

Isle of Wight NHS Trust

RIF01

# Community health inpatient services

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RIF01	St Mary's Hospital	General Rehabilitation Unit and Stroke Unit (rehabilitation)	PO30 5TG







This report describes our judgement of the quality of care provided within this core service by Isle of Wight NHS 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 Isle of Wight NHS Trust and these are brought together to inform our overall judgement of Isle of Wight NHS Trust

# Summary of findings

## Ratings

Overall rating for the service	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Requires improvement	

# Summary of findings

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# Summary of findings

## Overall summary

We rated the service as requires improvement because:

- Medicines were not stored safely and securely which may pose risks to patients.
- Equipment was not always managed safely and in line with the trust's operating procedures. These included pressure relieving equipment which had not been serviced.
- There was a lack of lifting equipment which impacted on the care and treatment people were receiving.
- Patients' records were not stored safely which posed risks of data protection breaches.
- Patients told us that at times staffing caused delays to the timeliness of care.
- Some of the nurses did not have a clear understanding of the Mental Capacity Act 2005 (MCA). Mandatory MCA and Deprivation of Liberty Safeguards (DoLS) training for all registered nurses was below the trust target, which may impact negatively on care. Appraisal compliance was below the trust target on the stroke unit and general rehabilitation unit.
- Therapy staff did not work seven days a week so stroke patients were not always able to have specialist assessments within 72 hours.
- Patients were sometimes moved at night, and experienced delays leaving hospital.
- There were high levels of nursing staff sickness on the stroke unit.
- Managing risks was not robust. Senior staff were not always aware of the current risks and issues, so there was no plan to address them.

- Formal feedback about the stroke service was limited from patients and their families.

However

- Staff understood their responsibilities to raise concerns and report incidents, and learning actions were identified.
- The trust took part in local and national audits to measure and promote improved outcomes for patients.
- Patient pain was managed effectively, and patients varied dietary and nutritional needs were met.
- Since the inspection in September 2014, the service had developed admission criteria for the general rehabilitation unit, which supported the staff in admitting appropriate patients.
- On the general rehabilitation unit safeguarding adult level 3 training was 100%.
- There was a multidisciplinary approach on the stroke unit and the general rehabilitation unit. Nursing, therapy and medical staff were caring, compassionate and patient centred in their approach.
- Patients were involved in making decisions about their care and treatment.
- There was evidence the trust used learning from complaints to improve the quality of care.
- The service promoted equality, supported people to be independent and met the needs of people in vulnerable circumstances.

# Summary of findings

## Background to the service

The Isle of Wight NHS trust is an integrated trust providing ambulance, acute, community and mental health services. The inpatient service we inspected included general inpatient rehabilitation and stroke inpatient rehabilitation.

The inpatient general rehabilitation unit and the stroke unit both located at St Mary's Hospital. The two wards became part of the medicine clinical business unit in 2016, as part of the trusts 2015 to 2019 clinical strategy.

There were 22 beds in the general rehabilitation unit for active rehabilitation and eight beds for medical patients. The care of medical patients, who were admitted to the general rehabilitation unit, was transferred to the care of

a consultant based on the based on the general rehabilitation unit. The average bed occupancy from April 2016 to October 2016 for the general rehabilitation unit was 99%.

There were 26 beds on the stroke unit. The stroke unit provided acute stroke care (reported under medicine) and inpatient rehabilitation for stroke patients. The average bed occupancy from April 2016 to October 2016 in the stroke unit was 97%.

Across both wards, there was multidisciplinary working, which included nursing, therapy, medical staff and the patient and their representatives.

## Our inspection team

Team Leader Joyce Frederick, Care Quality Commission

The team that inspected the community inpatient rehabilitation beds included one CQC inspector and two specialist advisors. The specialist advisors had a specialist knowledge of community inpatient rehabilitation services.

## Why we carried out this inspection

We carried out this short notice inspection of the Isle of Wight NHS Trust to follow up on some areas that we had

previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service or if we had not inspected the service previously.

## How we carried out this inspection

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

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

We carried out a short notice visit from 22 to 24 November 2016. We spoke with 12 patients, four relatives

and 27 members of staff. These included nursing staff, healthcare assistants, ward clerks, junior and senior doctors, stroke specialist, physiotherapists, occupational therapists, housekeeping staff, porters, a volunteer, personal assistants and managers. We received five comments cards back about care on the stroke ward. We reviewed seven care records. We observed care and treatment. We attended two ward nursing handovers, and two multidisciplinary team meetings. We observed

# Summary of findings

interactions between patients and staff, considered the environment and reviewed a range of management documentation and feedback from other agencies involved with the trust.

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

## What people who use the provider say

Patients told us they were treated with kindness and dignity during their admission to the general

rehabilitation unit and the stroke unit, but there had been some delays with meeting their needs. Patients and relatives told us they had been involved in care and treatment plans.

## Areas for improvement

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

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

The trust **MUST** take to improve

- Ensure medicines for return to pharmacy are stored securely
- Ensure patient records are secured stored so as not to breach patient and to prevent unauthorised access.
- Ensure risks are managed in a timely way, and all risks identified.
- Ensure compliance with safeguarding, MCA and DoLS, and adult resuscitation training improves.
- Ensure that there is record of all agency and bank staff inductions.
- Ensure that there are sufficient pieces of equipment designed for the safe moving and handling available to support patient needs.

Action the provider **SHOULD** take to improve

- Improve appraisal rates on the stroke unit and the general rehabilitation unit to meet or exceed the trust target.
- Ensure systems and processes prevent pressure relieving mattresses being used that are beyond the manufacturers recommended servicing date.
- Continue work to ensure therapy staff had undertaken stroke specialist assessments within 72 hours.
- Reduce number of delayed discharges.
- Reduce the number of bed moves at night.
- Continue work to have increased support from adult social care.
- Continue to encourage the engagement of nursing staff in clinical supervision.
- Increase feedback from patients and relatives about their care in the stroke unit.

Isle of Wight NHS 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 because:

- Staffing levels did not always meet the needs of patients on the general rehabilitation unit and the stroke unit. Patients in the stroke unit and the general rehabilitation unit that we spoke with told us nursing staff were very busy, and raised some concerns about the timeliness of staff responding to their needs.
- The general rehabilitation ward had only one stand aid hoist with a 'seat' available for patient use. This impacted upon patient and caused delays with meeting their needs on the general rehabilitation unit.
- Mandatory safeguarding training was below the trust target of 90% for nursing and medical staff. Adult resuscitation training specifically was low at 62% and level 2 safeguarding children at 57%.
- We checked several pieces of equipment for when they were last serviced. Two pressure relieving mattress motors we checked were last serviced in 2014.

- Medicines were not always stored safely. In the general rehabilitation unit, medicines for return to pharmacy were found in an unlocked box in a treatment room that was not locked.
- Medical records were not stored safely and securely which posed risks of unauthorised access and breaching patients' confidentiality.

However

- Investigation of incidents to patients was thorough, and any actions identified to prevent reoccurrence of incidents were shared with staff.
- Concerns were identified by the service in respect of infection control and hand hygiene through local audits. The service took action to improve the outcomes and we observed these improvements during the inspection.
- All staff knew if they had any concerns about a patients' safety, to report it to the nurse in charge.
- Staff assessed patients in the stroke unit and the general rehabilitation unit for key risks to their health and wellbeing.



# Are services safe?

- Staffing was actively reviewed, and action was ongoing to recruit to vacancies. Agency and bank staff were given inductions that used to fill staffing gaps.

## Safety performance

- The trust collected NHS Safety Thermometer data in relation to care provided to patients. This is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls. Both the general rehabilitation unit and the stroke unit displayed their patients' safety thermometer information for the public to see.
- On the general rehabilitation unit and the stroke unit 93% of care was harm free from January 2016 to November 2016. The most frequent type of harms occurring were grade 2 pressure ulcers and falls. The sisters told us that all harms were investigated. For example, following investigation of a grade 2 pressure ulcer factors contributing were found to be a patient's reduced mobility and not giving the patient information. The senior nurses shared these findings with staff, as part of lessons learned aiming to reduce the incidence of harm to patients.

## Incident reporting, learning and improvement

- Staff on both the general rehabilitation unit and stroke unit knew how to report incidents and what type of incidents needed to be reported. The highest number on incidents reported by the general rehabilitation unit and stroke unit was slips, trips and falls and pressure ulcers. The clinical business unit has analysed the incidents, and actions put in place.
- In relation to reducing falls' incidences actions included ensuring for all patients identified at risk of falling and those patients aged over 65 years lying/standing blood pressures taken, and the development of a policy to support staff in identifying when close supervision of a patient was required. The matrons had discussed the need to establish a timeline for the close supervision policy to be produced by, at a meeting with the ward sisters in October 2016. The trust had also produced a leaflet providing information for staff and patients about reducing the occurrence of falls, which we saw on both units. Staff were aware of the information booklet, and told us they encouraged patients and family members to look at the leaflet.

- From November 2015 to November 2016 there had been no never events in the general rehabilitation unit or the stroke unit. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The service had reported approximately 92% no harm and low harm incidents, and approximately seven percent moderate harm incidents. Moderate harm incidents are defined as an incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.
- In the general rehabilitation and stroke unit from January 2016 to November 2016 there had been three moderate harm incidents requiring investigation. These all related to patients falling. One of the falls had resulted in a patient fracturing a hip and requiring surgery. Serious incidents were investigated, by staff from a different clinical business unit using root cause analysis.
- We viewed records of these investigations, evidencing investigations were completed and action taken accordingly to reduce the likelihood of similar incidents occurring. The sister discussed the learning from these incidents at ward meetings, to help prevent similar incidences occurring.

## Duty of Candour

- The duty of candour states that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- All senior staff we spoke with had an understanding of the duty of candour legislation. Action included a letter that was sent to a relative that included a final investigation report following an incident. The family were offered support and advised to contact the ward sister and meetings were also offered.

## Safeguarding

- Safeguarding adults and safeguarding children was included in the mandatory training plan for all staff. On the general rehabilitation unit safeguarding adult level 3 training was 100%. Data from the trust showed that level

## Are services safe?

1 safeguarding adults training at 71% and level 2 adults safeguarding training at 94% compliance. For children safeguarding level 1 was 75%, and level 2 safeguarding children face to face was 57% which was below the trust target of 90% compliance.

- On the stroke unit we ask for detailed safeguarding training data but this was not received. Over all trust compliance was 86% for level 1 children safeguarding, 66% for level 2 children safeguarding and 54% for level 3 children safeguarding training at October 2016. Overall trust compliance for level one adult safeguarding training was 85% at March 2016.
- Trust wide training records showed for September 2016 showed medical staff 80% had completed level one safeguarding vulnerable adults training against a trust target of 90%.
- Of the medical staff 93% had completed child safeguarding level 1 training, however only 66% had completed child safeguarding level 2 training against a trust target of 90%.
- Staff had an understanding about how to recognise a safeguarding concern and what action to take. One member of staff we spoke with did not know who was the trust lead for safeguarding. However all staff knew if they had any concerns about patients' safety to report them to their line manager.
- The ward sisters told us about three safeguarding alerts and how these were investigated, and described actions taken following investigations. A senior staff member on the stroke unit told us how intentional rounding increased for restless patients, and after a handover a registered nurse and healthcare assistant review their patients to check they are comfortable.
- Staff had access to safeguarding adults and children's policies on the trust intranet site.

### Medicines

- Staff stored medicines for return to pharmacy in an unlocked box in a treatment room on the general rehabilitation unit that was not locked. This risk had been identified by staff, and was on their risk register; however, no action had been taken. The service was due to review the risk on 31 March 2017.
- There was a system of electronic prescribing in the general rehabilitation unit and the stroke unit. The trust implemented electronic prescribing and medicine

administration in 2012. In February 2016 13 percent of hospitals had implemented the tool, recommended in an independent report produced for the Department of Health.

- Pharmacists and pharmacy technicians supported all wards by providing clinical input and maintaining stock levels. The pharmacist could access patients' prescription, clinically screen for appropriateness, and dispense remotely and securely. This reduced delays caused by waiting for pharmacist attendance on site. Medicines, including emergency medicines, were available to people when they needed them.
- We observed nursing staff administering medications to patients and ensuring the patient took the medication before signing for them.
- Medicine drug fridge temperatures were monitored centrally in the stroke unit, via the automated drugs storage unit. If out of range the unit would alarm, alerted on screen, and an error report was printed at ward level. An email would automatically be sent to the pharmacy lead. In the general rehabilitation unit nursing staff monitored medicine fridge temperatures, as the unit did not have an automated drug storage unit. We saw that the temperatures had been monitored in the general rehabilitation unit, and staff knew what action to take if the temperatures were not within minimum and maximum range.
- The trust medicine reconciliation targets for September 2016 were reported as over 80% complete at 24 hours against the trust target of 80% to be complete within 24 hours.
- Controlled drugs were stored, administered, recorded and disposed of correctly. We checked this on the general rehabilitation unit.
- Staff stored intravenous fluids in locked cupboards on the stroke unit and the general rehabilitation unit.
- The trust had medicines management policies and standard operating procedures in place to ensure the safe handling of medicines in accordance with national guidance.

### Environment and equipment

- At the previous inspection in September 2014, there had been a concern with the amount of equipment and maintenance of equipment. We checked several pieces of equipment for when they were last serviced.

# Are services safe?

Equipment such as electric patient plinths, electrically powered hoists and machines that used when taking patient observations we checked, did have up to date servicing records.

- Two pressure relieving mattress motors we checked were last serviced in 2014. A ward sister said, she felt the problem was when patients were transferred from other areas with this equipment in place, the equipment arrived with out of date servicing. When we reviewed the minutes of three meetings chaired by the matrons the sisters had not raised the issue of equipment arriving past the recommended service date, for the matrons to explore as potentially a trust wide issue.
- Staff we spoke with and a patient raised a concern about having only one particular hoist rather than two, which caused delays with meeting patients' needs. The equipment was a hoist that was used to assist people to stand, with 'a seat'. The sister we spoke with said the ward was aware of this concern, and exploring funding opportunities to purchase the equipment.
- Staff we spoke with did not raise any concerns about the availability of any other equipment on the ward. Staff told us there was an equipment library they could access if needed.
- We were informed that equipment that was not powered was not serviced regularly, for example aids to help people transfer. The physiotherapist explained before a piece of equipment used, staff were asked to inspect it was working correctly. We also saw a poster on the wall supporting staff with equipment checks, and action to take if a fault found. When we reviewed the incident records for the two wards, no incidents had occurred due to faulty equipment.
- Both the general rehabilitation unit and the stroke unit had resuscitation equipment, and this was tamper proof. Staff checked resuscitation equipment daily against an equipment checklist to ensure essential equipment was available and in working order. Staff on the stroke unit had highlighted expiry dates of items on the trolley to support the checking process.
- There was a 'gym' area, adjacent to the general rehabilitation unit and the stroke unit for physiotherapists and occupational therapists to provide rehabilitation for patients.

## Quality of records

- The trust used a combination of paper and electronic records. Access for electronic records was password protected and staff said this was secure. We did however find some sets of notes open on the reception desk in the stroke unit.
- We reviewed seven medical, nursing and multidisciplinary notes across the two inpatients' areas. Patient documentation we reviewed which was in paper format, reflected the patients' care requirements, rehabilitation goals and individual preferences. The multi-disciplinary patient care records recorded progress and were up to date. Staff reviewed patients' care plans regularly and updated them to reflect patients' care needs.
- Medical records were stored in a trolley, which was not locked and placed in an office area, which was not locked. This could potentially cause a data breach if a member of the public went into the office area unauthorised. The senior staff were monitoring this risk through a risk register, and planned to review medical notes storage in March 2017. Nursing records were stored with the patients at the end of their beds in folders, or outside their room if in a single room.
- Records were legible and were signed and dated by the member of staff completing the record.

## Cleanliness, infection control and hygiene

- From January 2016 within the general rehabilitation unit there had not been cases of clostridium difficile (C.difficile), and in the stroke unit there had been a case in August and September 2016. A root cause analysis undertaken, initial comments made about environmental tidiness.
- An audit undertaken by infection control in October 2016 identified concerns with the cleanliness of the environment in the stroke unit. The audit results were 60% for environmental tidiness and 78% for environmental cleanliness. The infection control team supported with the completion of an action plan, which when we reviewed confirmed actions had been undertaken.
- The same audit in October 2016 in the rehabilitation unit had results 100% environmental tidiness and 88% environmental cleanliness. When we inspected in November 2016, we found that action had been taken to address these concerns.

## Are services safe?

- On the stroke unit the safety thermometer information from January 2016 to December 2016 showed there had been one patient with a urinary catheter who had developed a urinary tract infection. On the general rehabilitation unit two patients with a urinary catheter had developed a urine infection.
  - The control of infection team carried out urinary catheter care audit in June 2016. In the stroke unit there was 60% compliance with urethral catheter management audit, and 58% compliance with urethral catheter insertion audit. There was 67% compliance on the general rehabilitation unit with both urinary catheter audits.
  - Following these audits, the plan was for the ward sisters to discuss the audit findings with nursing and medical staff. This was to ensure staff understanding of the criteria for urinary catheter insertion, risks involved in over utilisation and benefits of early identification and removal of catheters.
  - The general rehabilitation unit and the stroke unit were visibly clean at the time of the inspection.
  - We observed staff adhered to the bare below elbows policy and hand washing policies.
  - There were handwashing facilities in all clinical areas, including dispensing hand gels. We observed staff washing their hands between patients.
  - Staff had access to personal protective equipment such as gloves and aprons in all clinical areas.
  - One patient told us the hand gel had been empty in a toilet they went in. When the ward sister made aware the hand gel was immediately replenished.
  - Hand hygiene audits undertaken by staff from the stroke unit had ranged from March 2016 to May 2016 from 58% to 74%. From June 2016 to November 2016, hand hygiene audits undertaken by the stroke unit had been 100%. An independent audit undertaken by the infection control department of hand hygiene compliance in the stroke unit in October 2016 showed 100% compliance.
  - Hand hygiene audits undertaken by staff from the general rehabilitation unit from April 2016 to June 2016 compliance ranged from 91% to 100%. The July 2016 audit was not submitted, but in August 2016 results were 88% and 86% in September. An independent audit undertaken by the infection control team in October 2016 showed 100% compliance.
  - Infection prevention and control training was part of staff mandatory training.
  - There had been no meticillin-resistant staphylococcus aureus (MRSA) bacteraemia from January 2016 to November 2016. Senior staff undertook monthly audits to check compliance with MRSA screening.
  - On the stroke unit compliance with MRSA screening had been 100% from August 2016 to October 2016, and on the general rehabilitation unit 95%. When we inspected in September 2014, compliance had deteriorated where the use of the beds not managed by the service with clear admission criteria.
  - The physiotherapy parallel bars in the patient gym that had rusted in places. The physiotherapist told us new parallel bars were being purchased as the rusted bars could not be cleaned properly posing infection control risks to patients.
  - On the stroke unit 'I am clean stickers' were in use to identify equipment which had been cleaned and safe for use.
  - The general rehabilitation unit and the stroke unit had single rooms, which were used for isolation of patients to control infection control risks.
  - Patient-led assessments of the care environment (PLACE) for cleanliness in 2016 was 98% against an England average of 98%.
- ### Mandatory training
- Staff told us mandatory training was provided by e learning, although subjects such as resuscitation and moving and handling were provided as face-to-face training. The training included information governance, diversity, health and safety, fire safety, moving and handling, conflict resolution and resuscitation.
  - Records provided by the trust showed that overall 82% of staff had completed all their mandatory training at October 2016 on the general rehabilitation unit. This was below the trust target of 90%. Adult resuscitation training compliance was low at 62%. The sister was aware and taking action to address this gap. On the stroke unit overall compliance 86% of staff, against a target of 90%.
  - Two nursing staff we spoke with told us that when they started it had been organised for them to attend a trust wide induction programme, and complete mandatory training.
- ### Assessing and responding to patient risk
- Staff assessed patients in the stroke unit and the general rehabilitation unit for key risks to their health and

## Are services safe?

wellbeing. This included risk assessments for falling, developing pressure ulcers and malnutrition. Nationally recognised risk assessment tools were used, including the waterlow score for pressure sore assessment risk. Malnutrition universal screening tool (MUST) was used to identify adults at risk of malnutrition. Staff recorded this information in patients' records and shared the information at handover periods. If risks were identified, plans of care were developed, followed to prevent harm and reviewed.

- The service used a pathway for stroke patients to ensure risks such as patients swallow was checked. A speech and language therapist advised stroke patients were then reviewed daily, and care plans updated as required to safely meet nutritional needs. Both the stroke unit and general rehabilitation used the nationally recognised national early warning score (NEWS) system to identify patients at risk of deteriorating or needing urgent review. The scoring system alerted staff to take the appropriate action if a patient was identified at risk of deterioration. This included alerting a doctor to support the patients. Nursing and medical staff told us the system worked well. We observed a handover where a patient's NEWS had increased and action taken, which included increasing the frequency of patient observations and the administration of oxygen. We also saw in two patients' notes where their NEWS had increased, and action taken as appropriate.
- The inpatient general rehabilitation unit and the stroke unit used the trusts emergency telephone number to summon emergency assistance in the event of a patient suddenly deteriorating. The trust employed a falls prevention nurse following a risk review of the number of patient falls.

### Staffing levels and caseload

- The trust used an electronic safer nursing care tool, which adjusted staffing levels depending on the acuity of patients. For example, patients with major physical/social or mental health needs were 'special' and designated as one to one care. Both the general rehabilitation unit and the stroke unit had agreed numbers of qualified and unqualified nurses that should be on each shift.
- In November 2016, the stroke unit had 6.85 registered nurse vacancies against an establishment of 23.22. Two registered nurses due to start at the end of November 2016, which would leave 4.85 registered nurse

vacancies. The general rehabilitation unit had 5.91 registered nurse vacancies against an establishment of 21.04. The service had no vacancies for health care support workers. Staff were supported by escalation process to help the nurse in charge fill staffing gaps. From November 2015 to November 2016 the general rehabilitation unit had used 24% and the stroke unit 27% bank and agency staff hours, to manage nursing staff sickness, absence and vacancy.

- The service shared the induction paperwork and told us that all these staff had verbal inductions, but the written evidence recording inductions took place was low. When we asked for data, the general rehabilitation unit provided records and only one induction list signed for 2016. The sister was aware of the need to increase staff awareness of the need to ensure there was a written record of staff inductions.
- The service leads, in a presentation discussing the review of falls incidents, noted that the use of agency and bank staff were a factor in three of the patient falls, but did not say how.
- The sisters told us their units did run one staff member short at least once a week. When we checked four random days over three months, on the stroke unit one night had run short of a healthcare assistant who was needed to provide 1:1 care. On two of the other dates we could see that the 1:1 requests had been filled.
- Due to the registered nurse vacancy, following discussion with the matrons, the stroke unit was running with two registered nurses at night instead of three whilst recruitment ongoing. The sister said a third healthcare support was being booked to provide extra support to meet patients personal care needs. The matron and sister had made this decision, rather than booking a registered nurse through the bank or agency. A member of staff told us that frequently the fifth staff member at night was moved, to support other areas of the hospital.
- On the general rehabilitation unit on the four random dates we reviewed over a three month period the ward was short of a registered nurse on one late shift. If needed, the sisters told us that a nurse from the critical care outreach team could support if there was a clinical emergency.
- Patients in the stroke unit and the general rehabilitation unit that we spoke with told us nursing staff were very busy, and patients did raise some concerns about the



## Are services safe?

timeliness of staff responding to patients' needs. For example, two patients we spoke with said there been delays in response to answering their call bells when they needed assistance to use the toilet.

- The nurse in charge of both inpatient general rehabilitation unit and the stroke unit ensured that planned and actual nursing staffing numbers displayed each day. The nurse in charge collected this data on 'daily evidence sheets', which all detailed actions taken to address any staffing gaps. When we inspected the staffing numbers displayed were up to date. The sisters worked in a supervisory capacity, if their units were short the sisters joined their teams in giving direct care to patients.
- Since our inspection in September 2014 the hospital had stopped using additional beds at short notice on the community general inpatient rehabilitation unit. These beds were now permanently open, with admission criteria in place for the use of the beds. The service had also reviewed the staffing, and increased staffing numbers on the unit.
- The ward sisters told us twice a year they took part in completing for four weeks patient acuity (healthcare needs) Monday to Friday for four weeks. The ward sisters had seen changes in their staffing as a response. On the community in-patient general rehabilitation unit two additional healthcare assistants had been added to the ward numbers, who were new to start in December 2016.
- Physiotherapists, occupational therapist and speech and language therapists worked Monday to Friday. Patients did have care plans with goals, for nursing staff to follow. An occupational therapist told us a bank holiday would be staffed by therapy, to meet national guidance for stroke patients.
- Occupational therapy and speech and language therapy were both actively recruiting when we inspected in November 2016. Occupational therapy were re-advertising for a band 7 occupational therapist for the stroke unit, and speech and language therapy had a locum in place for the stroke unit, whilst permanent recruitment ongoing.

- On the community inpatient rehabilitation ward there was a geriatrician who worked two whole days and two half days a week, and a full time consultant who specialised in neurorehabilitation. There were also two full time junior medical staff. A consultant told us that for week of 31 October 2016 there was only one junior doctor, as the service had not been able to get agency cover. The consultant was not aware if there were any specific medical recruitment drives to address risk. The consultant did not tell us that the general rehabilitation unit being short this week had an impact on patient care.
- On the stroke unit there were two full time consultants and two junior doctors. At the weekends there was not always a stroke consultant available. A medical consultant would be available for stroke rehabilitation inpatients and patients attending the transient ischaemic attack clinic at the weekends. The stroke services action plan included an action for stroke physician job plans to be flexible in order to meet the medical requirements within 9 to 5 hours. The requirement was for 95% of new stroke patients to be seen by a stroke consultant within 24 hours.

### Managing anticipated risks

- The trust had a whole system escalation surge plan 2015/16 that was drafted in partnership with the clinical commissioning group, the independent sector, local area team, primary care providers and the council. The plan details what local providers would do in the event of an incident or an emergency to make best use of all locally available resources as demand rises and capacity is limited.
- Hospital business continuity plans were in place. Arrangements included a back-up generator in case of power failure.
- The trust undertook joint major incident scenario based training with local emergency services. An event was carried out during the inspection and although the outcome was not known, initial feedback was from the contributors was positive.

# 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 requires improvement because:

- Therapy staff did not work seven days a week so patients were not always able to have specialist assessments within 72 hours, and rehabilitation goals agreed within five days.
- The quality of nurse hand overs varied, affecting the information staff had to care for patients.
- Some of the registered staff did not have a clear understanding of the Mental Capacity act (2005). Mandatory MCA and DoLS training for all registered nurses was below the trust target.
- Patient discharges from hospital had been delayed, affecting patients' well-being.
- Patients were experiencing bed moves at night, which caused them distress.
- Appraisal compliance on the stroke unit and the general rehabilitation unit was below the trust target of 90%.
- Nursing staff engagement with clinical supervision had a low uptake.

However

- Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards.
- Staff monitored patients' pain and patients reported staff managed their pain effectively.
- Patient's nutritional needs were met. The trust provided specialist meals for patients with dietary and cultural needs. Speech and language therapists and dieticians supported patients with specific dietary problems or swallowing difficulties.
- The trust took part in national and local audits to measure and promote improved outcomes.

## Evidence based care and treatment

- Staff provided care to people based on national guidance, such as the National Institute for Care Excellence (NICE) guidelines. The criteria for admission to the community inpatient rehabilitation beds was based on NICE guidelines.

- The stroke pathway started in A&E, and included assessment for thrombolysis, as well as a chest X-ray, a swallow assessment and a CT scan.
- Staff used the National Institute of Health Stroke Scale (NIHSS) to assess the impairment caused by a stroke.
- The service participated in the national audit programme for stroke, the Sentinel Stroke National Audit Programme (SNAPP)
- We spoke with physiotherapy and occupational therapy staff who all described the recognised assessment tools they used, and the recommended therapy sessions for individual patients during their course of rehabilitation. The therapist had been using a structured tool. The tool was called SOAP which was an acronym for 'Subjective, Objective, Assessment, Plan'.
- Staff in the general rehabilitation unit for the last five years had submitted data for the Rehabilitation Outcomes Collaborative (ROC) database. This included information about patients' health conditions and the effects of the condition on patients' ability to perform daily activities. By contributing to ROC the service was supporting improved understanding to questions such as 'what are the effects of conditions on patients' and 'what is the best way to provide rehabilitation'.
- We reviewed the trust clinical audit programme. The division of integrated elderly and community care had participated in four audits in 2015, including the national audit of inpatient falls.
- The falls audit plan 2015 identified a number of areas for improvement, which the trust had acted upon including the appointment of a falls co-ordinator. The trust used a scale recognised by NICE to assess the risk of pressure ulcer development. This enabled staff to categorise the risk of skin breakdown and prompted them to take the right action.
- The trust used skin bundles for both preventative care and treatment of pressure ulcers. Staff assessed patients at risk of malnutrition or dehydration using the malnutrition screening tool developed by the British Association for Parenteral and Enteral Nutrition.
- Patients at risk of venous thromboembolism (VTE) received VTE prophylaxis in line with NICE guidance. The trust monitored this to check compliance.

# Are services effective?

- Ward staff told us that policies and procedures were available on the trust's intranet. Policies reviewed referred to national and best practice guidance.

## Pain relief

- Staff used a numerical score to monitor for any pain experienced by patients. If a patient was unable to communicate verbally, for example a stroke patient, medical, therapy and nursing staff also took into account a patients' body language. Medical staff prescribed pain relief and titrated against the patients pain scores.
- Patients we had conversations with told us their pain was well controlled and that nursing staff administered pain relief in a timely manner.
- We observed a patient who needed analgesia when we talking to them. The patient rang the call bell, and nursing staff responded promptly.
- The service had access to an acute pain team if needed.

## Nutrition and hydration

- Nursing staff on admission assessed a patients' risk of malnutrition using a nationally recognised assessment tool. The senior staff on the stroke unit and the inpatient general rehabilitation ward monitored compliance using the risk assessment tool. From August 2016 to October 2016 in the general rehabilitation inpatient unit compliance had been 100%, in the stroke unit compliance had been 90% or greater.
- Meal times were protected, which meant that patients' meal times were not compromised by interruptions.
- Patients had access to dieticians and speech and language therapists for advice and support with specialist diets or swallowing difficulties.
- Speech and language therapists assessed patients' ability to swallow safely and provided staff with clear guidance to manage these patients safely.
- Staff monitored fluid intake and output and dietary intake for patients assessed at risk of malnutrition or dehydration to ensure they had a suitable dietary intake and were hydrated. We observed staff correctly recorded this on fluid balance and food intake charts.
- We observed that staff ensured patients positioned well before eating, to ensure they could eat and drink safely. Three patients were enjoying their meal in the day room, when we observed meals during a lunch-time.

- We observed that staff offered patients hand hygiene wipes to clean their hands before eating, which they helped patient use if needed.
- We observed staff assisting patient with their meal if required. This included putting desserts that arrive in cartons into a bowl, so as patients could manage to eat independently. The support of a housekeeper, volunteers and family members prevented delays and staff rushing patients with their meals.
- Staff sat at the same level as patients, did not rush their meal, asked for and respected patient wishes, such as what food they wanted, whether they wanted gravy and what drink they wanted to accompany their meal.
- We saw a patient being fed hot meals by a volunteer retired clinician who told us of a new initiative the trust had trialled in the stroke unit. This involved volunteers being trained and signed off as competent to assist feeding patients. Clinical staff on the wards said this has freed up staff time and this initiative would be welcomed to other clinical areas.

## Patient outcomes

- The trust contributed to the Sentinel Stroke National Audit Programme (SSNAP). This audit is based on 10 domains of both patient centred and team centred (organisational) indicators. These included, for example, indicators for assessment, multidisciplinary treatment and discharge, which are scored at levels A (best performing) to E. The SSNAP audit aims to improve the quality of stroke care and treatment by auditing stroke services against evidence-based standards and national and local benchmarks.
- The combined indicator for the Isle of Wight was level C for the quarter April 2015 to June 2015. This had deteriorated to level D from July 2015 to July 2016. The score for multidisciplinary assessment had been D for multidisciplinary treatment and B for discharge from July 2015 to July 2016.
- The lead nurse for stroke care had an action plan in place to support improvement. This included recruitment by speech and language therapy and occupational therapy to develop plans for seven day working. There was no timescale given on the action plan.
- The stroke and general rehabilitation ward had 12 readmissions within the stroke service from April 2016 to October 2016, and five to the general rehabilitation inpatient beds from April 2016 to October 2016. This



## Are services effective?

equated to a rate of approximately 4.5%. The service monitored readmissions monthly to see to ensure improvements to patient care could be made if required.

- The stroke unit was able to take part in early supported discharge for patients, due to the community stroke rehabilitation team provided by the trust.
- The service had undertaken local audits to measure outcomes for patients and drive improvements in patient care. For example an audit of quality indicators for older persons care in August 2015, had led to teaching sessions for junior medical staff. These had included assessment of cognitive impairment in older people, delirium assessment and management in older people, and falls assessment.
- Medical staff had also written a new admission to the general rehabilitation unit falls proforma, which the general rehabilitation unit had piloted since August 2016. Medical staff planned to re-audit use of the falls proforma in February 2017.

### Competent staff

- Staff told us they received annual appraisals in which they had the opportunity to discuss training needs and career progression. Records provided by the trust showed appraisal compliance from April 2016 to January 2017 was 80% on the general rehabilitation unit and 67% on the stroke unit. Both were below the trust target of 90%. The matrons at a recent weekly sisters meeting had reminded staff about the need to ensure annual staff appraisals were undertaken.
- All new members of staff completed corporate and local induction programmes. The trust had a specific two-week induction in place to meet the needs of overseas nurses. Eight overseas nurses from the general rehabilitation and the stroke unit attended from November 2015 to August 2016. The trust had a preceptorship course in place for newly qualified nursing staff. Two newly qualified staff who joined the general rehabilitation unit, had been working through the programme from November 2015 to August 2016.
- Staff told us they were given the opportunity to attend role specific training. This had included understanding pain, stroke awareness and leadership development days. However a staff member told us they had only

been able to attend mandatory training for the last two to three years due to staffing levels. When we reviewed role specific training records, several staff had been able to attend role specific training.

- Senior staff on the general rehabilitation unit and the stroke unit also provided staff with the opportunity to complete competencies specific to their role. Two staff had completed a competency pack for rehabilitation and other staff working towards it. Staff had started completing the stroke training and awareness resources (STARs) training on line stroke competencies and received face to face training for stroke care. There are 19 core competencies that included the effects of stroke, communication and rehabilitation.
- The general rehabilitation inpatient unit and the inpatient stroke unit had an induction list in place for agency and bank staff. Data submitted after the inspections showed compliance with documenting induction completed was poor.
- We were told that agency and bank staff had always had a verbal induction. Senior staff on the general rehabilitation unit and the stroke unit were raising awareness with their teams of the importance of using the induction checklist, and recording that induction had taken place.
- The matron had provided a clinical supervision training session in January 2016. At the time of our inspection, the stroke unit had recently set up group clinical supervision. Senior staff on the general rehabilitation unit told us there had been three informal clinical supervision sessions as a peer group from May 2016 to July 2016. However, the uptake of clinical supervision was low.
- The trust has devised a ward accreditation programme, which the trust intends to use in the future. Staff told us that the aim of the programme was to drive improvements of quality care delivery and improve patient experience for example to reduce infection rates and safer medicine management. Both the general rehabilitation unit and the stroke unit had an action plan in place to support improvements in quality.
- The trust monitored registered nurses who needed to revalidate with the National Midwifery Council (NMC). This is a new process all nurses and midwives will need to complete in order to renew their registration. The trust had provided information sessions for registered nurses about re-validation.

## Are services effective?

- Medical staff revalidation with the General Medical Council (GMC) was managed at executive management level. We asked for data regarding compliance for medical staff working on the general rehabilitation unit and the stroke unit but this was not received.

### Multi-disciplinary working and coordinated care pathways

- Multidisciplinary working was evident in the general rehabilitation unit and the stroke unit. We saw records of multidisciplinary team (MDT) meetings and on the stroke unit we attended multidisciplinary team meeting that evidenced a multidisciplinary approach about making decisions with regard to care, treatment and discharge planning for patients.
- However at the meeting communication was more focussed on updating others on progress rather than future planning. For example, goals of care for each patient were not discussed at the meeting. We discussed this with the stroke specialist lead, who was undertaking some work to ensure goal setting was evident at the meeting.
- On the general rehabilitation unit and stroke unit multidisciplinary 'huddles' were held at 9am and 2pm Monday to Friday. At the 'huddle' a nurse, physiotherapist, occupational therapist and a doctor would be present. We attended a 'huddle' on the stroke unit, and this brief meeting enabled the multidisciplinary team to be clear about each patients plan for that day. For example, the nurse in charge clarified that one patient had a discharge planning meeting at 2pm that afternoon, and another referred to the community stroke rehabilitation team as ready for discharge. The patient the nurse in charge referred to the community stroke rehabilitation team was discharged the same day.
- The sisters on both wards commented that a care manager from social services did not join them at the 'huddles'. Nursing staff then had to contact adult social care themselves, if support needed from adult social care with patients discharges. This delayed the discharge planning process, while nursing staff sought out help from adult social care.
- The general rehabilitation unit and the stroke unit had access to clinical psychology help if needed to meet patients health needs.

- The service also worked closely with the community stroke rehabilitation team and the critical care outreach team.

### Referral, transfer, discharge and transition

- Since we inspected the service in September 2014, there were clear referral criteria for patients suitable to be admitted to inpatient rehabilitation. Staff told us these helped them to ensure that patients were safe to be cared for on the ward. Patients had to be medically and surgically stable, and any medical patients admitted to the unit, were those whose discharge from hospital was delayed.
- On one of the days we inspected there were four medical patients awaiting discharge. A senior nurse explained that when these patients transferred, the patients care was transferred to a consultant based on the general rehabilitation unit or on the stroke unit.
- The service held discharge planning meetings to support effective discharge, which would involve the patient, relatives, nurse, physiotherapist and occupational therapist. A staff member from social services did not attend. At the time of our inspection in November 2016, discharge planning meetings were scheduled to take place on the stroke unit and the general rehabilitation unit.
- The general rehabilitation unit and the stroke unit reported there were delays to discharge. The trust provided information for the period April 2016 to October 2016 indicating there were 17 patients whose discharge were delayed, which amounted to 532 days. The main causes were waiting for placements in nursing or residential homes and packages of care. The delayed discharges included a patient who had a fall and a fracture, and then required a nursing home to meet their needs on discharge rather than the residential home that had been planned.
- Senior staff told us they also experienced issues at times with placing patients who were not weight bearing. In November 2016, at the time of our inspection, there was one non weight bearing patient on the general rehabilitation unit.
- There were two staff at the trust who lead the service for assessing patients ongoing continuing healthcare needs. This was with regard to whether a patient needed NHS funded care on discharge to meet their

## Are services effective?

needs. A sister told us it could take up to a week to arrange a meeting where a decision would be made by a multidisciplinary team, about the type of care a patient needed on discharge.

- Staff we spoke with gave two examples where social workers had declined information from the stroke unit saying the patient fit for discharge. For example, a patient declined as fit for discharge, because the social worker said the patient needs a 'best interests' meeting although this had already taken place. The trust was looking at different ways of working and to have better representation from the social care team as part of their discharge planning.
- Patients told us they had moved wards sometimes several times, and out of hours. The trust provided information that there had been 93 patients moved at night within the medicine clinical bed unit from April 2016 to November 2016. It is widely recognised that multiple patients moves including out of hours have a negative impact on patients' well-being.
- During our inspection in November 2016, we were on the ward at 10pm when a patient was moved to the day surgery ward. When we spoke with the patient they said the staff had been kind and caring, but was not happy about being moved. A member of staff told us that day surgery was frequently opened at night.
- In September 2016 the trust had launched a new integrated discharge policy. On the general rehabilitation unit there was copy of the policy and a display of discharge materials to raise awareness for staff, patients and relatives about processes in place to support patients discharge from hospital. This included a patient information leaflet 'planning for discharge from hospital'.
- Staff followed processes to ensure discharge information was provided in a timely manner to GPs and other health and social care professionals when patients were discharged from the inpatient wards. Both the general rehabilitation unit and the stroke unit sent discharge summaries electronically to the patients GPs, and gave the patient a paper copy.

### Access to information

- The nurses used a handover sheet to support handovers. The handover sheet contained summary medical and care information on the individual patients. Other information such as if the patient was do not attempt cardiopulmonary resuscitation was included.

- We observed two handovers, at one the handover sheet not updated, but oncoming staff were told about a patient who had deteriorated and action being taken. At this handover, the condition of the patients' pressure areas was not discussed either.
- Nursing staff told us when they transferred patients between wards or teams, staff received a brief handover of the patient's medical condition and on-going care information was shared. This helped to ensure the transfer was safe and the patient's care continued with minimal interruption and risk.
- On the general rehabilitation unit the nurses used a 'doctors communication book' to ensure messages needing action did not get forgotten. Staff also used a whiteboard to support discharge planning, to ensure tablets to take out ready, transport arranged and any other support patient required for discharge arranged.
- Staff reported no problems with accessing test and laboratory of diagnostic imaging results.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Senior staff in the stroke unit and the general rehabilitation unit demonstrated, an understanding of the Mental Capacity Act 2005(MCA) and associated Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
- For the period, 1 June 2016 to November 2016 there had been 15 DoLS applications made across the general rehabilitation unit and the stroke unit.
- When we inspected there was one patient on the stroke unit who a DoLS had been applied for on their admission. The patient's condition had improved and they were now more settled, and the DoLS no longer required.
- We observed staff asked for patient's verbal consent before care and treatment was given.
- Training about the Mental Capacity Act was part of the trust's mandatory training programme. Records provided by the trust showed the general rehabilitation unit had a compliance rate of 100% for band 6/7 nursing staff, and 41% for all registered nurses at November 2016.

## Are services effective?

- On the stroke unit the compliance rate was 100% for band 6/7 nursing staff and 57% for all registered nurses at November 2016. Three of the registered staff we spoke with did not have a clear understanding of the

Mental Capacity Act. We were not assured through this that patients' care such as best interests processes and access to advocacy would be delivered in accordance with the Act.

- The sisters had plans to improve compliance with mandatory training which included MCA (2005) training.

# Are services caring?

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

## Summary

We have rated caring as 'Good'.

- We observed all staff, nursing, medical, ancillary staff, treated patients with kindness and compassion during our visit. Staff maintained patients' dignity and respect at all times.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.
- Feedback received from formal surveys was mostly positive.
- Patients received emotional support, and there was access to nurse specialists.

However

- Feedback received from formal surveys about the stroke unit was limited. The service was taking action to increase response rates.

## Compassionate care

- Patients, in the general rehabilitation unit and the stroke unit, told us they were treated with kindness and dignity during their admissions to the individual units. They confirmed staff protected their dignity when care and treatment given.
- Comments from patients included, "staff have been so patient with all the patients in the bay, kind and caring", staff "good and kind" and "dignity good". A relative commented service has been "absolutely fantastic".
- Five comments cards were received about the care patients receiving on the stroke ward. These were all positive, and included a comment, 'they have all made me feel special'.
- We observed staff interactions with patients showed compassion and care. This included non- clinical staff, such as ancillary staff and porters as well as clinical staff across all locations. We saw staff speaking with patients in a caring and gentle manner, and patients assisted with their meals in a sensitive and caring manner.
- The trust in August 2016 went from using the national Family and Friends Test (FFT) to a local survey called 'I want great care'. The local survey included the question in the FFT about whether a patient would recommend

the service. From May 2016 to October 2016 86% of patients from the general rehabilitation unit would recommend the service against the England average of 87%. From July to September 2016 84% patients responding to the local survey felt they were treated with respect and dignity, and 96% held the staff in high regard.

- On the stroke unit there were only three responses to the local trust survey and these were all positive, but the trust recognised that this low level of response did not give the data good validity. The FFT showed there had not been any responses from May 2016 to October 2016. The staff on the on the stroke unit have been asked to actively encourage patients and their families to give feedback.
- The trust scored 87% for privacy and dignity, compared to the England average of 88%, for the patient-led assessment of the care environment (PLACE) audit in 2016.

## Understanding and involvement of patients and those close to them

- Patients told us that they had been kept informed and involved in the goals of their care and plans. A relative also wrote on a comments card that they had been kept informed and any questions had been answered.
- Patients were actively involved in ensuring they could prepare themselves a meal as part of their rehabilitation. Patients during their rehabilitation would prepare a simple meal, supported by occupational therapy assistant (OTA) staff. Staff were also provided with the opportunity to understand patients' needs better for a safe discharge. For example, an OTA told us that a patient may suddenly remember a threshold into their kitchen they had forgotten to tell staff about. The OTA would then use this information to ensure the patient could access all areas of their property safely.
- From July 2016 to September 2016 76% of patients completing the 'I want great care' survey on the general rehabilitation unit felt they were involved and informed about their care. On the stroke unit there were only three responses that were all positive, but the trust recognised that this low level of response did not give the data good validity.

## Are services caring?

- Information leaflets appropriate to the purpose of each ward were available for patients to support them in fully understanding their care and treatment.

### Emotional support

- We saw evidence in the medical notes of self-care being promoted for patients, and saw this in action with patients being assisted by staff to walk to the toilet. Also staff providing aids, such as plate guards so as patients could eat independently. Patients told us how this assistance promoted their sense of well-being.
- Staff also boosted patients' well-being by having a pat a dog service on the wards. A staff member told us how much patients enjoyed patting the visiting dog.
- Feedback from relatives on the stroke unit following a patient's death, was very positive about emotional support they had been given by all staff. A relative wrote '...and also your caring for myself in my sadness'
- There was access to specialist nurses such as a stroke nurse specialist, diabetic nurse specialists and a Parkinson's disease nurse specialist. During our inspection in November 2016, staff on the general rehabilitation unit had arranged for a patient to have joint meeting with the diabetic department and the orthoptist. Staff wanted to enable the patient to be more comfortable and independent to improve their well-being.
- A hospital and anxiety depression score was being recorded for patients on the general rehabilitation, and used to inform clinical decisions. The multidisciplinary team completed mood screening with patients on the stroke unit. The stroke lead had noted compliance had decreased from April 2016 to September 2016 to 86%. The stroke lead had put an action in to increase mood screening to 95%.

# 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 because:

- The service were working with commissioners to best meet the rehabilitation needs of patients in the most appropriate environment.
- A protocol 'transfer into patient beds on the general rehabilitation ward', ensured appropriate patients were admitted.
- Staff promoted equality, and demonstrated knowledge and skills in responding to patients whose illnesses and conditions put them in vulnerable circumstances. Staff understood how to communicate with people who had impaired cognition and capacity.
- Most stroke patients spent most of their hospital stay on the stroke unit.
- The trust considered all complaints and concerns seriously. There was evidence the trust used learning from complaints to improve the quality of care.

However

- The trust response times to complaints was slow.

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

- Senior staff worked with the commissioners of local services such as GPs, the local authority, other providers and patient groups to plan and co-ordinate services to meet the needs of local people.
- The general rehabilitation unit admitted patients who were medically fit, but required further care and treatment before they were safe to discharge. The single point of access team determined which patients were eligible.
- The service had a protocol 'transfer into patient beds on the general rehabilitation ward'. Staff we spoke with found this document very supportive to use in discussions with colleagues, to prevent patients being admitted with health needs they were unable to meet.
- The stroke unit provided acute stroke care (reported under the medical service) and inpatient stroke rehabilitation.
- The service were reviewing the number of inpatient rehabilitation beds provided following discussions with commissioners, who felt that more rehabilitation for

patients needed to be provided in the community. Senior staff in the medicine clinical business unit in November 2016 were arranging 'drop in' sessions for staff, to consult on this change.

## Equality and diversity

- Equality and diversity training was included in mandatory training for staff. Compliance with equality and diversity was 88% on the general rehabilitation unit 100% on the stroke unit.
- Staff we spoke with us told us if needed it was possible to access interpreting services. Some staff members were not sure how to access the interpreting services, and said they would seek the support of the nurse in charge.
- We saw during our inspection that patients' information leaflets were available in different languages if required.

## Meeting the needs of people in vulnerable circumstances

- Discussion with staff evidenced they had an understanding about meeting the needs of patients with complex needs, such as those with a learning disability or living with dementia. For example in the wards there were clocks and date boards. The date boards needed to be updated by staff, and we could see that this had taken place.
- The trust had refurbished the stroke unit and decorated it in colours schemes that made it easier for people with cognitive impairments to identify door openings.
- The stroke unit and the general rehabilitation unit had clear pictorial signage for bathrooms, so patients with cognitive impairment were supported with way finding.
- There was information about the trust Memory Service on the general rehabilitation unit and the stroke unit. Staff referred patients to the Memory Service with a diagnosis of dementia. The service provided assessment, treatment and therapy. Also advice and support for relatives friends and carers.
- The patient-led assessment of the environment of care (PLACE) for dementia was 79%, against an England average of 83%.





# Are services responsive to people's needs?

- Several staff had undertaken role specific training to support them in caring for people living with a dementia.
- Therapy staff undertook teaching sessions to help patients and relatives to manage following their stroke.
- We observed in all inpatient areas patients privacy and dignity was respected. Patient accommodation was either in single rooms or in shared bays. Shared bays were consistently same sex bays and staff always pulled curtains round the patient when care was being delivered.
- We observed that patients were using specialist stroke chairs during our inspection, as required to meet their needs.
- The service were able to access the trust learning disability liaison nurse if support needed to care for a patient with a learning disability.
- The stroke unit also held a weekly social activity on a Thursday for an hour called 'sing about: singing for recovery'. The activity was based on recognised music therapy, specifically designed to help those in recovery and living with long term conditions, such a stroke. Potential benefits were improvements in breathing, movement, speech and confidence. During our inspection in November 2016, we saw patients taking part and enjoying the singing.
- We observed patients enjoying interacting with each other in a day area on the general rehabilitation unit, focusing on a 'Christmas stocking' competition staff had created.
- Patients and their families were able to sit in a garden area, as part of their rehabilitation and progressing to discharge.
- Patient-lead assessments of the care environment (PLACE) 2016, scored ward food 80% against an England average of 88%.
- The general rehabilitation unit and stroke unit had many leaflets available for patients and relatives, providing information about health conditions and support available.

## Access to the right care at the right time

- The average bed occupancy from April 2016 to October 2016 on the general rehabilitation unit was 99% and the stroke unit 97%. This high bed occupancy is a concern, optimum bed occupancy is suggested to be 85% by the national audit office (NAO). The NAO has suggested

hospitals with average occupancy above 85% can expect to have regular bed shortages, periodic bed crisis and increased numbers of health-care acquired infections.

- There had been an average of approximately 12 patients a month from January 2016 to October 2016, on the general rehabilitation unit, who had been held on a waiting list. The patients had waited a short time for a bed, with an average wait of one and a half days.
- On the stroke unit staff monitored daily the number of stroke patients on the ward, any stroke patient in another ward at the hospital, number of medical patients and number of neurological patients. Data the service submitted showed that from January 2016 to September 2016 84% of patients spent 90% of their stay on the stroke unit, just 1% below the national average.
- A stroke transient ischaemic attack (TIA) service was in place. At weekends there was a stroke nurse supported by the on-call medical registrar. Since our inspection in September 2014, carotid doppler's were now available seven days a week, so patients could always access the care they needed.

## Learning from complaints and concerns

- There were 58 complaints relating to medical care in total (26.9% of all complaints or more than a quarter). The trust took more than 30 days to respond to the majority (56%) of complaints that had already been closed. Nearly one in five complaints (19.9%) took more than 60 days to close.
- We found wards considered complaints and concerns seriously and took action in response to complaints. From January 2016 to November 2016 the general rehabilitation unit had received two complaints and the stroke unit three complaints.
- Records of ward meetings showed complaints and actions that needed to be taken in response to complaints were discussed, and lessons learned disseminated. For example at a meeting in September 2016 senior staff discussed the need for staff to identify themselves on documentation more clearly. This followed a complaint investigation relating to missing patient property.
- On both the stroke unit and the general rehabilitation unit there was written information on how to raise concerns and complaints.



# 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 requires improvement because:

- Action to address a risk relating to medicines storage had not been addressed, in a timely manner.
- Managing risks was not robust. Senior staff were not always aware of the current risks and issues, so there was no plan to address them.
- There were high levels of nursing staff sickness on the stroke unit.
- Staff not always involved in a timely way to changes in the provision of the service.
- The NHS staff survey published in 2016, showed staff dissatisfaction and poor morale.

However

- Staff had an understanding of the trust's vision and values and applied this to their units.
- There was a governance framework to monitor quality, performance and risk at ward, service and trust level.
- The service was undertaking work to increase support for staff.
- The sisters were undertaking audit, as a measure of the quality of care.

## Service vision and strategy

- Staff told us the work the trust had done with the clinical commissioning group entitled 'My Life, a Full Life'. The aim was to keep older people and people with long-term conditions, through partnership working, able to lead a full life.
- We observed that the general rehabilitation and stroke unit had developed their individual vision to support the rehabilitation. For example on the general rehabilitation unit, it included to 'empower patients' and 'maximise independence'. The staff had supported this vision with priorities. These included to improve communication with relatives and carers regarding the patient's journey, and to reduce the incidence of grade 2 pressure ulcers.
- The trust had its own vision and values. The vision was 'quality care, for everyone every time'. The trust's values were 'we care, we are a team, we innovate and improve'.

All staff we spoke to knew about them, and had been consulted about these. Staff descriptions and observations of the care and support they gave patients indicated they incorporated the values into their work.

- The service was currently evaluating their vision and strategy and considering merging the stroke and general rehabilitation inpatient unit. The commissioners wanted to see more rehabilitation for patients provided in the community, which would mean the service reducing the number of inpatient rehabilitation beds in the hospital.

## Governance, risk management and quality measurement

- The medicine clinical business unit had a risk register in place with 24 risks identified. The general rehabilitation unit and stroke unit had eight outstanding risks which all had a lead and review dates.
- These included staffing and medicines awaiting return to pharmacy that were not in a locked container or a secure location, which had been on the risk register since July 2015. The service was actively managing nurse staffing with ongoing recruitment, which had been on the risk register since July 2015, but the issue with medicines was to review at March 2017. This was discussed with staff at the time who realised it was a safety concern, but senior staff did not suggest that action would be taken promptly to address the concern. We submitted a notice to the trust following the inspection to address this concern urgently. The trust sent an update dated 16 December 2016 stating that the estates department had now fitted a lock to the treatment room.
- We noted there were more than eight outstanding risks for the general rehabilitation unit and stroke unit which included prevention of falls, non-compliance with targets for level 2 child safeguarding and Mental Capacity Act (2005) training and difficulty with obtaining junior doctor cover to cover absence.
- The medicine clinical business unit made a monthly presentation to the quality risk and patient safety group that included incidents, serious incidents requiring investigation, risk update and patient experience. The service had monthly meetings at senior level, including

## Are services well-led?

meetings with ward managers. The matron had items on the agenda that included incidents and subsequent learning and the risk register. However, risks such as the medicines storage had not been addressed in a timely manner, and not all current risks for the stroke unit and general rehabilitation unit were on the list entitled 'outstanding risks/ issues'.

- The general rehabilitation unit and the stroke unit sisters held meetings every other month, which included discussion about incidents and actions to take forward and risk management. The sisters ensured notes of these meetings taken, so staff unable to attend a meeting aware of information discussed.
- The ward sister undertook audits. Audits included weekly audits of compliance completion of patient risk assessments as a measure of quality of care. This enabled them to follow up any gaps as they occurred with individual staff to improve care.

### Leadership of this service

- The sisters on the stroke unit and the general rehabilitation unit had raised concerns with the head of the medicine clinical business unit that nursing and medical staff had not been involved in the initial stages of developing new models of patient rehabilitation. The sisters feedback was listened to, and 'drop in' sessions arranged for all staff to be part of the discussions.
- All staff spoke positively about their local leadership. Staff spoke positively about the teamwork they experienced in their work areas. They said they felt respected and valued by their immediate managers. Staff commented that the matrons were 'accessible and supportive'.
- A member of staff said that more senior members of the staff come on to the ward, and had not introduced themselves. A senior nurse said that expectations about her role were not clearly defined.

### Culture within this service

- The sisters on the general rehabilitation unit and the stroke unit said morale was much better since the wards had become part of the medicine clinical business unit. However, there were mixed views from other staff. Staff said the new registered nurses starting had booster morale. Two junior medical staff we spoke with said they

felt well supported. However, staff also had concerns about staff being moved to other wards at night, patients being moved at night and not always being able to participate in role specific training.

- Nursing staff sickness was 12% on the stroke unit in October 2016, as identified on their draft ward accreditation assessment. The trust consider good to be 3% or less. The ward sister on the stroke unit, had been requested to manage staff sickness as appropriate. Sickness on the general rehabilitation unit was 3%.
- A member of staff felt confident to raise concerns. They had raised concerns about a risk to senior the senior management of the trust on 31 October 2016, but at the time of our inspection 22 to 24 November 2016 had received no feedback. The concern had been an immediate one.

### Public engagement

- Feedback from patients about the service was acted on. For example on the general rehabilitation unit, patient and or relative feedback and ward response was displayed. For example, 'relative said did not know who to raise their queries and concerns to'. The ward responded 'The ward sister will complete a weekly round and speak to each patient. We have introduced a feedback box and message to matron box if relatives would like to be contacted'.
- We viewed the patients' experience and data from the NHS inpatients' survey which was published in June 2016. Between the period of August 2015 to January 2016, a questionnaire was sent to 1250 patients and the trust received 646 responses. This showed that the trust was about the same in areas such as involvement in their care, food and support to eat, cleanliness and support after discharge.
- However the trust was worse when compared to other trusts in receiving adequate advice after discharge, explanation of operation and waiting lists and planned admissions. With regards to the overall view of the service, patients were less satisfied with being asked their views about the quality of care during their stay. Other areas which showed the trust was not fully engaged with patients as they did not receive adequate information about making a complaint, side effects of medicines on discharge. We asked the trust if an action plan developed following the publication of the NHS inpatients survey in June 2016, but we did not receive an action plan.

# Are services well-led?

## Staff engagement

- Results from the 2016 NHS Staff survey the trust was in the best 20% of trusts for one question, and in the worst 20% of trusts for five questions (including overall engagement score). The trust was in the middle 60% for the remaining 26 questions and the response rate. One of the areas the trust scored worst on was 'recognition and value of staff by managers and the organisation'.
- Following the NHS Staff survey published in 2016, the stroke service was leading on a pilot a project 'happy staff mean happy patients'. The lead nurse for stroke services explained the plan was to introduce 'Schwartz' rounds. The stroke lead did not give us a start date at our inspection in November 2016. Schwartz Rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.
- Information was shared with the staff teams. Information was displayed in suitable areas of the

general rehabilitation unit and the stroke unit about governance, risks, training and hospital information. Information was shared by email correspondence and information was available on the trust's intranet.

- Staff told us they found the team brief sent out every Wednesday by the executive useful to read. Staff said this was divided into three sections, national, trust wide and service specific, which they found helpful.

## Innovation, improvement and sustainability

- The stroke unit and another ward in the medicine clinical business unit was involved in an NHS improvement project entitled 'bed space cleaning'. The project team included five staff. The project to devise a standardised, effective process for cleaning bed spaces between patients at ward level. The trust, along with 22 other NHS organisations, were invited to participate in collaborative programme run by NHS Improvement. The team involved was then planning to roll out the newly designed standardised bed space cleaning process to the rest of the trust.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not met:</b></p> <p>People who use services and others were not protected against the risks associated with unsafe care or treatment.</p> <p>12 (g) Medicines for return to pharmacy were not stored securely.</p> <p>12 (e) Equipment required for the safe care and treatment of patients, including helping them to be safely moved was not readily available.</p> <p>12 (c) The trust had not ensured that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely because:</p> <ul style="list-style-type: none"><li>• Staff training in adult resuscitation training was low.</li><li>• Staff understanding of safeguarding was not in accordance with the regulations as not all registered staff had a clear understanding of the Mental Capacity Act (2005). Mandatory training for safeguarding and the use of the Mental Capacity Act (2005) were significantly below trust target levels.</li><li>• Induction for bank and agency staff was not routinely recorded or evidenced.</li><li>•</li></ul>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>How the regulation was not met:</b></p>

This section is primarily information for the provider

## Requirement notices

17(2)(c) Records must be stored in accordance with current legislation and guidance. Records on the general rehabilitation inpatient unit and the stroke unit were not securely stored to prevent unauthorised access.

17(a) and (2)(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from carrying out the regulated activity. Risks were not always responded to in a timely way, and not all risks that were current were identified as outstanding risks.