Halstead Community Hospital Ward

Quality Report

Halstead Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Halstead community hospital ward is a purpose built 20-bed ward located within Halstead Hospital. People cared for require rehabilitation, for example following a fall or surgery, and all are over the age of 18. Halstead Community Hospital ward is managed by Central Essex Community Services C.I.C (Community Interest Company).

We chose to inspect Halstead Community Hospital Ward as part of the first pilot phase of the new inspection process we are introducing for community health services. Halstead Community Hospital Ward was last inspected in 2013; at that point it was not meeting national standards in respect of assessing and monitoring the quality of service provision.

In general, we found that Halstead Community Hospital ward provided safe care. People were protected from abuse and avoidable harm and mechanisms were in place to monitor, report and learn from safety incidents such as falls and pressure ulcers.

We found examples of good leadership, and most staff felt very well supported by their managers. Staff said that they had good training and development opportunities; although clinical supervision arrangements were not as robust. Staff spoke with passion about their work and demonstrated commitment to provide the best care they could.

Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. The majority of patients and their relatives were positive about the care and treatment they had received.

Results of internal customer surveys conducted in 2012/13 of all services provided by Central Essex Community Services were generally favourable although it is not possible to benchmark the results against other similar organisations. The vast majority of people spoke positively about their care, and we saw some good examples of staff delivering compassionate care to patients and their families.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm.

Are services effective?

The community inpatient services at Halstead Community Hospital ward were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices and sufficient staff available to meet the needs of people accommodated within this facility.

Are services caring?

The majority of people said that they had positive experiences of care. We saw good examples of care being provided with compassion and of effective interactions between staff and patients. We found staff to be hard working, caring and committed. We noted many staff spoke with passion about their work and were proud of what they did.

Are services responsive to people's needs?

Halstead Community Hospital ward responded to people's needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time and without delay.

Are services well-led?

The ward was well-led. There were organisational, governance and risk management structures in place. The senior management team were visible and the culture was seen as open and transparent. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns. Many staff told us that it was a good place to work.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

People were protected from abuse and avoidable harm as staff were confident of adult protection triggers to report serious incidents or report concerns if they suspected poor practice. Mechanisms were in place to monitor, report and learn from safety incidents such as falls and pressure ulcers. However, further work is needed to ensure consistency regarding incident classification and reporting.

We found that national guidance was being implemented and monitoring systems to measure performance were in place. There was good collaborative working within the multi-disciplinary team (MTD) and staff available to meet the needs of patients was sufficient in terms of numbers and skill mix.

We saw good examples of care being provided with compassion and of effective interactions between staff and patients. Staff spoke with passion about their work and were proud of what they did.

The service is responsive to the needs of the local population and systems are in place to ensure learning from information gathered from the experiences, both positive and negative, of people who used the service. People from all communities could access services and effective multidisciplinary team working, including liaison between ward staff and community based teams, ensured people were provided with care that met their needs, at the right time and without delay.

The ward was well led. The senior management team were visible and the culture was seen as open and transparent. Governance arrangements were in place to deliver high quality care. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns. Many staff told us that it was a good place to work.

Summary of findings

What people who use the community health services say

The Friends and Family Test (asks a single, standard question: "How likely are you to recommend our ward to friends and family) was conducted at Halstead Hospital between April 2013 to September 2013. The results were mainly positive with the majority of people confirming that they would recommend the ward to friends and family.

An internal customer survey was conducted at Halstead Community Hospital between May 2012 and March 2013. A sample of 296 patient views were collected prior to their discharge, and the results were generally favourable. Negative findings included: information provided to patients about medication and treatment; patients being regularly informed about their care; and patients' reported involvement in decisions about their care.

There have not been any patient comments through the NHS Choices or Patient Opinion websites. There was one Share Your Experience form submitted to CQC (in June 2012) raising concerns about staffing levels and sickness.

Areas for improvement

Action the community health service SHOULD take to improve

- Strengthen current systems regarding the provision of information to patients and families in relation to discharge planning arrangements, especially for those patients who lack capacity.
- Enhance staff understanding of clinical supervision and ensure there is management oversight and processes to ensure consistent practice.

Good practice

- The care provided was person centred and based on evidence based guidelines
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.
- The effective multidisciplinary team working practices that were person-centred and focused on patient independence.

Halstead Community Hospital Ward

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Tracy Taylor, Chief Executive, Birmingham Community Healthcare NHS Trust

Head of Inspection: Amanda Musgrave, Care Quality Commission

The team included CQC inspectors, an analyst and a variety of specialists: Physiotherapist (adults and children), Pharmacist and patient 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Halstead Community Hospital Ward

Halstead community hospital ward is a purpose built 20-bed ward located within Halstead Hospital. A range of NHS services are delivered from Halstead Hospital by Central Essex Community Services C.I.C. and Colchester Hospital University NHS Foundation Trust.

Services delivered here include:

- Community cardiac services
- Community hospital ward
- Health visiting
- Outpatient physiotherapy clinics
- Parkinson's disease clinics
- Podiatry
- School nursing
- Unscheduled therapy – domiciliary service

Halstead community hospital ward provides inpatient care to up to twenty people in the community hospital. People cared for within this inpatient facility require rehabilitation and all are over the age of 18. Patients can be referred by their GP's, via the Rapid Assessment Unit (RAU) at Braintree Community Hospital or direct from two local acute Hospitals.

Why we carried out this inspection

This location was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

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

The inspection team looked at the following services: always looks at the following core service areas at each inspection:

- Services for adults requiring community inpatient services

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the provider.

We carried out an announced visit on 21January 2014. During our visit we held focus groups with a range of staff we observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the service.

The team would like to thank all those who attended the focus groups and listening event and were open and balanced in the sharing of their experience and their perceptions of the quality of care and treatment at Central Essex Community Services C.I.C.

Community inpatient services

Information about the service

Halstead community hospital ward provides 20 inpatient beds at Halstead Hospital. A total of 427 people used the inpatient facility at Halstead hospital between November 2012 and October 2013. During our inspection, we spoke to approximately eight patients and six staff and reviewed information from comment cards that were completed by people using the inpatient service. Five comment cards were reviewed for Halstead ward and the comments were overwhelmingly positive about the care people had received. One respondent stated that some staff were quite sharp and that she felt that her husband did not always get his medication on time including pain relief.

Summary of findings

People were protected from abuse and avoidable harm as staff were confident of adult protection triggers to report serious incidents or report concerns if they suspected poor practice. Mechanisms were in place to monitor, report and learn from safety incidents such as falls and pressure ulcers. However, further work is needed to ensure consistency regarding incident classification and reporting.

We found that national guidance was being implemented and monitoring systems to measure performance were in place. There was good collaborative working within the multi-disciplinary team (MTD) and staff available to meet the needs of patients was sufficient in terms of numbers and skill mix.

We saw good examples of care being provided with compassion and of effective interactions between staff and patients. Staff spoke with passion about their work and were proud of what they did.

The service is responsive to the needs of the local population and systems are in place to ensure learning from information gathered from the experiences, both positive and negative, of people who used the service. People from all communities could access services and effective multidisciplinary team working, including liaison between ward staff and community based teams, ensured people were provided with care that met their needs, at the right time and without delay.

The ward was well led. The senior management team were visible and the culture was seen as open and transparent. Governance arrangements were in place to deliver high quality care. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns. Many staff told us that it was a good place to work.

Community inpatient services

Are community inpatient services safe?

Safety in the past

We found that community inpatients were protected from abuse and avoidable harm as staff were confident about reporting serious incidents and providing information to the ward matron or senior manager if they suspected poor practice which could harm a person. All staff we spoke with were aware of the safeguarding policy and had received training at the appropriate level with regards to safeguarding vulnerable adults. The 2014 mandatory training records reported 100% attendance at Safeguarding Adult and Children levels 1-3 at Halstead Hospital Ward.

Information highlighted by the NHS Safety Thermometer assessment tool (used by frontline staff to measure a snapshot of these harms once a month) identified an increase in pressure ulcers between April 2013 and June 2013 for the over 70's group. However, this snapshot figure is of all patients identified with a pressure ulcer and includes patients that may have been admitted with existing pressure damage as well as those patients that have developed a pressure ulcer whilst in hospital.

A staff nurse had undertaken leg ulcer management training, which included four days practice sessions at clinics, to assist other ward staff if any ulcers were found.

Patient Led Assessments of the Care Environment (PLACE) had been conducted and scores were displayed in the ward area. The results for this ward were all above the national average.

Infection Prevention Committee Minutes of September 2013, also noted that no healthcare associated infections for Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium Difficile (C.diff) had been attributed to Halstead Hospital for the first two quarters of 2013.

A medication audit completed by the organisation in 2013 had identified that the storage arrangements for medicines at Halstead Hospital did not meet standards for secure storage. The organisation had plans in place to ensure that suitable storage would be installed in March 2014. We looked at the current medicines storage arrangements and found that medicines in the ward storage area were stored safely for the protection of patients. However, we had concerns in regards to the safe storage of medicines for one patient who was looking after their own medicines. We observed that the patient had left their medicines unattended on top of their bedside locker. This meant that the medicines would be accessible to unauthorised people or people they were not prescribed for.

Daily recording of the refrigerators used to store medicines were conducted and monitored. This meant that staff took appropriate action to check that refrigerator temperatures were appropriate and to ensure the efficacy of medicines was not affected.

Learning and improvement

We found that mechanisms were in place to monitor and report safety incidents, including "never events". Staff were familiar with the reporting system and could provide examples of reporting serious incidences and the lessons learnt. For example, twenty-six falls had been reported between April 2013 and December 2013 for Halstead Hospital community ward. A root cause analysis (RCA) investigation was conducted for each of these incidents, and we saw an RCA which had been completed in full following a fall two days before our inspection. The provider identified that there was an increasing trend in the number of falls that had been reported during the six months to December 2013. As a result, a review was undertaken in order to monitor the incidence of patient falls in relation to the numbers of staff on duty, the ratio of agency staff and the location of staff on duty when falls had occurred. The outcome of this review has yet to be reported.

A customer experience report is produced on a monthly basis for the Board and provides an overview of customer experience across all locations. This report includes an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. Complaints are categorised as only concerns, moderate or severe. There were no severe complaints to date in November 2013 and 55 complaints attributed to the inpatient wards at all three sites. The report outlines individual complaints and how they were dealt with and the key learnings to be shared. One complainant at the Halstead Hospital Ward highlighted a number of issues whilst being an inpatient. This complaint was investigated and a response sent to the complainant within 19 days. A face-to-face meeting was also held for the complainant to talk about their experiences and hear the staff's response.

Community inpatient services

Systems, processes and practices

The vast majority of staff reported that their managers were supportive. They told us they were able to raise issues without fear of negative consequences.

The provider had policies and processes in place regarding incident reporting which were available for staff to refer to. On the ward staff were routinely monitoring quality indicators such as falls and pressure ulcers through the NHS safety thermometer. However the Board didn't receive regular reports about safety thermometer information collected at ward level. Incidents of concern were reported by staff on the Datix incident reporting system.

The 2013/14 Pressure Ulcer strategy acknowledged there was still some confusion amongst staff around what should be reported and a delay in reporting pressure ulcers. At a minimum, the Board expected that all grade two and above pressure ulcers should be recorded using the Datix incident reporting system. Once reported on Datix, incidents were reviewed and a judgement was made about whether the pressure ulcer was acquired at the providers site (Central Essex Community Services acquired). The number of grade 3 and 4 pressure ulcers (Central Essex Community Services acquired) were reported as serious incidents and the number of grade 1 and 2 pressure ulcers categorised as incidents and reported internally. Pressure Ulcer incidents graded 3 and 4 were reviewed at the Stop the Pressure group.

Although Grade 3 and 4 pressure ulcers were defined as serious incidents they were reported separately from the organisation wide serious incidents.

We saw that all members of the multidisciplinary team were involved in root cause analysis investigations and action plans had been developed and implemented. We saw one investigation outcome, following the fall of a patient, had resulted in the purchase of special beds, which could be lowered to ground level for those patients identified to be at high risk of falls

Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:

- hand washing facilities and alcohol hand gel available throughout the ward area
- staff following hand hygiene and 'bare below the elbow' guidance
- staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care
- suitable arrangements for the handling, storage and disposal of clinical waste, including sharps
- cleaning schedules in place and displayed throughout the ward area,
- clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Patient records were kept securely in key coded trolleys and we were able to follow and track the patient care and treatment easily as the records we reviewed were mostly well kept, up to date, and accurately completed. In addition staff were able to easily locate and obtain any additional notes we required when conducting our patient record review

An audit of resuscitation equipment had been conducted in September 2013, and received 50% compliance with the expected standard overall. Issues found included:

- Having no standard resuscitation council notices indicating where the defibrillator is located on the ward
- The suction machine was plugged in but not charging
- The checklist did not meet the checklist in Provide policy

An individual action plan with timescales was developed. The November 2013 update indicated that all the identified issues were resolved.

Monitoring safety and responding to risk

We found that staffing levels and skills mix, supported safe practice. We noted that the November 2013 quality and safety committee board report identified a staffing shortfall of three full time equivalent qualified staff and one healthcare assistant. However, staff told us that plans were already in progress to recruit these additional staff and whilst bed occupancy from April 2013 to October 2013 was reported as 89%, no staff shortages had been reported.

Patients were allocated to beds according to the level of observation they required. For example, patients who were identified to be at risk of falls were accommodated in beds closest to the nursing station so that they could be closely observed and monitored.

Information relating to patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as

hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents. The notice board reported that there had been no healthcare associated infections attributed to the ward in the previous six months, and a high compliance of over 90% on the cleanliness and hygiene audits.

A range of risk assessments were undertaken to ensure staff and patient safety, of which all the staff we spoke with were aware. These included: ward environment; lone working; manual handling; Control of Substances Hazardous to Health (COSHH); and ward security. We observed that a risk assessment that had been carried out for a new piece of equipment, the outcome of which had been the provision of additional staff training to ensure safety to staff and patients when using such equipment.We also observed that one member of staff was unwell and unable to lift anything heavy. The ward matron had supported them by assigning them with light duty tasks such as updating paperwork.

Anticipation and planning

There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and bed capacity issues. The majority of staff we spoke with reported that they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The 2014 central log for mandatory training confirmed that nearly all staff on the Halstead Hospital ward had attended required mandatory training.

Patient dependency assessments were used to determine the numbers of staff required but only when patient acuity levels were judged by staff to be high and the skill needs analysis, used to determine the appropriate ratios of qualified and unqualified staff within the ward compliment had been conducted using a model developed for the acute hospital sector. However, staff told us that where additional staffing numbers were required that these requests were met through ward staff working additional hours or agency staff. An example was given where following identification of additional staff requirements to ensure the safe and effective care of a bariatric patient, additional staff were rostered and shifts covered by off duty staff or agency staff.

Where staff identified potential concerns relating to patient safety, these were assessed and placed on risk registers, so the risks could be assessed and minimised through action plans. The November 2013 quality and safety committee board report identified risks raised by staff and noted three falls with the resulting actions.

All patients admitted to the community hospital ward undergo screening for Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA). This screening is used to identify those patients who were at 'high risk' of acquiring MRSA so these risks could be minimised. Results are recorded in patient notes and also documented in discharge planning records. Staff told us that by recording this information on discharge planning records other professionals, such as the patients GP, were also able to plan appropriate aftercare if required.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

We observed that care provided was evidence based and followed recognisable and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. For example, staff were using tools such as the Mini Mental Test to determine capacity and the Malnutrition Universal Screening Tool (MUST) to determine patient's nutritional needs.

Policies were available electronically via the intranet and some in paper format so all staff had access to these. They reflected national guidance with appropriate evidence and references. For example, all inpatients were screened for Methicillin-resistant Staphylococcus aureus (MRSA) following national guidance from the Department of Health (DH). The policy noted the evidence base and references included the DH Saving Lives guidance for: reducing infection, delivering clean and safe care and The Health Act 2006, Code of Practice for the Prevention and Control of Healthcare Associated Infections. Staff we spoke with could direct us to these policies. One staff nurse described the guidance and showed us the procedures for admitting and discharging patients to the ward.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. For example, we

reviewed the records for one patient who had been assessed as lacking capacity to make decisions and for whom a decision had been made not to attempt cardio pulmonary resuscitation (DNA CPR). We saw that the appropriate people, including relatives had been involved in the decision making process and that the decision had been clearly documented in the patient's notes and this had been subsequently reviewed and updated. We also observed the occupational therapist obtaining consent from a patient to enter their flat to carry out an assessment to ensure the safe and effective discharge of the patient.

Monitoring and improvement of outcomes

We saw that the performance and delivery of this service was included within the quality and safety board report for senior leaders. Performance data included outcomes of clinical audit activity such as the High Impact Intervention (HII) audits that relate to key clinical procedures that can reduce the risk of infection if performed appropriately and the NHS Safety Thermometer Programme. Staff we spoke with were aware of the current outcomes and this information was clearly displayed on ward notice boards.

Staffing arrangements

There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and bed capacity issues. When patient acuity levels were judged by staff to be high, patient dependency assessments were used to determine the numbers of staff required. The skill needs analysis, used to determine the appropriate ratios of qualified and unqualified staff within the ward compliment, had been conducted using a model developed for the acute hospital sector.

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff worked in a supernumery capacity until completion of their induction. We found that professional body registration checks took place at the time of initial recruitment and annually.

Staff told us there was good access to mandatory training study days. They told us that the content was appropriate and included infection prevention and control, moving and handling, medicines management and health and safety. We looked at the mandatory training attendances as recorded by Provide in January 2014 and we found that overall an average of 98% of staff have met their training requirements on the Halstead Hospital Ward. This shows the provider ensured staff have the right skills, experience and support to deliver safe efficient care.

All staff we spoke with reported they had received an appraisal within the last year. This gave them an opportunity to discuss their work progress and future aspirations with their manager. Staff confirmed that clinical supervision was provided, usually in groups, and handover sessions were used often used as a forum. Whilst therapists told us that they received regular clinical supervision, information provided within the organisation's Learning and Development Quarter 2, 2013 report identified that only 27% of staff were receiving clinical supervision within this period. However it is noted that the provider has already taken action to improve their performance through the review and introduction of a revised clinical supervision policy. Further work is needed by the provider to ensure effective implementation and monitoring of compliance with the standards set within this policy.

A practice development facilitator has recently been appointed. The provider told us that this individual was tasked to undertake a workforce modelling project, looking at national and international models of staffing. The future staffing capacity needs of the organisation is to be determined as a result of this workforce modelling exercise.

Multidisciplinary working and support

We observed and staff we spoke with told us, that there was effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Weekly MDT meetings, involving the general practitioner, nursing staff, therapists as well as social workers and safeguarding leads, where required, ensured the patient's needs were fully explored. This included identification the patients existing care needs, relevant social/family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support. We saw evidence of the outcomes of these meetings in patient's files

We observed staff working well together, healthcare professionals valuing and respecting each other's contribution into the planning and delivery of patient care.

Communication between staff was effective, with staff handover meetings taking place during daily shift changes.

Community inpatient services

We heard staff handover discussions that included information regarding risks and concerns of each patient, discharge date and plans as well as any issues that required follow-up.

Electronic patient records that detailed current care needs were available for all patients ensuring staff were fully informed of the patient's diagnosis and current physical and emotional needs.

Are community inpatient services caring?

Compassion, dignity and empathy

We observed all staff treating people with dignity and respect and taking extra time with patients who didn't have full capacity to fully understand the advice being given. We saw one patient with a Zimmer frame walking to the toilet, a nurse took time out of their task to walk with this patient. This demonstrated that staff cared about meeting patients' individual needs.

Compliance with same-sex accommodation guidelines was ensured through the designation of single sex bay areas and ample provision of toilet and bathing facilities. We observed curtains being drawn around each bed prior to delivery of care and discussions with patients in regards to their care. One patient told us that "staff always closed the curtains whilst giving me care". We also observed staff respecting patient dignity whilst assisting with their toileting needs.

The majority of patients and their relatives were positive about the care and treatment they had received. Patients told us "the staff have been wonderful" and "the staff are caring".

We observed staff treating people with compassion and empathy. One example being where staff had arranged for a large (bariatric) bed to be put in place so that the partner of a palliative care patient who wanted to spend a night with them could lie together.

Involvement in care

Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found by looking at care plans, reviewing clinical guidelines and talking to families and staff that care was planned to follow best practice as set down by national guidelines. Whilst all staff groups felt very involved in the delivery of care, one group told us they would like to offer additional patient involvement activities were additional staffing and funding made available.

We saw good evidence through observation of practice and review of patient records that staff are assessing the patient's capacity to be able to give valid consent using a Mini Mental Test (designed to give the examiner an indication of the mental state of the patient), for most patients upon admission. We found that relatives and/or the patient's representative are involved in discussions around the discharge planning process. For example, relatives being informed of potential discharge dates and patients and relatives having discussions with members of the multidisciplinary team to ensure a smooth transition home upon their discharge from hospital.

Staff had a good understanding of consent and applied this knowledge when delivering care to patients. Staff we spoke with had received training around consent and had the appropriate skills and knowledge to seek consent from patients or their representatives. On the majority of instances we observed positive interactions between staff, patients and/or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered. One person said "The treatment is very good; the nurses and other staff have been very helpful". The exception to this was where on two occasions, where the patients did not have full capacity; we observed staff speaking to relatives and/or the patient's representative, excluding the patient from these discussions.

A range of literature was available for patients, relatives and/or their representatives and provided information in regards to their involvement in care delivery from the time of admission through to discharge. This included: complaints processes, key contacts information and follow-up advice for when the patient left hospital. However, whilst we observed in patient records that provisional discharge dates and progress against these dates was recorded, patients and their families told us identified that they were not always satisfied with the sufficiency of information provided to them concerning their discharge from hospital. Further work is needed by the provider to ensure effective communication with patients and their families in regards to discharge planning arrangements.

Community inpatient services

On the majority of occasions we observed positive interactions between staff and patients, this was particularly the case at meal teams. However, we did observe a lack of involvement between staff and patients sitting in the day room. We saw the TV was left on and patients left on their own within this area when not receiving specific care.

Trust and respect

We observed staff treating patients with dignity and respect when attending to care needs. Where patients had to be isolated, for example if they had an infection, we saw the staff respected their dignity and placed a sign on the door stating "Please speak to the nurse in charge" rather than noting their condition.

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care. We observed patients being encouraged to use the communal dining area at meal times with minimal assistance provided by staff. Staff told us that building and sustaining a trusting relationship with patients was crucial in ensuring patients felt confident to mobilise independently and not become institutionalised.

The mandatory training log January 2014 noted that 100% of staff on Halstead Hospital Ward had received equality and diversity training. Staff we spoke with confirmed that they had received this training and could demonstrate through the care planning process that they were taking into account each person's culture, beliefs and values. Staff described that there were no large ethnic minorities within their catchment areas. However, they were all aware where support could be obtained if it was required, for example, a translator if English was not the person's first language.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. We observed positive interactions between staff and patients, where staff knew the patients very well and had built up a good rapport. We saw staff providing reassurance and comfort to people. One example being the calm and positive manner a member of staff displayed when explaining to an elderly patient who was confused and wanted to go home.

A further example was the emotional support we observed being given to a patient who was receiving palliative care (comfort care given to a patient who has a serious or life-threatening disease) in a side room. We observed staff interactions with this patient that demonstrated a knowledge and understanding of the patient's emotional needs.

An advocacy service, provided by Age Concern Essex, is available at Halstead Hospital, providing additional assistance to patients in making any crucial decisions about their future. A bereavement room, equipped with kitchen facilities and couches that could fold out to become beds, is also available for those relatives who wish to stay at the hospital overnight.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

There was evidence from staff we spoke with that staff were meeting the needs of patients admitted for rehabilitation and palliative care. For example, there were good mechanisms for information sharing between in-patient and community teams and a willingness to engage with other service providers, such as the mental health teams and acute trusts, to ensure that all care needs were met.

Staff were knowledgeable regarding the community in which they provided services and the written information provided to patients upon admission to and upon discharge from hospital, were reflective of this. Whilst there were no large ethnic minorities within the catchment areas, written information in different languages or other formats, such as braille were not readily available. However, staff knew how to obtain support when required. For example, a translation service was available if the patient's first language wasn't English.

Patients were complimentary about the meals provided to them and specific patient's dietary requirements were displayed in the kitchen area. Staff were knowledgeable about meeting the religious and cultural nutritional needs of their patients. We also observed staff asking patients what they would like for lunch 30 minutes before lunch was served. Ensuring that people were provided with suitable and nutritious food and drink based on what they would like currently like to eat. In addition, we also observed

refreshments being offered by a member of staff who was in constant contact with nursing staff, so that refreshments were not offered to those patients whose food and fluids were restricted.

Access to services

Accessibility to the Halstead Community Hospital Ward was good as services were provided on one level with no stairs and there was plenty of free car parking available on site.

Patients could access the ward by referral from three main routes which were either from the rapid assessment unit (RAU) at Braintree Community Hospital, from the rehabilitation wards at the acute hospitals or from the palliative care team (comfort **care** given to a patient who has a serious or life-threatening disease). The system in place meant that patients with specific needs could be admitted in a timely manner to receive appropriate care.

Vulnerable patients and capacity

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLs). In addition to the mandatory training, staff working within this inpatient facility had received training for caring for patients with dementia and those who displayed challenging behaviour. Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.

Where patients lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. For example, we reviewed the records for one patient who had been assessed as lacking capacity to make decisions and for whom a decision had been made not to attempt cardio pulmonary resuscitation (DNACPR). We saw that the appropriate people, including relatives, had been involved in the decision making process and that the decision had been clearly documented in the patient's notes and this had been subsequently reviewed and updated. In another patient's records we found that consent had been gained for assisting them with their personal care.

Arrangements were in place with another provider, Colchester General Hospital, for those patients admitted with mental health needs. Staff knew how to access these services, including referral back to local mental health teams upon discharge if a patient was admitted from out of area. Staff spoke positively about the effectiveness of relationships with the mental health team.

Leaving hospital

The discharge and transfer of patients was well managed. Effective systems are in place to ensure that discharge arrangements met the needs of patients. For example, a specific patient discharge list, which included details such as a drugs chart, mental capacity assessment and infections data. These details are completed and copies sent with the patient on discharge or to their GP.

Discharge planning commences at the point of admission for all patients when a provisional discharge date of six weeks was assigned. This date was flexible and increased or decreased according to the patient's progress. Information relating to the average length of stay and time to discharge was displayed on notice boards in the ward area and the provisional date was also displayed on a board behind each bed so patients, their representatives and healthcare staff were aware of the expected discharge date and could prepare accordingly.

Multidisciplinary team meetings (MDT) were held every Monday which included the GP, nursing staff, social workers, physiotherapists and occupational therapists as well as a member of the safeguarding team. Patients discharges were discussed at the MDT and all the staff worked towards the provisional agreed discharge date. Staff told us that there was no pressure to discharge patients earlier, nor were discharges delayed as a result of awaiting decisions about funding. Patients could be fast tracked without the full MDT panel if they were deemed to be medically fit. We saw evidence of discussions around discharge during our review of patient files.

Where patient discharge was delayed, the staff had recorded the reasons for this in the notes. For example, the discharge of a patient who was in a wheelchair and lived on a first floor flat had been delayed due to a therapist assessing their needs and ensuring the environment to which they were returning was safe and manageable.

Community inpatient services

If patients were medically fit for discharge but required an onward appointment which could be several weeks away, arrangements are made to support them at home in-between; for example, home care support was arranged by the team.

The patients and relatives told us they had been given information relating to their discharge from the ward. However, they also told us that they were not always kept informed of the changes promptly which meant there were issues with families having to rearrange their schedules. Further work is needed by the provider to ensure effective and prompt communication with patients and their families in regards to discharge from hospital.

Learning from experiences, concerns and complaints

Staff told us that the provider was open and transparent about complaints and concerns and that they were encouraged to improve or develop services where issues had been raised by patients and their families. The provider's Board meetings include a Customer Experience report which looked at trends in complaints, compliments, feedback from visits by the Executive Team and other patient feedback.

Staff were knowledgeable in regards to the processes available to advise patients and relatives about how to make a complaint and aware that a log of all complaints was held on a centralised system.

Patient Advice and Liaison Service (PALS) leaflets were available but these were not clearly visible. However, patients were aware of how to raise a complaint and that they would do this by speaking with the ward staff or to the PALS team.

Complaints were reported monthly and we were told that the ward matron cascaded this information to ward staff. Staff told us that discussions were held with staff involved in the complainants care and that any issues that were raised by patients outside of the complaints process would be addressed immediately. The organisation also collected feedback from families who used the service and acted upon the results. For example, a customer survey had been conducted at Halstead Hospital Ward in April 2013 and whilst the overall results were very positive, action had been taken to improve the provision of information to patients, an area of poor performance identified within the survey.

Staff told us that local resolution of complaints was preferred and staff were involved in the investigations. In cases where the complaint was escalated, an investigator from outside the speciality was appointed. Then a formal process, monitored by the customer service team, was followed. A process including defined timescales for investigation and draft response and development of action plans addressing areas of concern identified within the complaint.

Are community inpatient services well-led?

Vision, strategy and risks

Staff were clear about the organisation's vision and noted that the corporate induction for all new staff included the provider's core values and objectives for the organisation. Information relating to core objectives and performance targets were visibly displayed in the ward area. Staff told us that the Board and senior managers were visible and approachable.

As a not-for profit social enterprise organisation, every employee, from frontline medical staff to admin support staff, were given the opportunity to become an owner of the company for just £1. As an owner, they have a say in the future direction of the company and could make suggestions for improvements. The majority of staff we spoke with had taken this opportunity and received regular updates regarding their suggestions for improvements.

The provider's priorities, as outlined in the Quality Account of June 2013, for 2013/2014 focused mainly around patient safety. Priorities that were applicable to the inpatient ward were: working with other relevant organisations to develop a holistic and integrated frailty pathway; maintaining MRSA and Clostridium Difficile performance; and building on the pilot approach to Customer Engagement.

We looked at performance and quality data at ward level. This showed that information relating to patient safety and risks and concerns were accurately documented, reviewed and updated at least monthly. The risk register, which included key risks such as fractures, aggression and complaints.

Quality, performance and problems

We saw that the Board received quality and safety reports every other month that included information such as

staffing vacancies, numbers of falls and pressure ulcers, medication incidents, serious incidents and HCAI indicators by service level. We noted that discussion about quality indicators had become more detailed and focused in the last six months.

We observed some positive examples of learning and changes to practice following reporting and escalation of serious incidents. One example being the decision taken by the Board to purchase adjustable height beds for the ward, and the implementation of a monitoring system introduced to ensure a falls risk assessment was conducted on all patients within six hours of admission, following the report of a serious incident concerning a patient fall.

Leadership and culture

The majority of staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with senior managers would be acted on.

Staff told us that their managers were visible, accessible and approachable and that opportunities were available to speciality link nurses to develop skills, knowledge and experience in their specialist areas. For example infection control.

Whilst care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. The staff roles and responsibilities were clearly defined with a sufficient skill mix of staff across all staff grades and all staff spoke of their commitment to ensuring patients were looked after in a caring manner.

Patient experiences and staff involvement and engagement

Staff told us they were communicated with in a variety of ways, for example newsletters, emails and briefing documents. We saw evidence of this. Staff told us they were made aware when new policies were issued and that they felt included in the organisation's vision.

There was very active engagement with The League of Friends whose role it was to assist people in the local community and to support charitable work at the hospital. Money donated by the League of Friends had been used to purchase equipment to improve the experiences of patients.

The Friends and Family Test (asks a single, standard question: "How likely are you to recommend our ward to friends and family) was conducted at Halstead Hospital between April 2013 to September 2013. The results were mainly positive with the majority of people confirming that they would recommend the ward to friends and family. The majority of patients we spoke with were also complimentary about the care they were receiving and the staff delivering care.

Learning, improvement, innovation and sustainability

Staff new to the organisation received a two day induction, which included e-learning, and were supernumery to the identified staffing requirements for a period of one month following completion of their two day induction.

Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data demonstrated a 98% mandatory training completion rate for staff working at Halstead Community Hospital ward. The remaining staff who had to complete their training were either ill, working on nights or were absent when courses were held. Staff told us that night shift allocations were flexed to ensure mandatory training attendance.

We noted that the majority of the training was done through e-learning; this is a computer generated way of learning. Staff watch a video or briefing and have to answer questions on a specific subject. The e-learning training included modules around dementia and safeguarding vulnerable adults, which also included managing patients with challenging behaviour. The ward matron had taken the initiative to improve the effectiveness of e-learning, by arranging for staff to complete the training in groups, enabling a more interactive training experience. Other training such as manual handling was classroom based as staff needed to carry out practical tests to confirm competence.

In addition to the mandatory training requirements, staff are encouraged and supported to access other training. One example being a staff nurse who had been supported in undertaking additional training in the management of leg ulcers.

There was an open culture that supported learning whereby staff were trained in performing root cause

analysis (RCA) and were encouraged to report incidents and errors. Staff received feedback to aid learning and information was cascaded within the teams and across the organisation to improve patient care and treatment. This was done via staff meetings and through staff newsletters. Staff said they were supported with additional learning and practice development.