit, none of the patients on the ward were self-administering. Ward staff told us that this was due to the number of agency staff on the ward who did not know the patients well enough to carry out the assessments.
- We also found examples of good practice. The trust subscribed to a service called 'Medicines: A Patient Profile Summary', known as MaPPs, which produced a profile summary of patients' medication in electronic format which could be printed to take home and/or stored for uploading to the clinical record. Staff told us this was beneficial for patients being discharged and starting self administration.
- On Alistair Farquharson pharmacy information was displayed on the wall at reception and next to the drugs cupboard. Information included contact details of the pharmacy with which the trust had a contract and how to order discharge medication including controlled drugs (CDs). Also how to order stock medicine from pharmacy company and trust guidance on NPSA alerts.
- On Mayflower, the ward pharmacist visited the ward on a daily basis between 9 and 12.30. Duties included medication management, stock control and completing medication for discharge. A Datix report was seen regarding a drug error and a lessons learnt audit was kept in the treatment room.
- On Foxglove, there had been two drug errors in the past year and a process of re-education rather than punishment was favoured in both cases. Nurses were reassessed prior to returning to drug rounds. There were nurse prescribers on inpatient wards, for instance, on Ainslie, there were two nurse prescribers.
- One patient on Japonica we spoke with at 10am, told us they hadn't had their morning medicines, which were due at 8.00. We could see a nurse was still administering medicines to other patients in the ward. At the time of our visit the patient's medicines were in their bedside locker but they told us they were often left out on the

table if deliveries arrived and the key wasn't available. They told us "staff are fantastic but there is too much pressure on professionals", and "another stranger doing the medicines today" and said there were a lot of agency staff who didn't work as hard as the staff nurse. Other patients told us: "medication is regular. If the doctor changes anything he will tell you why. Like he told me why he stopped my diabetic tablets. They don't leave until you take it." Another said "my meds come regularly at the same time. They tell you what it's for" and another said "medication comes around in a trolley at about the same time every day. On Mayflower we were told "Yes they do (tell me about my meds) but you can ask them as well."

### Environment and equipment

- Recent reconfiguration of inpatient services had meant movement of some equipment and closing of some wards. This had meant that the location of some equipment needed tracking and the inpatient leadership had been doing a lot of work around this. They had also identified training needs for some staff who had moved wards and were using equipment they may never have used before. For example on one unit which was now closed, there was no intra venous (IV) requirements, however some were now going to be carrying out IV therapy and would need training in the IV pumps. The trust quality and patient safety teams were looking at specific staff training to alleviate this. They were also trying to deescalate any old and unnecessary equipment and make sure that it was removed. This was assessed by ward sisters and staff.
- Community inpatient services covered a wide geographical area. There were many different services provided in many different places. There were a variety of different arrangements for managing estates and premises. For example, Foxglove and Japonica wards were located at an acute trust hospital. Properties work was completed by the acute trust while small maintenance was done by estates. Others had NELFT trust estates cover all of the works. In others it was difficult to get desired work completed.
- PLACE environmental assessments (self-assessments undertaken by teams of NHS and private/independent health care providers, and include at least 50% members of the public): In the 2015 the trust scored 100% for cleanliness (2% higher than the national

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average for trust sites of 98%). With regard to community inpatient units Ainslie scored 100%, Mayflower 99%, Brentwood 99% and Alastair Farquharson 99%.

- We found that premises were on the whole, well maintained for instance, on Japonica there were eight single rooms, five open bays with five beds each and a fifth bay with three beds. Bays were colour coded for identification which was an idea from staff and patients. Showers were located in each bay. Japonica matron told us they took dignity of patients seriously. There was a therapy room on the ward and a kitchen. Male and female bays were colour coded. Orange, pink and green were female bays and blue and yellow male.
  - Entrances to all ward areas were secure, entry was granted by a member of staff via an intercom for visitors during the day and at night.
  - Senior managers told us that equipment was obtained through a variety of contracts. For instance, beds and pressure relieving equipment was obtainable within 24 hours of request from one company who also serviced this equipment. The trust's Medical Equipment Management Services (MEMS) were the maintenance and procurement for other equipment.
  - However, we also found a number of issues relating to premises and equipment. At Alastair Farquharson we found an old building that was not fit for modern needs. For example, Sherwood ward, a 17 bedded female ward (apart from one male in isolation bed thus meeting same sex requirement) shared one bathroom and one toilet. There were eight commodes stored in the shower room which would have to be removed before anyone could have a shower. The female toilet and shower room looked dirty. Four commodes and two bedpans were also stored in the bathroom. The storage room was untidy with hoists stored right at the back. A lot of equipment would have to be removed to get to the hoists. Managers told us these were stored there for tidiness in preparation for our visit and they would normally be kept on the ward. A room leading to the conservatory had dual use as a day room and a therapy room. Activities also took place in the day room. It also contained a vending machine, television, record player and board games which raised privacy issues for patients. Visitors and patients had free use of the day room and toilets were also located off the day room.
- Physios demonstrated the use of a portable screen for use that offered some privacy. When we asked about bathing and showering the sister told us they usually tried to give a shower before patients went home. On Whitmore ward, there were separate male and female ward areas divided as six and nine beds. Curtains on the male side were blue and pink on the female side. They were open wards for patients with dementia and at risk of falls. There was a second bathroom with six commodes stored there. Both baths were accessible despite some equipment being stored in them. The shower room was free of clutter. The bariatric wheelchair was labelled 'out of order' and was reported to estates over two months ago. With regards to fridge temperature checking, there were sometimes no entries for three to four days at a time. Servicing stickers were in place on some beds but not others. For instance, the next service was due in December 2016 on some while others stated December 2015 while others had no sticker.
- On Japonica we found the resus trolley had been checked twice daily and was up to date. Beds and BP machines had been PAT tested and were up to date.
  - On Foxglove we found that the servicing of hoists was in date however, there was no evidence of PAT testing on beds and the BP machine PAT test was out of date
  - On Mayflower the resuscitation trolley was not checked daily. There were three bed pan macerators at the hospital. One had been out of action for three weeks and one for a day.
  - With regards to therapy services we found that on Alastair Farquharson the OT had procured a stock of cosy feet slippers and Buckingham caddies to sell to patients, but there was basic service provision because of poor facilities. For instance, there was no plynth available to treat patients such as amputees effectively. In the therapeutic kitchen there was no running water, the oven was not connected and there was no fridge or privacy.
  - On Mayflower, the OT and physio liaised with equipment providers but had to liaise with a number of these due to post code of patient which meant further workload due to paperwork and phone calls.
  - The environment was limiting on Foxglove in terms of treatment areas and group space and staff were unable

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to identify a solution during some time periods. Outside of the winter pressure months a 6 bedded bay within Foxglove was converted to a group activities area for group exercise. Longer term solutions were currently being made with the acute trust landlord for reconfiguration of wards to enable outdoor access and redesign of the rehab space.

- On Mayflower one patient told us “the bed is broken, missing a spring. This is the third day since it was reported. I asked a nurse this morning and she said they are waiting for a man. This means nothing to me”.

### Quality of records

- The overall standard of documentation was good. We found that risk assessments were fully completed for each patient, these included skin integrity, nutrition, pain assessments and falls risks. Overall records we reviewed were up to date, written legibly, dated and signed.
- On Japonica we found therapy notes to be clear, legible, dated and signed. On Alistair Farquharson physio notes and care plans were completed at bedside contemporaneously, signed and dated with consent documented.
- Records were audited, by line managers on Japonica ward and reported to the Matron. However, we found gaps in records even though the audit was 100%. This indicated that the record audits may not have been robust. However, it was not all records that were audited on a monthly basis, only a selection and the records we viewed may not have been the records that were audited. The overall standard of documentation was good. We found that risk assessments were fully completed for each patient, these included skin integrity, nutrition, pain assessments, falls risks.
- On Japonica there were 13 laptops for staff who took them on to bays. A SMART card facility was used. Care plans were paper based and work was in progress to become ‘paper-light’. There had been two meetings so far about standardising electronic records and how they can be mapped to their paper based records. A recent band 5 peer review record keeping audit was seen that was 96% compliant. Where non compliance was

recorded the ward sister had reviewed the records themselves. A band 6 audit was seen detailing oversight of caseload audit and review of patient records. Results were seen and were 95% compliant.

### Cleanliness, hygiene and infection control

- The infection control process was regularly audited by both the infection, prevention and control (IPC) team and the ward staff. SNAP audits were done monthly alongside environmental and hand hygiene audits. Departmental Patient and Quality Safety Group (DPQSG) meetings reviewed quality and performance in relation to infection control. Minutes of the DPQSG from January 2016 and December 2015 showed infection control discussed in relation to inpatient services.
- Japonica, Foxglove, and Ainslie were clean and tidy. Hand washing facilities and hand sanitising gels were readily available. ‘Bare below the elbow’ policies were adhered to. Japonica and Foxglove wards provided modern environments. We saw clinical and domestic waste was separated and waste bins were covered and operated by foot pedal. The Japonica, Foxglove, Ainslie ward areas provided a safe environment for people who used services which were effective for cleaning and maintenance. There were monthly calendars of infection prevention and control (IPC) link practitioners for 2016 who would cascade information to their teams throughout the year. Each month had a specialist topic. For instance, April’s was ‘zika virus’, September’s was legionella.
- At Alistair Farquharson had both an incident of e-coli and c-difficile. Neither were attributable to the trust. They worked with Thurrock CCG IPC team to do a post incident review which was reported as a SI. It would have been a KPI breach if it had been attributable to the trust. We observed waste segregation and guidance for staff on labelling prior to disposal.
- On Japonica, staff told us the main challenge on Japonica was currently transition as the site where the ward was, was owned by an acute trust which meant relying on that trust’s contractors and estates. Issues around responsiveness of cleaning staff were reported. They had an allocated cleaner from 7.30 am to 3.30 pm and from 4.30 so issues had to be escalated to cleaning supervisors between 3.30 and 4.30. The 4.30 cleaner had set tasks and then went off shift at which time the

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cleaning supervisor provided cover. We observed the ward was clean and housekeeping staff were seen regularly. It was reported they were still testing this system's effectiveness although there had not been any issues thus far. There was an 'information for staff' noticeboard that included dress code information and guidance for staff on using personal protective equipment (PPE). Hand cleaning techniques were on display in both visual and written form. There was information on 'sharps and contamination injuries, accidental exposure to blood borne viruses' guidance for staff on action to take following an accident and reporting procedures such as contacting infection control link and services. The names and contact details of the IPC team were given. There was a sink, soap, hand gel and notices regarding hand hygiene with technique displayed at the entrance to the unit. We observed Sodexo staff did not clean their hands on entry for delivery of food. They removed dirty cutlery and crockery and did not clean their hands on leaving. There was a bug of the month display including signs and symptoms, preventing spread, isolation and treatment. The staff information board showed weekly infection control responsibilities such as sluice room and COSHH control, medical equipment labelling, guidance on what MEMS inventory and equipment test labels look like and to check equipment before use.

- IPC training data showed Alistair Farquharson Centre was 93%, Mayflower 88% and Thorndon 94%. At the Alistair Farquharson Centre we found examples that demonstrated needlestick injuries were regularly assessed.
- One patient on Japonica told us "they are always cleaning, wiping everything down after they finish using them. It's never been dirty". Another said "it's as clean as it can be. It's very good"

### Mandatory training

- The current training compliance for community inpatient services was 90%. Foxglove had the lowest compliance score for training at 81%. The teams had achieved 97% for the number of staff who have been trained in basic life support. Fire safety awareness has the lowest compliance score overall for the service with 76%. Mandatory training checks were reviewed at the DPQSG meeting.

- Staff used 'at learning', an electronic learning tool that contained a flagging system for when training was due.
- The central training department kept training records and sites also kept their own records. Mandatory training figures for Alistair Farquharson showed overall figures of 91% attendance rates against trust targets of 85%. Other units also showed compliance rates above the trust target.

### Assessing and responding to patient risk

- Senior managers told us that escalation of risk was normally done from a ward level. Ward managers discussed risk with their line managers who escalated to the service director, then onto the risk register, if required. Live issues were discussed and the risk register was observed. The deputy directors meeting reviewed the risk register. Due to transition, inpatient units had an action plan around moving of equipment and staff. Japonica ward had identified such risks and were working through the action plan. For instance, IT access for therapy staff was resolved by moving them to a larger room. One risk for management was the number of staff changes over a short period of time. Staff retention and wellbeing was an area for attention in the midst of this.
- The trust had a policy for managing deteriorating patients. This included comprehensive guidance for staff on the trust's resuscitation procedures and staff roles and responsibilities. On Japonica patients' vital signs were rated red/amber/green (RAG) rated. There was a falls board in reception showing assessment and prevention of falls and information on avoiding slips, trips and falls while in hospital.
- The physio on Japonica was a 'falls champion' and utilised their skills on the ward and home visits.

### Staffing levels and caseload

- Staffing remained an area of concern for the trust. A risk register item was they were currently running at a 50% vacancy rate for substantive nursing staff for community inpatients in the Essex region. The issues included bordering with London's higher pay areas. There had been a focus group to look at staff retention. Due to recent service reconfiguration there had been issues around staff being asked to move to work in different units and the refusal of staff to do so. There had been

## Are services safe?

work done around making leadership more attractive, training staff to do their nurse training. They were intending to go to Ireland to recruit from universities and they were holding local recruitment days including time at universities.

- In North East London again recruitment was an issue. Senior managers told us they had struggled to get therapy staff, especially occupational therapists (OTs). Band 5 therapy staff were needed but have had to employ a band 8A who was now in post to help relieve pressures. There was a target of 1:8 ratio of patients to therapy staff. The trust had also moved some senior nursing staff to the Essex boroughs to try and make the global risk less.
- For instance, Key Staffing Indicators as at 31/10/2015 showed vacant nursing post rates running at between 20 and 45% with Alistair Farquharson the highest. Shifts had been filled by bank and agency staff. The staffing indicators showed that shifts were being filled in most cases.
- In the past, poor communication with HR meant it had taken up to six months to process new recruits in to the service. On Foxglove, the matron was now able to book agency staff directly hence taking control of the process herself. Agency usage and staffing issues were discussed at matron and ward manager meetings. They held an HR surgery on the ward each month where the matron could fast track recruited staff to vacant posts. They also now had a dedicated HR person that supported the ward. Before they felt that communication was poor.
- In Essex there had been a three month period without a matron due to sickness absence. The ward managers were proactive in this time, especially surrounding the use of agency staff. Agency staff were included as part of the team, allowing them to be involved in the sense of team spirit.
- On Alistair Farquharson staff told us that across all inpatient units there was a 50% vacancy rate which was on the risk register. Part of mitigating against this was to make agency staff feel like part of the team. On Mayflower agency nurses were used on a daily basis to fill staffing gaps. There were two on duty on the day we visited. Only agencies that were in the trust framework were used. The trust were encouraging the use of common agency staff by allowing block bookings, make them part of the teams and involving them in staff training. Ward staff on Ainslie told us that staffing was a challenge and the trust was continually trying to recruit. Some agency nurses had worked there for two years and are included as part of the team, attending in house training.
- On Mayflower staffing levels had been raised as a concern along with the over use of agency staff which had been raised through Datix by staff. One staff member told us “there should be more incentives for permanent staff to join the bank. You will be paid less if you work on the bank”. Another added “that’s why many go and join the agency and work in the London area”.
- The trust was using MIDAS, a business intelligence tool that looked at staff sickness rates, turnover rates, training and other HR data. We were given a demonstration of MIDAS at Alistair Farquharson, which showed a whole time equivalent (WTE) of 214 staff against an actual WTE of 177 staff for the last complete month. The rolling staff turnover rate was recorded as 8%.
- The acuity tool used to look at staffing was the Hurst safer staffing tool. On Japonica the staff allocation board showed six nurses and five HCAs all on the early shift. All named. It showed the late shift had four of each and the night shift three of each, all named. There were named nurses for bays. The Japonica matron told us they were using safer staffing Hurst tool. The ward currently had additional staff on duty due to being in transition. The allocation sheet on the ward noticeboard showed team names as ruby, sapphire, diamond and emerald with each allocated to a bay area. Teams audited each other’s assessments at weekends; peer reviewed. Foxglove was staffed for 27 beds. There were four nurses and five HCAs on the early (7am -3pm) shift and four and three on the late (1pm -9pm) and three and three on at night (8.30pm -7.30am). On Mayflower we found that if there was a deprivation of liberty safeguarding (DoLS) arrangement in place then there would be extra staff.
- On Alistair Farquharson we found that rota didn’t reflect the actual time staff started work. Staff were starting their shifts at 7.15am when the rota said 8.15am. We discussed this with the acting ward manager that the rota should reflect the time staff actually start work.

## Are services safe?

- At Mayflower all occupational therapist (OT) posts were vacant. On Alistair Farquharson there were two whole time equivalent OT posts and one had been vacant for eight months. OT posts had been filled by locums. They were only able to deliver a basic service provision because of staffing, which had meant ensuring safe discharge rather than rehabilitation. There was a disparity in pay across the trust with some receiving London weighting and therapy staff were unclear about whose role it was to recruit.
- One patient on Japonica told us “there are enough staff. Sometimes they are a bit short but not often. They are overwhelmed sometimes. They deal with one person before moving to the next. I can’t fault the treatment”. Another said “I wrote on a matron report- you can’t get better nurses, matron or cleaners”. On Mayflower we were told “they do work hard. I might have to wait a bit. 10 to 15 minutes but they do catch up. They do give me a wash everyday”. “At night they don’t take much notice”.

### Managing anticipated risks

- The community health service maintained a risk register. The service’s risk register was monitored by the clinical commissioning group (CCG). The main risk to

community inpatient services was identified as high use of agency staff due to vacancies. Staff we spoke with were able to demonstrate awareness of the key risks to patients. For example, risks of falls and pressure damage. Depending on risks identified to people who used services staff were aware of how to arrange further support by referral for specialist assessment or supply of additional equipment. Pressure ulcers assessed as a severity of grade two or above were referred for investigation as a serious incident and a RCA was undertaken.

### Major incident awareness and training

- There was a major incident policy in place. The director on call would declare a major incident and then each member of staff depending on their level of seniority (bronze, silver and gold) would be allocated specific responsibilities. There was an on call training pack in place and the manual was regularly updated. On Japonica managers told us they could flex up from 52 to 57 beds and had a major incident plan. On Mayflower we found that staff had undertaken major incident training and there was a business continuity plan.

# Are services effective?

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

## Summary

- We rated effective as good. This was because the service used National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. We saw evidence of references to the use of national guidelines within a number of the trust's policies. Staff could access guidance and pathways on the trust intranet.
- Patient's assessments were completed using templates that followed national guidelines. For example, skin integrity, falls risks, nutrition, pain management, and activities of daily living. Records we viewed were completed in a timely way and at appropriate intervals.
- Patients received pain relief as prescribed on both a regular and as prescribed basis. Patients were routinely checked to ensure they were comfortable and their pain was adequately managed.
- Staff understood the importance of nutrition and hydration. Patients received adequate assistance to eat and drink.
- There were appropriate arrangements in place for supervision and appraisal of staff. Staff were also able to access key skills training appropriate to their role. However agency staff did not always receive induction to the wards.
- We found good examples of integrated and multidisciplinary working. Patient discharge was appropriately planned and managed to ensure effective care and transition with community services.
- There was a lot of information available to staff on the intranet on mental capacity and deprivation of liberty safeguards (DoLS) and staff understood their roles with consent and capacity. Staff were encouraged to document best interest and capacity decisions. Ad hoc training was also provided by safeguarding team as and when required, who also had a regular presence on the wards.

## Evidence based care and treatment

- The practice development team reported that good practice guidance would be issued by health education department within the trust. Practice development leads then rolled this out to appropriate teams. Distribution of NICE guidance was carried out by a specific team.
- The service used National Institute for Health and Care Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. We saw evidence of references to the use of national guidelines within a number of the trust's policies. Staff could access guidance and pathways on the trust intranet.
- The practice development team felt the trust were well supported by NHS knowledge and library services, who produced updates on best practice. Clinical nurse librarians linked in with different practices and the frailty bulletin was a good example of this.
- Staff understood their individual roles and responsibilities in the delivery of evidence based care. Staff referred to relevant codes of practice. Staff used nationally recognised assessment tools to screen patients for certain risks. For example, multi-universal screening tool (MUST).
- Patient's assessments were completed using templates that followed national guidelines. For example, skin integrity, falls risks, nutrition, pain management, and activities of daily living. Records we viewed were completed in a timely way and at appropriate intervals.
- Staff we spoke with understood how NICE guidance informed local guidelines. We observed staff following appropriate assessment
- Alistair Farquharson were part of the National Intermediate Care Survey which used the Barthel index as an outcome, however, there was usually no time to complete the form at baseline as the patient was not seen at this stage. The Barthel scale was used to measure performance in activities of daily living

## Are services effective?

(ADL). The visual analogue scale (VAS pain scale) was also used. SMART was used as an outcome when fully staffed where goals were measured at baseline and discharge.

- On Mayflower OTs and physiotherapists (physios) reported that the mobility scale and goal achievement was used as an outcome measure. There was no acknowledgement of national standards or best practice.

### Pain relief

- Patients received pain relief as prescribed on both a regular and as prescribed basis. Patients were routinely checked to ensure they were comfortable and their pain was adequately managed.
- Pain control was discussed in handover in relation to patients' care and wellbeing.
- Patients told us they were asked routinely about pain. "They do ask you if you want to take some medication like pain killers". Another told us "They ask you if you want paracetamol. It's provided when I need it". "I had a lot of pain. When I talked to them they gave me a codeine. An hour later I got another one and asked to see the doctor. It took an hour to see him".

### Nutrition and hydration

- On Alistair Farquarson, a 'read out to me' form identified preferences such as 'my usual warm drink with milk and two sugars', and, 'I prefer a beaker' thus individualising care.
- Dinner trays were coloured red to indicate if a patient needed assistance at mealtimes. Elsewhere a knife and fork symbol was used with the magnet system for assisted eating and drinking.
- On Foxglove we observed nutrition and hydration being discussed in handover. It was clear that staff understood the importance of hydration.
- Assessments for wound management included a body map. We witnessed completion of these. For instance, one had been completed for care of a pressure ulcer on the spine which had been reviewed in accordance with frequency of review stated as every three days. Evaluations had been completed and signed by staff. The malnutrition universal screening tool (MUST) and national early warning score (NEWS) were also in place

- On Japonica we were told "the food is very good, with choices, you get a menu. I've gone vegetarian to help with my issues. It's never hot enough but it's never been cold". Another said "the food always looks the same every day. I have never been asked about halal food which I would like but the food is hot and tastes nice". "Food is not too bad. Sometimes you don't get what you ordered. I've never had it cold. For breakfast you can have cereal, brown or white toast." A relative told us "they gave me a plastic apron to use on my mother, which the other ward (local acute hospital) would not give me". On Mayflower we were told "I get lactose free milk in my tea. Five times a day. Food has never been cold or burnt" and "the food is not bad. It's not what I was expecting but it is edible. I've told them what I can't eat. They provide me with water all day". On Foxglove we were told "food is excellent. Nice and warm with a good selection of main courses and cold stuff, salads and a sweet dish". Another relative said: "my mum has not been eating, so a nurse put mash in to her soup to help her eat more".

### Patient outcomes

- Senior managers told us that outcome tools such as the timed up and go (TUG) score Barthel Score and Average Length of Stay (ALoS) were used and key performance indicators were set. All of this information was put onto the trust's dashboard system.
- The trust were designing a frailty index and implemented dementia scoring to ensure evidence based practice.
- On Japonica we found a 'CQUIN target in place for screening patients aged over 75 for dementia. If a patient scored highly the service carried out a blood test, CT scan and tried to rule out organic impairment. Screening was recorded in RiO (an electronic care record system) and monitored by performance analysts who contact managers if they do not meet the screening target.
- The service were involved in the National Intermediate Care Audit.

# Are services effective?

## Competent staff

- Bank induction took place 'in house' via a trust team. Bank staff could access trust training and had access to all key skills training too. With agency staff there was an expectation that individual agencies equipped staff with the suitable skills needed.
- The clinical development programme was in addition to mandatory training for inpatient staff and linked in with the chief nurses group and allied health professional leads group. The group also looked at outcomes of SIs, complaints and risk issues. The trust had a continuous professional development panel where applications for courses were adjudicated.
- The preceptorship programme began in January 2016 and took place twice a year. It consisted of four sessions that took place over the course of a year and followed on from staff induction. There were skills basics as well as general learning on specific roles.
- In terms of retention there were 16 places available for health care assistants across the trust for a university secondment to do nurse training. There was a rotational programme on offer for newly qualified staff to gain experience in both physical health and mental health teams. A 'talent escalator' sought to publicise opportunities for career progression by staying at the trust. There were ten places available across the trust on the return to practice programme. This year it was increased to 15. Practice experience facilitators supported students in each locality within the trust and linked with mentors and universities.
- Practice Development reported that there were structures of support for inpatient staff such as a nurse consultant in frailty and long term conditions to support staff with knowledge and implementation of the butterfly scheme and dementia awareness. There were tissue viability nurse specialists and a link worker system for falls and infection control.
- Staff can contact the practice development team to request training in specific skills. For example, recently a manager contacted them to fill a skills deficit left by two nurses going off sick.
- On Japonica we found that all staff had an allocated supervisor and 1 to 1 monthly supervision. There was a supervision tree on the wards, and staff could identify

who their supervisor was. There was a standard supervision document and templates were role specific with prompts that included the staff charter and behaviour. The supervision policy was seen. Dated as approved in May 2013 with a review date of 2016. Staff supervision notes went into staff files and there was a quarterly audit to check they were being completed.

- The trust provided clinical supervision targets and rates by core service and team (between April 2014 – March 2015) as part of our data request. It had set the clinical supervision target at 85%. There was an overall score of 67% supervision rate for community inpatients. Ward managers told us supervision rates were higher. Appraisal rates from the quality reports showed rates had risen through the year, from a red rating in May and June 2015, to an amber rating in October and November to a green rating in December and January 2016.
- On Ainslie we found that qualified nurses did in house training for key skill such as catheter, dementia, dysphasia and wound management. One member of the team was currently doing a course on managing the deteriorating patient at a local university. Staff on Ainslie gave examples of caring for patients who had learning disabilities and had called on the learning disability team to advise on aspects of care. We were told that they encouraged involvement from the family which enabled people to engage better.
- On Alistair Farquharson we spoke with one ward staff member who told us they had worked on the ward for over six months but had not received any induction in to their role.

## Multidisciplinary working and coordinated care pathways

- Senior managers told us there were several care pathways which were used within the trust such as intermediate care pathway and stroke rehabilitation. They have found that community inpatient services have some of the most frail patients, with others going to step down beds and rehabilitation taking place at home. Although it was not commissioned at present there was support for those patients with non-weight bearing status to be accepted for rehabilitation. There

## Are services effective?

was a deteriorating patient pathway for unwell patients and several well embedded patient pathways such as the continuing care checklists, for those who need increased care once discharged.

- On Alistair Farquharson staff told us there were different CCG requirements and funding for different patients which meant that pathways were flexible. There was an intermediate care bed review with the intention of closing this unit. Staff were aware of the proposals.
- Ward staff on Ainslie gave us examples of multidisciplinary working, stating they had a social worker for the unit who attended multidisciplinary team (MDT) meetings. They also reported good relationships with the dietician, Parkinsons' nurse, district nurses, speech and language and tissue viability. We were told they called GPs for medicines reconciliation.
- On Mayflower a consultant ward round took place three times a week and an MDT meeting weekly which included a named nurse, consultant, therapist, pharmacist and the dementia crisis team. A dietician visited the hospital at least weekly although a band 6 told us that there were regularly delays in obtaining speech and language assessments.
- On Foxglove the staff handover was informative and staff had all the required information to hand. However, there was no evidence of multidisciplinary involvement during this meeting. For instance, no reference was made to any other provider of care in relation to the integrated approach to patient care. We were subsequently informed there was an daily multidisciplinary meeting at 9am attended by nursing, bed management and therapies. In addition there was a weekly meeting on a Thursday with social services representation. The consultant ward round included a geriatrician, SHO and ward manager. Patients were examined and medication reviews completed. Patient consent was sought first.
- On Foxglove there were two consultants covering the ward. One once a week and one twice a week. There was no night time or weekend medical cover available on Ainslie. A doctor from a local GP consortium was used out of hours which often took several hours to come which meant the patient could sometimes end up going back to the acute setting. On Mayflower the ward had consultant cover both male and female on different

days (Monday and a Friday). Medical cover was provided Monday to Friday 9 to 5. An out of hours doctor covered weekends up to 11pm with overnight cover provided by the local GP out of hours provider. Staff told us they received a varied response from who took up to four hours to respond.

- On Alistair Farquharson the OT did a daily handover to nursing staff, and attended weekly MDT meetings. In theory the NELFT inpatient rehab therapists should meet every month but in reality this is not happening due to staffing issues. On Mayflower the OT and physio attended MDT meetings and liaised with social care providers. On Ainslie physios and OTs went in to the local acute hospital to assess patients prior to accepting as referrals.

### Referral, transfer, discharge and transition

- Senior managers told us the admission process from acute hospital to rehabilitation differed depending on area. In Essex there was a screening nurse who assessed suitability for admission to rehab once the patient had been referred from the acute trust. They would try and avoid hospital admission if possible. However, this was being decommissioned at the end of April. District nurses could refer to community beds if they felt it was necessary and now had the ability to go through the single point of access. There were waiting times once the patient was identified as appropriate, but this was changeable. In North East London there was a target to transfer the patient within 72 hours of acceptance of referral. There were fines in place if this was not adhered to.
- On Foxglove we found that most discharges went by patient transport but if the family were collecting, then individual preferences could be taken in to consideration. Patients were never discharged at night. On Ainslie the expectation was that patients would be discharged within three weeks but some required longer rehabilitation and the service was flexible to meet this need. On Alistair Farquharson patients we were told that patients are not discharged at weekends due to transport being unavailable.
- On Mayflower all patients had home visits to establish a safe home environment. On Japonica, occupational therapists carried out home visits with all patients and where there were any complex needs. Physiotherapists

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attended the visit with social worker colleagues if required. On Ainslie, therapists had cars and took patients home on discharge with equipment and to settle in. There was a 7 day a week therapy service. A breakfast club allowed patients the opportunity to make breakfast and hot drinks prior to discharge. After discharge patients were followed up at home by phone or with a visit to ensure safety, compliance with exercise and to check on care package being in place.

- Therapy staff reported there was often pressurised team morale due to the workload and to meet goals in time for discharge. Timescales for rehabilitation were around 21 days with therapy services usually only five days a week which amounted to only 15 days therapy. On Mayflower there was only one exercise group per week and currently no activities of daily living (ADL) groups. Patients were not encouraged to go to the day room for meals or socialising.

### Access to information

- On Japonica there had been some issues with staff accessing IT following the move to the new site such as NHS.net and Japonica ward email. The ward still had guest access to RiO. There were RiO champions.
- On Alistair Farquharson we spoke with one ward staff member who told us they had worked on the ward for over six months but had not received a SMART card although it had been requested several times. The member of staff did not know anything about either RiO or SystmOne as they had never received training or been shown.
- On Foxglove the IT system in use was RiO. The administrator kept paper cards of all patient details in case the IT system went down. Agency nurse told us they could not access RiO.
- On Mayflower a paper based record system was in place. SystmOne was to be used from July 2016. Information was available via the MIDAS business management system. Paper records we saw were up to date and written clearly.

### Consent, mental capacity and deprivation of liberty safeguards

- On Japonica, the safeguarding information board contained a 'six principles of safeguarding adults from harm' that included the contact details of the trust safeguarding team including out of hours contact. Guidance on Deprivation of Liberty Safeguards (DoLS) was on display, including what met the DoLS criteria. There was a DoLS process flowchart; step by step guidance for staff on actions to take for a patient who lacks capacity.
- The safeguarding team delivered training on mental capacity, DoLS and prevent. There was a lot of information available to staff on the intranet. Staff were encouraged to document best interest and capacity decisions. Agency staff received the same safeguarding training as permanent staff and ad hoc training was also provided by safeguarding team as and when required, who also had a regular presence on the wards.
- On Alistair Farquharson we reviewed care records. A DoLS checklist showed the patient had capacity and was reviewed weekly from admission six weeks ago. A general anxiety disorder assessment score (GAD) showed a score of 1- not difficult at all. Consent form was completed for photography and filming, signed by the patient and staff. An assessment for wound management including body map had been completed.
- On Foxglove we were given the example where staff had recently met with family to discuss a DNACPR that was requested by the family. The form had been signed by the family doctor and nurse. Staff were proud of this sensitive piece of work.
- On Ainslie physios and OTs now obtained and documented patient consent to treatment in additional areas such as exercise groups.

# Are services caring?

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

## Summary

- We rated caring as good. This was because patient dignity was observed in all interactions we observed. We also observed staff to be caring in their interactions.
- All patients we spoke with told us that staff were kind and treated them with respect. We did not come across any examples where this was not the case.
- Patients and relatives felt involved and included. We found examples where relatives had been allowed to stay on the ward, take their loved ones out for a walk in hospital grounds and reported positive interaction with all staff.

## Compassionate care

- A patient on Foxglove told us “the staff are very kind and treat you with respect”. “What they do is admirable. It’s not easy. They are trying to do a difficult job and on the whole they are succeeding”. A relative told us “I think she is being treated really well here. She is cleaned and well fed. All the staff have been very patient. They are kind and doing their job well.” One patient on Foxglove told us they had been admitted that morning. “Jennifer and Cheryl have been wonderful in helping us settle in”.
- There was real evidence of compassionate care. Staff were observed to be very caring taking in to account the individual preferences and needs. Staff were seen sitting in the lounge area communicating with patients’ friends and family.
- On Japonica we observed an exercise group. All patients were asked if they would like to participate. Clear instruction was given and sensitive, positive encouragement however, engagement was not good because of disturbances from other patients and visitors coming in to the room.
- On Mayflower patient dignity was observed in all interactions. We also observed staff to be caring in their interactions.
- The handover on Foxglove took place at the entrance to each bay. Patients and visitors could easily overhear personal and confidential information.

- On Alistair Farquharson there was a ‘dignity dos’ poster and ‘culture of compassionate care’ poster on display by the nursing station.
- On Foxglove we observed curtains and doors were always closed whilst staff attended to patients’ needs.

## Understanding and involvement

- Patients and relatives were involved in decisions about treatment and care. Patients gave us examples of this such as being asked about pain and having things explained to them by doctors, pharmacists and nurses. We observed nursing staff seeking consent before carrying out tasks and therapy staff involving patients in their own treatments.
- On Japonica we found an example where a patient was able to meet her husband in the evenings and take the dog for a walk in the hospital grounds. Another patient on Japonica told us “my daughter takes me for a wonder around the hospital and she can do it as long as she tells ‘them’”. We were also told “overall it’s better than most hospitals. I can visit when I want. They have never stopped us”. “They are always helpful and kind”. On Foxglove we were told “The matron came over and introduced herself to us. So did the physio and OT”.
- The Friends and Family survey had been completed on Ainslie and ward managers told us they shared lessons learned from this feedback at team meetings. For instance, they had focussed on patient interaction skills. We were told “patients were confused about why they were being asked to do things for themselves. It was about staff being sensitive in the way this was put. The feedback we get has improved since.” We were also told “In the morning we ask every patient about what matters to them. We ask people about their routines on admission”.
- On Alistair Farquharson visiting times were long; from 10.30 to 21.30 with protected mealtimes.
- On Foxglove a relative told us they had not come across one patient who was not happy to be here. “They had held an Easter bonnet raffle and a Christmas party where staff dressed up. They had also held a Macmillan coffee morning”.

## Are services caring?

### Emotional support

- On Mayflower a patient told us “they are good. I’ve been here quite a while and I have no problems with the nurses. In fact it is the only hospital where I can have a laugh with them.”
- On Ainslie we were given an example of care where an eastern European patient was admitted who could not speak English and felt isolated. The ward made arrangements for her daughter to be able to stay all the time in order to prevent mother becoming isolated.
- We spoke to patients on Ainslie who told us “I am receiving first class care”, “very happy” and “the hairdresser comes on Tuesday”.

# Are services responsive to people's needs?

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

## Summary

- We rated responsive as good. This was because there was a staff engagement director for equality and diversity and staff equality and diversity was a priority in the trust. A LGBT group had been set up and was learning from the black and minority ethnic (BME) network to help it grow. Equality and diversity training was mandatory for all staff.
- Community inpatient services covered a wide geographical area. There were a variety of different arrangements in place of planning to meet people's needs. The trust worked effectively with a number of local acute trusts, from where most patients were referred, and worked to referral criteria. Trust hospitals understood their own referral processes and relationships with local acute providers. The trust also worked with a number of commissioning groups within their respective locality and had recently undergone some inpatient service reconfiguration.
- Services were meeting the needs of vulnerable people. For instance, magnetic symbols on boards above patient beds identified needs, preferences and conditions. Assessments for wound management were completed and reviewed in accordance with the stated frequency. Community therapy assessments had taken place. MDT notes showed updates on preparation for discharge.
- Patients reported to us that their care and treatment needs were being met. It was reported that call bells were being responded to appropriately and night staff were also responsive.

## Planning and delivering services which meet people's needs

- Senior managers told us the model of inpatient care aimed to give those who needed a rehabilitation bed the chance to be admitted. However, if they wanted to be cared for at home the trust aimed to also give people this option.
- In Essex the model of care was known as 'the patient journey' which supported bed changes and the intermediate care team to provide a more urgent service

and more continuity for patients. They were beginning to help community services to provide a triage system that should make stepping people up to a community inpatient bed easier. There was a trust community care pathway facilitation bed management team who had oversight of bed availability and what was going on with acute partners and whether a patient could be moved from acute to home.

- Senior managers reported that services were planned by commissioners and implemented by the trust. We were told the trust was presently in a financially challenging place as the acute trusts that surrounded them had complex challenges and performance issues. The CCG were carrying out equality and impact assessments for inpatient services such as in Brentwood. There were planned service changes elsewhere. Examples included the challenge of acquiring the Anslie Unit in Waltham Forest and the movement to Japonica ward from Grays Court Community Hospital.
- The average percentage bed occupancy across this core service between 1 May 2015 and 31 October 2015 was 86%; ranging from 89% at Mayflower to 75% at Ainslie. The average length of stay across the 12 month period from 1 December 2015 to 30 November 2015, was 18 at Ainslie, 21 at Alistair Farquharson, 18 at Foxglove and 23 at Mayflower.
- On Japonica we found that 'length of stay' meetings took place where all patients were looked at individually and any delay to treatment was discussed and escalated as appropriate. Ward managers told us they worked closely with local acute providers and staff from their community care pathway facilitation team visit acute locations; intensive rehabilitation services (IRS) had a local community hospital base and visited three boroughs. Inpatient and frailty meetings were attended by managers as part of the supported care in Havering. The staff information board showed the cardiac arrest number, porter's number and estates numbers; both in and out of hours.
- Ainslie aimed to assess patients within 24 hours of referral. This was a key performance indicator (KPI).

# Are services responsive to people's needs?

Patients needing more than three weeks care would be 'slow stream'. This was an initiative started in January. The expectation was that patients would be discharged within three weeks but some required longer rehabilitation and the service is flexible to meet this need. There were 16 beds on each of the two floors. Two block beds were CCG commissioned for 'slow stream'. When 'slow stream' patients were present the service flexed down to 14 beds on the unit to ensure safe staffing levels. CCG agreed for this for the period of admission. The referral criteria was anyone over 18 years. Staff told us they had not really had any inappropriate referrals but where patients' conditions had deteriorated they had been referred back to an acute setting. Nurses told us they would always raise an incident on Datix and do a discharge alert within 24 hours when this had occurred.

- On Alistair Farquharson we were told that referrals came from GPs and the local acute trust. There was currently a waiting list of seven men and two women. Patients were sometimes admitted after 8pm. There were a number of factors that influenced this. A member of staff told us "we can't leave people in the day room due to dementia. Sometimes we can't get transport to discharge a patient before 3 or 4 and the cleaners don't start until 4. By the time the room is clean and ready people are transferred from Basildon it can be late. We don't discharge at weekends due to transport being unavailable. We are trying to encourage people to use own transport to avoid problems. If relatives can take home we can discharge at weekends although it is very rare". There was a waiting list for admission of seven males and two females.
- Mayflower received a majority of referrals from the acute medical wards of a neighbouring trust, who used a screening process to determine appropriate referrals. Patients with a catheter were not accepted. Senior managers told us they individually reviewed each patient's history before any transfer to identify why the patient has an in dwelling urinary catheter, and ensured a care plan was in place to effectively manage the patient need. There were occasional admissions, inappropriately admitted following the screening process, where patients had a much higher acuity than had been documented on referral information. In these cases ambulances had been called to transport back to

acute setting. There were currently ten patients waiting for a bed. Staff told us admission avoidance gate-kept the beds and there was a pressure with volume of referrals which had to be prioritised.

- Foxglove staff told us that most patients came from acute settings and most were over 60. Younger patients tended to have more complex needs. Some may be inappropriately referred such as if they had on going investigations that were not revealed at the time of referral. There was currently a waiting list of 12.

## Equality and Diversity

- There was a staff engagement director for equality and diversity. Senior managers told us there had been big movements towards making staff equality and diversity a priority in the trust and the BME Network had won awards for its innovation. A LGBT group had been set up and was learning from the BME network to help it grow.
- On Ainslie a member of the therapy team had completed a BME mentoring and support course with the backing of the manager.
- There was a network for staff with long term conditions. The 'Well Together' initiative worked around staffing issues. They were waiting to see if these were helping improvement in staff survey results.
- A multifaith calendar on Japonica highlighted a wide range of significant dates in 2016 as well as a synopsis of various religious belief systems. On the general information board the complaints and compliments procedure, trust values, a flow chart showing how to access the 'language shop' 24 hours by telephone, access to braille or large print and face to face interpreting via online request.
- Equality and diversity training was mandatory for all staff.

## Meeting the needs of people in vulnerable circumstances

- There were KPIs in place for patients accessing care within 72 hours of acceptance of referral from an acute trust and the Single Point of Access was in place for district nurses to refer patients to services.
- In Essex there was a push for people to being able to access more information regarding self-management of

# Are services responsive to people's needs?

long term conditions especially diabetes. There was a diabetic nurse specialist in place. They are also trying to encourage adult social care to assist in helping service users manage their long term conditions.

- On Foxglove we spoke with the ward administrator who liaised with relatives and social workers and ensured that packages of care and transport were in place prior to implementation of the discharge plan. Patients were given the choice of a morning or afternoon and a two person crew was always used to assist with mobility.
- We found a magnet system in place on inpatient units to identify and meet the needs of vulnerable patients that used magnetic symbols on boards above patient beds to identify preferences and conditions. These were folded away for confidentiality. For instance, a white butterfly indicated query dementia and blue for diagnosis. Resuscitation was stated on the board; red if no DNACPR in place, left blank if in place. A pink lady or blue man symbol went on to the board to explain carer preference. A 'skin' magnet represented pressure ulcer and a knife and fork for assisted eating and drinking.
- On some units we found the 'this is me' system was in place such as Ainslie but elsewhere, such as Japonica there was no 'this is me' document.
- Information packs were provided to families.
- On Alistair Farquharson we found the 'read out to me' form was in use. This identified preferences such as 'my usual warm drink with milk and two sugars', and, 'I prefer a beaker' thus individualising care.
- We found an example On Alistair Farquharson where an assessment for wound management, including a body map, had been completed for the care of a pressure ulcer on a patient's spine. This had been reviewed in accordance with the stated frequency of review, stated as every three days. Evaluations had been completed and signed by staff. MUST and NEWS were in order; assessment of activities of daily living (ADL) reviewed every seven days. A community therapy assessment had taken place and the care plan had been regularly reviewed. We reviewed care records. MDT notes showed updates on preparation for discharge including referral to memory club, awaiting care package, ordering of rails and discussion with family. There was a SSKIN, board in reception giving information on elements of the practice including moisture, nutrition and fluids. A pressure care

board detailed a pledge to 'stop the pressure'. This included a safety cross for pressure ulcers. This showed that for the current month one person had been admitted with a pressure ulcer. We reviewed care records. MDT notes showed updates on preparation for discharge including referral to memory club, awaiting care package, ordering of rails and discussion with family.

- On Ainslie we observed detailed assessments such as Waterlow scores, bodymaps with incident logs completed continence assessments had been completed.
- We observed the staff handover on Foxglove at which staff had all the required information to hand. The handover lasted 40 minutes and was enough time to discuss what was needed for good care. It was located in the therapy room which was conducive for a private meeting. However, there was no evidence of multidisciplinary involvement during this meeting. For instance, no reference was made to any other provider of care in relation to the coordinated approach to patient care. We were subsequently informed there was an daily multidisciplinary meeting at 9am attended by nursing, bed management and therapies. In addition there was a weekly meeting on a Thursday with social services representation.
- On Mayflower a patient told us "I can walk up and down on my own now. I read the paper and see the physio every day".

## Access to the right care at the right time

- On Mayflower the average length of stay was currently 21 days. Ten patients were currently waiting for a bed. On Japonica we were told that the timescale for rehabilitation was 21 days. Therapy services were only five days a week which amounted to only 15 days therapy. On Alistair Farquharson physios worked from Monday to Friday and left exercise sheets with patients over the weekends for health care assistants and relatives to use.
- On Alistair Farquharson we were told that patients were seen within 24 hours of admission by the therapy team but no evidence was produced to verify meeting this target.



## Are services responsive to people's needs?

- On Japonica one patient said "I use the buzzer at night. Not very long wait. Like five minutes". Another said "they are all kind and patient. They are all very caring. I've used the buzzer at night and they answer it more or less straight away". On Foxglove we were told; "call bell is very good at night. Staffing at night is better".
- The Dementia Crisis Team which attempted to link inpatients and their supported discharges. The team attended daily board rounds and MDT meetings. The Dementia Crisis Team in the community took telephone referrals and were involved in daily board rounds within the hospital to assess those who may be at risk of crisis on discharge. Over the busy winter period the dementia crisis team were asked to come to MDT meetings to assess all the patients who may need community support. The nurse specialists involved also work closely with the acute trusts.
- The intensive rehab service (IRS) picked up patients returning home. IRS linked with community inpatient services and took on people with early supported discharge. Patients from the community could be stepped up in to an inpatient bed also.
- Boards above patient beds contained the butterfly magnet system that indicated individual patient needs. For instance, white for query dementia and blue for a diagnosis. Resuscitation was stated on the board; red if no DNACPR in place, left blank if in place. A pink lady or blue man symbol went on to the board to explain carer preference. A 'skin' magnet represented pressure ulcer and a knife and fork for assisted eating and drinking.
- On Alistair Farquharson there was a library trolley in reception with books for people to borrow.
- A mobile shop visited Japonica on a daily basis enabling patients to purchase newspapers, toiletries, snacks, drinks. Staff members operating the mobile shop were employed by Sodexo. One patient told us "I visit the shop every day at about 10am".
- On Ainslie there were interpreters available through LanguageLine and members of staff spoke English as well as languages that reflected the diversity of the local population. We were told families never expected to fulfil an interpreting function but were involved in this role if they wanted to be.
- On Alistair Farquharson It was observed that patients were being admitted to the ward after 8pm. Several admissions were as late as 11pm.
- On Mayflower there were no nightlights on the wards. Patients were checked every two hours or more frequently.
- On Japonica and Foxglove the Barthel scale was used to measure performance in activities of daily living (ADL). Patients scoring less than eight on 60/80 were offered cognitive talking group. Those scoring more than eight were further assessed for potential trigger referral to the memory clinic.
- On Japonica groups were run for exercise, reminiscence and cognitive talking groups. On Mayflower we found there was only one exercise group per week and currently no ADL groups. Patients were not encouraged to go to the day room for meals or socialising.
- Mayflower a patient told us "I've not had any trouble with the staff. They come after five minutes wait. They take their time to do what they need to with me. Like this morning. They came and woke me and washed and dressed me and put me in the chair". On Japonica we were told "last week we had a pampering session. We had our nails and feet done. At Easter we had a nice tea". On Foxglove a patient said: "the physio is going with me to visit the care home tomorrow".

### Learning from complaints and concerns

- There were seven complaints from May 2014 to December 2015, with two of these fully upheld and five partially. No complaints were referred to the Ombudsmen. The Trust received 3138 compliments during the 12 month period, 388 of which were in this core service.
- Inpatient services attempted to resolve complaints at the earliest point. Senior managers told us that staff were asked to approach patients with the mind set that 'patients know best' and make clear rationales when dealing with complaints. Directors will see patients with concerns wherever possible. They may not undertake the whole investigation but allow patients to understand that their concerns are being taken seriously. The themes that tended to arise out of complaints were staffing issues.

## Are services responsive to people's needs?

- There were monthly staff meetings on wards to look at complaints and staff engagement.
- On Japonica ward the general information board displayed the complaints and compliments procedure. The matron told us there was currently one open formal complaint that the ward themselves had made formal after it was reported by the family as informal, so they could receive due process for the issue reported. Key

themes for the hospital where Japonica was based were around food. A nutrition steering group had been set up and became operational in April 2016. This included meeting with the catering manager. Current patients and people who have used the service had transport arranged for them to come in and attend this meeting which included a meal. The matron did a food tasting in March 2016 to ensure it was appropriate for patients.

# Are services well-led?

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

## Summary

- We rated well led as good. There was a clear strategy in terms of the future role and development of community inpatient services and their integration with community services provided in people's own homes.
- Staff reported to us that they had confidence in their leadership, who they found responsive, and that members of the executive team were visible.
- There was a governance structure that enabled managers and senior managers to appropriately monitor and review the quality of the service.
- We found an example where senior managers had responded appropriately to staff concerns about bullying and harassment.
- Recent reconfiguration of services had involved staff and public engagement in the process.

## Service vision and strategy

- Senior managers told us that for both the North East London and Essex areas, the main vision was to integrate services and have patients at the heart of all they do. One of the community inpatient directors was a Vanguard leader for the trust.
- Senior managers told us the vision was to provide more care in people's own homes which was according to their wishes. The community treatment team aimed to care for people in their own homes, resolve crises and step people up into community beds instead of a lack of care leading to an acute admission. There had been a large bed reduction programme for the community inpatient services in the North East London sector. There were now 52 beds (57 in winter). In Essex there were 79 community inpatient beds and the acute trusts felt a need to fully fill these beds. The template will be a bed reduction and a promotion of a hybrid model encompassing dementia beds, rehab beds and intermediate care beds.

## Governance, risk management and quality measurement

- Departmental Patient and Quality Safety Group (DPQSG) and Local Patient and Quality Safety Group (LPQSG) meetings were held monthly in each locality. Samples of minutes of the DPQSG meetings from December 2015 and January 2016 showed that set items regarding the quality of services were reported on, reviewed and progress updated. This included a monthly complaints, lessons learnt, risk register, serious incidents (Sis) and final reports and performance updates that incorporated a number of items. This included bed occupancy, targets, complexity of patients, on going live issues such as an increase in patients with urinary catheters from a local acute hospital, staff turnover and admission avoidance.
- There was a monthly patient safety dashboard. If something needed attention and was a concern then an exception report was written which went to the integrated care director (ICD) and the quality and patient safety committee. For example: if staffing on a ward was poor the matron will be contacted through to the head of nursing if needs be.
- On Japonica, the clinical audit team informed the service of which audits they needed to complete. Cyclical audits were: falls, MUST and Waterlow which occurred every six months as the standard. Each service completed their own. At ward level peer review audit occurred on a weekly basis and nursing and therapy staff did audits of assessments and care plans. The staff information board showed the matron's charter audit dates, operational monthly team meeting dates. There was a manager's meeting monthly attended by all matrons, rehabilitation manager, bed managers, integrated care managers and pharmacy. There was a separate team leader staff meeting held monthly.
- On Mayflower, there were no ward based audits being undertaken at present.

# Are services well-led?

## Leadership of the service

- Ward managers felt confidence in their leadership. Ward staff told us that directors and the chief executive officer (CEO) were very visible. For instance, on Japonica the CEO visited the team prior to their move of wards to discuss challenges of the move. This was followed up by a visit on Christmas eve to see how the move had gone. Attention was drawn to the fact that patients did not have a TV for Christmas which was acted on the same day. The executive director and executive lead had been on the ward as well as the integrated care director who assisted with the move and were seen carrying out everyday tasks such as making the beds. One manager told us they were in an interim role and felt supported. Managers told us they felt respected and valued in a culture of mutual respect. Trust values and staff charter upheld a culture of listening and acting on issues raised.
- There had been no qualified whistleblower reports received by CQC in the last two years (as of 17/02/2016) relating to this core service.
- On Alistair Farquarson, members of staff had left and raised concerns regarding bullying and harassment and feeling generally unsupported by unit management. The senior management team responded by taking the concerns seriously which were further corroborated from other sources. It was acknowledged that there were increased workload pressures and had approached this issue in a systemic way, looking at the size of the unit and contributory factors involved. An investigation had been initiated and the member of staff supported to perform duties elsewhere.
- '10 things matrons do' poster was on display on the general information board on Japonica.
- On Foxglove, a member of ward staff told us "directors are very approachable. They have an open door policy". A manager told us they had a "what can I do for you" approach.
- A team brief occurred every quarter and had to be disseminated to teams within ten days of issue.
- Mayflower staff told us the new matron was a 'breath of fresh air'. They had formalised the structure and treated band 6 nurses with respect.

- The Foxglove ward manager attended monthly meetings with service heads and monthly meetings with the deputy director. Ward meetings occurred monthly. There was a set agenda that included risks, complaints and compliments.
- On Alistair Farquarson therapy staff told us they felt well supported by managers but had no peer support. On Japonica and Foxglove therapy staff told us they felt supported and well led.

## Culture within the service

- Senior managers felt there was a very open and transparent culture around reporting risk and staff were given the confidence to use their initiative to benefit patients. Examples included the move for Japonica ward meant that teabags and coffee were not provided to the ward any longer. The ward manager was supported to just order these things as it was the patients best interests.
- An open and honest culture was valued by senior managers, who did walk arounds at times of day and night where staff were consulted on how they feel and what they would like to change. Recently on a walk around a manager was told by a HCA that they were concerned about their bank payments when doing extra shifts. She has now gone on to try and rectify this problem for them.
- Valuing staff was promoted. In team meetings if staff have done something outstanding it was recognised in team meetings.
- "You Said We Did" allowed staff to feel empowered to make change. The chief executive had an open door policy allowing staff to make their thoughts and opinions known. There were mechanisms in place for whistleblowing.
- Therapy staff reported there was often pressurised team morale due to the workload and to meet goals in time for discharge. Wards were nurse led rather than therapy/rehab led.

## Public and Staff engagement

- Two teams were brought together on Japonica in December 2015 and a lot of induction and orientation had taken place. The matron held meetings with band 7 and 6 staff to look at developing the service. Another

## Are services well-led?

unit had recently closed which had involved extensive work with Patient Experience Partnership (PEP) groups and Healthwatch, who came to focus groups and visited the new ward. Senior managers told us it was helpful to have the people who would be using it designing it. As a result of this they wanted to make Japonica and Foxglove as non-clinical as possible. They had tried to put in RemPods for dementia patients. These were temporary structures which have shown a decrease in falls and an increase in patient satisfaction. In Japonica there is a sensory room with sunflowers and there are coloured zones.

- PEP groups occurred in each locality on a monthly basis. Minutes provided showed these meetings were well attended and included a number of patient representatives and senior trust staff.
- On Alistair Farquharson the 'feedback' board was located in the day room along with the 'you said we did' outcomes. All of the comments were positive. For instance, "all of the staff are kind and helpful" was a typical comment. However, all of the 'you said we did' comments were on the theme of positive comments being fed back to staff, thus missing the opportunity to use the system for highlighting positive practice changes in how the service was delivered
- Each directorate had a PEP group where patients can come to talk and although it can be challenging it is also helpful. It showed that there was less engagement with the community health services compared to mental health even though the community services are larger.
- Friends and Family Tests (FFT) were carried out once the patient had been discharged. Any member of staff can ring up the patient and ask them 5 set questions about their stay. This information was then assessed by the service leads. For intermediate care there was very little negative feedback.

Test results were shared at team meetings. The trust had a weekly newsletter for staff which always contained FFT outcomes. Teams told us they can share their challenges and successes in the newsletter. FFT results for January was 94%.

- On Japonica, the matron had introduced 'patients' feedback to matron'. Every patient was given the survey sheet with a pre-paid envelope. If feedback produced something negative the matron would meet with the patient. The matron told us they had picked up some issues around cultural awareness from the feedback. This was fed through to the trust's education and development team.
- FFT survey results for for 'Q3 community beds' were seen and showed 94% likely to recommend and 96% met expectations, 96% easy to get care treatment and support. 92% of staff introduced themselves before providing care, 98% had been involved in their care. Comments from patients included 'excellent support', '... provided with a friendly smile'.

### Innovation, improvement and sustainability

- On Japonica, the sensory room was an allocated space for service user reminiscence or for staff to use for mindfulness. The electronic record RiO was developing a 'hot spot' feature where patient progress can be seen at a glance. The company has visited the ward. This feeds in to the quality and safety agenda.
- Introduction of the new integrated care assistant competency training was taking place across Japonica and Foxglove to give in service training and competencies across nursing, OT and Physiotherapy to all support staffing.
- No innovation or development plans known to therapy team members we spoke with.

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

Nursing care  
Treatment of disease, disorder or injury

#### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

- Equipment at the Alistair Farquharson Centre was inappropriately stored and therapy equipment was not properly maintained.
- Equipment such as blood pressure machines, beds and bed pan macerators were not properly maintained.

This is a breach of Regulation 15(1)(c)(e)(f)

#### Regulated activity

Nursing care  
Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- At Mayflower Hospital and the Alistair Farquharson Centre, the numbers of suitably qualified therapy staff were not sufficient to meet the needs of the rehabilitation service.

This is a breach of Regulation 18(1)