Derbyshire Community Health Services NHS Foundation Trust

RY8

Community health services for adults

Quality Report

Derbyshire Community Health Services NHS
Foundation Trust
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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)
RY8Y7	Clay Cross Hospital	Integrated Community Care Teams Brain Injury Team	S45 9NZ
RY846	Ilkeston Hospital	Community Matrons	DE7 8LN
RY8Y5	Newholme Hospital	Ashford Therapy Unit Community Therapy Service. Falls Clinic	DE45 1AD
RY8Y4	Ripley Hospital	Leg Ulcer Clinic	DE5 3HE

This report describes our judgement of the quality of care provided within this core service by Derbyshire Community Health Services NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Derbyshire Community Health Services NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Community Health Services NHS Foundation Trust.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated community health services for adults as good.

The service protected patients from avoidable harm and abuse. There was a culture of reporting incidents and we saw evidence that actions were taken as a result. Staff anticipated and managed the risks to people who use services and had a good understanding of how to safeguard patients from abuse. Staffing levels were planned and reviewed to ensure there were safe levels of care. Clinic areas were visibly clean and tidy and staff demonstrated good infection prevention and control procedures. Patients care records were accurate, complete, up to date, and legible and were stored securely. However, we noted the trust's medicine code was not always adhered to.

Care and treatment was planned and delivered in line with current evidence based guidance and standards, although there was no consistent approach to monitoring and auditing the quality of the service. We saw effective multidisciplinary working within the integrated community teams (ICT) and staff had the knowledge, skills and experience to deliver effective care and treatment. We saw evidence of staff knowledge and understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Most referrals to the service were handled by the single point of access (SPA) who assessed and triaged referrals to ensure that patients were directed to the most appropriate service. However, referrals to the community nursing teams based at Derby city were handled by a separate district nurse liaison service. Staff reported this service was ineffective, resulting in delays and inaccurate information being relayed to nurses.

Most patients had a single electronic patient record, which ensured all staff had access to information to provide effective care.

We spoke with patients using the services and all of the feedback was positive about the care they received. They told us they were treated with compassion, dignity and respect and were included in the planning and delivery of their care. The interactions we observed between patients and staff were consistently respectful and compassionate, with staff taking time to support, listen and reassure patients. Results from the NHS Friends and Family test (FFT) were consistently above 97%.

Services were planned and delivered to meet the needs of people. Care was provided locally and patients were seen in a timely manner. Community health services were provided by integrated community teams, which ensured patients received joined-up care. Community matrons were available to co-ordinate the care of patients with long term conditions. Specialist services were available, although the continence advisory service was not accessible to all patients in the community. This was because the service was commissioned differently between the city and county, however the trust were working with the commissioners to ensure an equitable service. Staff ensured care was provided for those people in vulnerable circumstances and that care was accessible to all. Staff responded proactively to complaints, aiming to resolve issues quickly.

Staff were familiar with the trust's vision and the 'Derbyshire Community Health Services (DCHS) Way', they consistently demonstrated the trust's values in their day-to-day work. There was a good governance structure; managers were aware of the risks in their areas and could discuss the actions being taken to reduce these risks. Local leaders were visible and staff told us that they felt supported and valued. Staff said managers were approachable and they felt able to raise concerns. Staff felt listened to and able to influence service delivery. Staff spoke positively about the organisation; were proud to work for their team and enjoyed their role.

Summary of findings

Background to the service

Derbyshire Community Health Services (DCHS) NHS Foundation Trust provides a range of community health services for adults across the whole of Derbyshire and parts of Leicestershire.

The trust manages services across three operational divisions. The majority of community health services for adults are within the Integrated Community-Based Services (ICBS) division. Community health services for adults within ICBS, were delivered in seven geographical areas: High Peak and North Dales, Bolsover and North East, Chesterfield, Derby city, Amber Valley, Erewash and South Derbyshire.

As part of the inspection we visited:

- Integrated Community Care Teams at Alfreton, Cavendish Hospital, Clay Cross Hospital, Stubley Medical Centre and Long Eaton Health Centre.
- Community nursing teams at Bakewell Medical Centre, Chatsworth Road Medical Centre, Repton Health Centre, Eckington Health Centre, Village Health Centre, Coleman Street Health Centre, London Road Community Hospital and Lister House Surgery.
- Ashford Therapy Unit at Newholme Hospital.
- Community Therapy Service at Newholme Hospital.
- Falls Clinic at Newholme Hospital.
- Brain Injury Team at Clay Cross Hospital.
- Cardiac Rehabilitation Service at Scarsdale Clinic.
- Continence Advisory Service at Repton Health Centre.
- Leg Ulcer Clinic at Ripley Hospital.

During our inspection, we spoke with 133 members of staff including, community nurses, district nurses, community matrons, generic support workers, integrated care managers, integrated care team leaders, physiotherapists, podiatrists, occupational therapists and administration staff. We observed care being provided both in clinics and in patient's homes. We spoke with 47 patients, 5 relatives and reviewed 22 patient care records.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health Visitors, Dentist, Dietitian, Occupational Therapists, Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

We inspected this service in May 2016 as part of the comprehensive inspection programme.

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 23 to 25 May 2016.

What people who use the provider say

Patients we spoke with were very positive about the care and treatment they received.

Friends and Family Test data for community health services for adults between January 2015 and January 2016 showed consistently that 97% of patients who would recommend the service to their friends and family.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure there is a robust process for maintaining a register of serial numbers for prescription pads.
- Ensure medicines are transported in securely sealed or tamper evident containers.

Action the provider SHOULD take to improve

- Consider how the Derby city district nurse liaison service can provide accurate referrals in a timely manner.
- Consider monitoring the time taken for the community nurses to see patients once referral as been made.
- Consider how the way of ways of working and caseloads for Derby city community nurses can be aligned with Derbyshire Community Health Services in a timely manner.
- Consider developing a consistent approach to obtaining feedback from the public in order to shape and inform the services being delivered.
- Consider developing a consistent approach to monitoring and auditing the quality of the service.
- Consider developing a consistent approach to monitoring outcome measures for patients.

Derbyshire Community Health Services NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated community health services for adults as good for safe because:

- staff understood their responsibility to report incidents and there was evidence that actions were taken as a result of these.
- staff had a good understanding of safeguarding and could describe the actions they would take if they suspected a patient required safeguarding.
- equipment was available for use in patient's homes and in clinic areas.
- patients care records were accurate, complete, up to date, legible and were stored securely
- staff anticipated and managed the risks to people who use services.
- clinic areas were visibly clean and tidy and staff demonstrated a good understanding of infection prevention and control procedures.
- staffing levels were planned and reviewed to ensure there were safe levels of care

However:

- prescription pads were not stored and medications were not transported in accordance with the trust's medicine code.
- There were vacancies within the out of hours Derby city community nursing team.

Safety performance

- Community nursing teams participated in the NHS safety thermometer programme, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Data is collected on a specific day each month to indicate performance in three key safety areas - new pressure ulcers, catheter related urinary tract infections (CAUTI) and falls.
- Between April 2015 and February 2016 the rate of harm free care averaged 93% for the community nursing team, this was slightly below the trust target of 94%, although slightly better than the previous year (2014/15) when the average rate was 92.6%.

Good

Are services safe?

- Staff we spoke to were knowledgeable about this initiative, but results of the safety thermometer were not displayed or shared locally to improve practice.

Incident reporting, learning and improvement

- Between January and December 2015, there were no never events reported for this service.
- Staff reported incidents through the trust's electronic reporting system. All staff we spoke with understood their responsibilities to raise concerns and report incidents and near misses. Staff said they were encouraged to report incidents, and staff said they received feedback. Staff we spoke with could give us examples of recent incidents they had reported.
- Between January and December 2015, there had been 203 incidents reported by staff in community health services for adults, 197 of these related to pressure ulcers.
- We saw that the risk of patients developing pressure ulcers was identified as a risk on the trust's risk register. We saw that the actions, such as education and training and investigating the cause of pressure ulcers, were in place to reduce the risk.
- Root cause analysis (RCA) investigations were completed on all pressure ulcers of a grade 3 or above, or any grade 2 pressure ulcers that were considered avoidable, to help determine the cause of the pressure ulcer and help prevent reoccurrence.
- Lessons learnt from incidents and RCAs were discussed at the monthly integrated care team (ICT) meeting. We saw, for example, minutes from the Southern Derbyshire ICT meeting where a RCA investigation into a pressure ulcer was discussed, and the need to improve documentation identified.
- Staff we spoke with were aware that improvements were needed in order to reduce the number of pressure ulcers and could discuss actions they were taking. For example, within the High Peak and Dale's locality, a pressure ulcer improvement group (PUIG) had started to meet to review the incidence of pressure ulcers and to provide a forum for shared learning. During our inspection we saw evidence of a presentation that was used to share information. We saw training materials, developed by the PUIG, were in use to educate community nursing staff.
- In one community nursing team information about the number and status of pressure ulcers in their area was displayed for all staff to see. This meant all members of staff were aware of the number of patients with pressure ulcers and what care had been instigated in relation to each patient. For example pressure relieving equipment provided or referral to tissue viability nurse.
- Within one community nursing team, there had been nine incidents between February and May 2016 relating to the incorrect administration of insulin. As a result of this, staff were undertaking additional training. Changes were also being made to the documentation for recording insulin administration in order to make this clearer.
- Staff had an awareness of the duty of candour requirements. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. More senior staff demonstrated greater understanding of this and one member of staff we spoke with was able to describe the actions they had taken following an incident to meet the duty of candour regulations. We saw from minutes that the duty of candour was discussed at a band 6 community nursing meeting.

Safeguarding

- The trust had a safeguarding policy in place. Safeguarding training was mandatory for all staff working within the trust and was part of the trust's essential learning course, which 97% of staff had attended.
- Staff we spoke with had a good understanding of safeguarding and could describe the actions they would take if they suspected a patient required safeguarding. Staff also spoke about their safeguarding responsibilities to others for example, carers and children of patients they visited.
- Some staff could give us specific examples of safeguarding concerns they had raised. In response to safeguarding concerns at one care home, the integrated care team (ICT) manager had worked with both the care home manager and the local authority in order improve the pressure area care for the patients. As a result, the ICT provided regular teaching sessions for care home staff, a dedicated support worker and held monthly meetings to review progress.

Medicines

Good

Are services safe?

- The trust had a medicine code which provided the procedure for the prescribing, storage, transportation and administration of medicines. However, we found the medicine code was not always followed. At Ashford therapy unit, prescription pads were kept in a locked cupboard but there was no record of the prescription serial numbers being maintained. This was not in accordance with the medicine code which stated that staff should keep a record of the serial numbers of prescriptions issued. In addition, we observed a community nurse collect medication from a GP surgery to administer to a patient at home. This medicine was transported in a bag, rather than in 'securely sealed or tamper evident container' as stated in the trust's medicine code.
- We checked the storage of medicine at one location and saw that medicines were secure, in date and a stock check was recorded monthly.
- Community nurses would prioritise patients who required insulin injections, to ensure patients received these in a timely manner.
- Many of the community matrons had undergone additional training in order to become non-medical prescribers. Non-medical prescribing is the prescribing of medicines and dressings by health professionals who are not doctors. This meant that potential delays in patients receiving their medication were avoided and patients did not need to attend unnecessary appointments with the GP.

Environment and equipment

- We visited three community locations where patients attended, and saw that equipment in these locations had been safety tested.
- Equipment for use in patients' homes was provided through a contract with an external equipment provider; staff confirmed that equipment was readily available. If required urgently, equipment could be available the same day if ordered before 4pm. Supplies of regularly used items were kept at local stores, so staff could easy pick up equipment if needed. Three clinicians employed by the trust, worked closely with the company to provide professional advice.
- Staff received a newsletter from the equipment provider and confirmed they received updates and education relating to new pieces of equipment.
- One relative told us that there had been a delay in the supply of a specialist wheelchair for a patient discharged from hospital several weeks ago. We spoke to the trust about the availability of wheelchairs who acknowledged there were delays, especially with specialist wheelchairs. The trust told us it was in the process of implementing an electronic administration system to support the monitoring of waiting times for wheelchairs. The trust had gained additional funding for the provision of wheelchairs from the commissioners. This funding was temporary for six months after which a full review of the current service specification would occur.
- We checked the availability of resuscitation equipment at two locations we visited and found it was clean, well-stocked and weekly checks were completed and recorded.

Quality of records

- Patients' individual care records were stored securely. For 14 of the 16 teams we visited, records were electronic. Two teams used paper care records; these were stored securely in locked filing cabinets.
- We reviewed 22 individual patient care records, of these 18 of these were electronic and four were paper. Without exception, 22 sets of records we reviewed were found to be accurate, complete, up to date and legible.
- The trust wide carried out a monthly audit of patient records. Not all staff were aware of the results of these audits, but we saw evidence that records audit results were discussed at ICT meetings and band 6 community nurse meetings.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies in place.
- We observed staff during visits to patients in their own homes, care homes and clinic sessions and found they demonstrated they had a good understanding of infection prevention and control. For example we saw staff adhere to an aseptic non-touch technique when changing a wound dressing.
- Staff followed trust's bare below the elbow guidelines. We saw staff clean their hands and use hand gel prior to and after care was given, use gloves and aprons appropriately and clean reusable equipment.

Good

Are services safe?

- All locations visited were visibly clean and tidy. We observed that clinical and domestic waste was correctly segregated and sharps boxes were available and used appropriately. Cleaning schedules were displayed and adhered to.

Mandatory training

- All staff were required to complete the essential learning course every two years, which included health and safety, infection prevention and control, safeguarding children and adults level one and manual handling. As of April 2016, 97% of staff with in community health services for adults had completed this, which was in line with the trust's target of 95%.
- Information governance training needed to be completed annually by all staff. The trust's target was 95%, and as of April 2016, 96% staff with in community health services for adults had completed this.
- All staff were required to complete annual fire training, as of April 2016, 97% of staff with in community health services for adults had completed this training, which was above the target of 95%.

Assessing and responding to patient risk

- At the first meeting with a new patient, staff completed a full patient assessment , whether they were in the patients' home or a clinic setting. For example, we observed staff in a patient's home obtain a comprehensive history and complete assessment in order to identify potential risks.
- We saw evidence that patients attending cardiac rehabilitation had a full assessment at the start of the programme including a pressure ulcer risk assessment.
- Patients attending podiatry clinics for the first time, would have would have a full assessment which included their risk of falls and an assessment of the circulation and sensitivity of their feet.
- Patient risk assessments were part of the electronic care record. We reviewed 22 care records and saw staff had completed a range of risk assessments, such as malnutrition and falls. We found where a risk had been identified; appropriate care had been planned and implemented.
- Staff were reminded of a patients allergy by an alert on the electronic record. We observed staff checking if patients had any allergies, for example, when considering the use of new wound dressings.
- We observed three nursing team handovers and saw that patient alerts were discussed, concerns were identified and escalated appropriately.
- There was a central single point of access (SPA) for community health services based at Clay Cross Hospital. Administration staff would record initial information and then direct the call to the appropriate local SPA. All calls would then be answered and triaged by a clinical navigator, who was a band 6 clinician who referred the caller to the most appropriate service; ensuring patients received timely and appropriate care.

Staffing levels and caseload

- As of 29 February 2016, the average vacancy rate for qualified nurses across all community nursing teams was 7.2%.
- The community nursing team based at Derby city was split into two teams, the general Derby city team and out of hours Derby city team. The highest vacancy rate out of all community nursing teams was for the out of hours Derby city team, who provided care between 6-10pm. This service should have had 5.15 whole time equivalents (WTE) but actually had 2.31, this equated to a vacancy rate of 44.9%, which was approximately three members of staff. Following the inspection the trust provided us with an update on the vacancy rate. As of June 2016, the vacancy for registered nurses was 1.35 WTE.
- In the general Derby city team, we spoke with 24 community nursing staff, seven of had concerns about the staffing levels. The vacancy rate this team, as of 29 February 2016, for registered nurses was 5%, this equated to 5.8WTE. We spoke with the managers for the general Derby city and out of hours Derby city teams, who told us they were actively recruiting nurses for this locality, and had just recruited eight qualified nurses. They were planning to overfill vacancies to/ allow some flexibility in the future for unplanned staff absences. Following the inspection the trust provided us with an update on the vacancy rate. As of June 2016, the vacancy rate for registered nurses had increased to 14.8 WTE; however, the trust had recruited into12.2 of these WTE vacancies, with staff commencing employed between July and September 2016.
- Derby city team had been part of Derbyshire Community Health Service (DCHS) since October 2015, when the team transferred over from a neighbouring organisation. Because of this, the teams were using different models

of care and had a different management structure. The managers of the team were aligning the structure to be consistent with DCHS as well as reviewing the caseload and the community nurses way of working. The trust had identified that the number of staff vacancies had the potential to reduce the numbers of staff able to attend their essential training and that it could also be a risk to patients. Both these risks were documented and managed on the trust's risk register.

- Other teams were proactively recruiting staff, for example, one manager told us they were recruiting a permanent member of staff into temporary maternity cover as they were aware there were several members of the team who were approaching retirement age.
- Staff across all other teams, whilst acknowledging there were busy times, felt their caseloads were manageable and they were able to deliver the standard of care they wanted to.
- Within nursing teams, a caseload-weighting tool was used to help plan workload on a day-to-day basis. This tool 'weighted' nursing tasks, with tasks being allocated 20, 40 or 60 minute time slots depending on the complexity of tasks. Additionally severity of the patient's illness was rated as red, amber or green, with 'red' patients being given a higher priority for care. A variation of this tool was use for the Derby City team, which allocated less time for each task (15 minutes rather than 20 minutes for a single time slot) this meant that nurses had less time to spend with patients.
- Patients were allocated to members of the nursing team by one of the senior community nurses, on a day-by-day basis, taking into account the dependency of the patients and the skills and experience of the nursing staff
- In June 2015 the trust used the Benchmark Recording Activity for Varied Outcome (BRAVO) tool to understand the dependency and acuity of patients requiring community care and to capture the activity of the community nurses in 10 minute time slots, over a two week period. Staff we spoke with were aware of this process and viewed it as a positive process. The BRAVO tool provided evidence to support staff if capacity and demand for services was an issue. One manager told us that as a result of the BRAVO review in 2015, three WTE extra nursing staff had been appointed to one ICT. A further BRAVO review was planned for May 2016, which would also include therapy, community matrons as well as nursing teams.

Managing anticipated risks

- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, for example due to adverse weather. This included identifying which staff were in walking distance of patients homes and staff having access to 4x4 cars to support access to patients in all community settings. The more vulnerable and highly dependent patients would be identified and these patients would be prioritised. We saw evidence of these plans and saw that plans were discussed at the ICT meetings.

Good

Are services effective?

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

We rated community health services for adults as good for effective because:

- Care and treatment was planned and delivered in line with current evidence based guidance and standards.
- Most referrals to the service were handled by a single point of access which ensured that patients were directly to the most appropriate service.
- Staff had the knowledge, skills and experience to deliver effective care and treatment.
- Staff worked with multidisciplinary teams to meet the needs of patients.
- Staff demonstrated good understanding of Mental Capacity act and Deprivation of Liberty safeguards.
- Most patients had a single electronic patient record, which ensured all staff had access to information to provide effective care.

However:

- There was no consistent approach to monitoring and auditing the quality of the service or outcome measures for patients in order to improve the quality of the service delivered.
- Staff reported the district nurse liaison service at Derby city was ineffective, resulting in delays and inaccurate information being provided.

Evidence based care and treatment

- Staff had access to trust policies, procedures and guidelines that were located in the 'staff zone' area of the trust intranet. We saw evidence of staff using these in day-to-day practice, for example a nurse using the Derbyshire wound management guidelines to establish an appropriate wound dressing.
- Staff also had access to an electronic version of the Royal Marsden manual, which provided nurses with up to date evidence based guidance for clinical procedures.
- We reviewed 22 patient care records and saw that care goals had been identified and personalised care plans developed that reflected best practice.
- Patients' assessments were completed using templates that followed national guidelines, for example for assessing patients for the risk of pressure ulcers and malnutrition
- We saw that physiotherapist teams documented care using the 'SOAP' format (subjective, objective, assessment and plan), which provided a structured format for recording patient care and is recognised best practice.
- Services provided reflected professional and national standards. For example, the cardiac rehabilitation programme was in line with the British Association for Cardiovascular and Prevention and Rehabilitation (BACPR). The falls service provided strength and balance training which reflected NICE quality standards.
- The brain injury service reflected the NICE quality standard QS74, community rehabilitation services for people with traumatic brain injuries.

Pain relief

- We reviewed patient care records and saw that patients' pain was assessed and care plans developed if patients were experiencing pain.
- Staff considered patients' pain when providing care. We observed staff checking out comfort levels, for example, when changing wound dressings, and therapy staff identifying what factors aggravated and eased patient's pain.

Nutrition and hydration

- We reviewed 22 patient care records and saw patients were assessed using a national tool for their risk of malnutrition. We saw evidence that care was provided appropriately in response to these assessments, for example, we observed a nurse discussing a patient's weight loss with them and explaining that they would make a referral to a dietitian. Compliance with the use of the malnutrition tool was reported to the trust board by their safety care priority group.

Technology and telemedicine

Good

Are services effective?

- The locations we visited did not use telemedicine to support patients to manage their care in their own homes.
- Staff told us they were in the process of being issued with smart phones. Those staff who had received these told us they helped to support effective patient care, for example by making it easier to take photographs of patients' wounds, which could easily be uploaded onto the care record to aid referral for specialist input and to monitor progress.

Patient outcomes

- There was no consistent approach to monitoring and auditing the quality of the service or outcome measures for patients in order to improve the quality of the service delivered. However, we did see some evidence of local audit and measuring of patient outcomes.
- Community matrons monitored, on a monthly basis, the number of patients who avoided a hospital admission. Between November 2015 and April 2016, an average of 174 patients avoided hospital admission, because matrons were able to provide care for them in their own homes.
- We saw, in the information provided by the trust, evidence that an audit relating to catheter associated urinary tract infection (CAUTI) and subsequent use of antibiotics in the community had been performed in January 2016. We saw actions plan had been developed which included plans for staff education, and plans made to re-audit at the beginning of 2017. However none of the staff we spoke with were aware of this audit or its actions.
- As part of the commissioning for quality and innovation (CQUIN) initiative, Erewash integrated care team (ICT) had piloted the use of the Derby Outcome Measure (DOM) tool.The CQUIN initiative is a payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For patients this means better experience, involvement and outcomes The DOM tool measured individual patient outcomes and demonstrated the effectiveness of the service. Patients were scored at the beginning and end of their treatment. Results for the quarter between April and June 2015 showed that 42% of patients had improved outcomes. For the quarter between July and September 2015, this had risen to 66%, and for October to December 2015, 70% of patients had improved outcomes. We saw documented in a CQUIN report there were plans for a wider roll-out of this tool.
- Patient outcomes measures were performed at the beginning and end of the cardiac rehabilitation programme to determine improvements in patient outcomes.
- Physiotherapy staff at Ashford rehabilitation undertake a yearly evaluation of the care given to patients with frozen shoulder.

Competent staff

- Staff we spoke with told us there were training opportunities available and they were supported to develop. They gave us examples of education and training they had recently completed. This varied from support to undertake non-medical prescribing courses and masters level study to clinical education such as completing a diabetes module or attending a day on recognising the deteriorating patient.
- We noted that staff who were working in the Derby city teams felt that their training opportunities were limited mainly due to capacity issues.
- All the staff we spoke with said they had appraisals with their line manager that were meaningful and useful and had objectives set. The majority of community health services for adults were within the Integrated Community-Based Services (ICBS) division. The average appraisal rate for community staff with ICBS was 95.6%. The majority of the staff we spoke with told us they had monthly 1-1 meetings with their line managers.
- There was a total of 79 community nursing sisters, of these 47 (59%) had a specialist district nurse qualification. The trust told us that a further six would achieve their qualification in September 2016, and that that they were supporting a further six, who would start the course in September 2016 and qualify in September 2017.
- From April 2016, all registered nurses are required to revalidate with the Nursing and Midwifery Council (NMC) in order to continue practising. Registered nurses told us they had had support from the trust and could demonstrate a good understanding of the requirements needed. We observed a team meeting where revalidation was discussed.
- New starters to the trust confirmed they had attended an in house 'fundamentals of care' course, and were

given support from other staff within the team. One new community nurse explained how they had first shadowed other community nurses, then performed care under supervision before being allocated their own caseload. This had made them feel supported and helped build their confidence.

- We saw evidence that Band 3 support workers demonstrated their competence at performing tasks, for example issuing a patient with a walking frame, before being able to perform these tasks unsupervised.
- The trust supported the role of the Band 4 assistant practitioner. These staff worked in support roles, alongside qualified nurses, occupational therapist and physiotherapist and were supported to complete a foundation degree and complete competency based assessments.
- The trust required nursing staff who care for patients in the leg ulcer clinic, to have had training in leg ulcer assessment and management, Doppler assessment (a procedure for determining the blood flow to the leg) and compression bandaging. Managers told us that staff who run leg ulcer clinics were experience nurses, the majority of which had completed courses in leg ulcer management. However, the trust were unable to report the number of nurses who had completed this training as they did not maintain records.
- The trust encouraged staff to undertake clinical supervision. Clinical supervision is a formal process for professionals to review and reflect on the clinical practice. We saw minutes from ICT meetings that demonstrated clinical supervision was discussed and staff were encouraged to attend. Some staff we spoke with said they participated in clinical supervision, either on a one-to-one basis or in small groups.

Multi-disciplinary working and coordinated care pathways

- With the exception of Derby city, integrated community care teams (ICT) provided care to patients in the community. These teams consisted of community nurses, district nurses, community matrons, occupational therapists, physiotherapists and support workers. Some ICT shared the same office space, which further promoted communication and multidisciplinary working. For other ICT, the community nurses were based in GP surgeries, separate to therapy staff. These teams told us they still functioned as an ICT because they were all able to access the single electronic patient record and attended monthly ICT meetings. They also had easier access to the GPs, if they required advice about a patient. All the ICT provided a 'joined up' approach providing patient centred care, staff spoke positively about this way of working and valued the contributions each other made.
- The Derby city team had been part of the trust since October 2015, when the team transferred over from a neighbouring organisation. Because of this, the teams were using different models of care and had a different management structure, although work was underway to align this team with the Derbyshire Community Health Services model.
- Community support meetings were held weekly in GP surgery's to discuss patients with complex needs. These were attended by community nurses, as well as professionals from other organisations such as GPs, social care, community psychiatry nurses. We observed one of these meetings and saw effective communication and partnership working between the different professional groups.
- We saw evidence of staff working closely with care homes in order to improve patient care and outcomes. For example, the continence team provided teaching to staff based in nursing homes. The service provided care home support teams who would visit the local care home weekly to review patients and proactively check for any potential problems.

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, acute hospitals, nursing and residential homes.
- With the exception of community nurse referrals for the Derby city team, there was a central single point of access (SPA) for community health services based at Clay Cross Hospital. This service operated seven days a week from 8am to 6.30pm. Administration staff would record initial information and then direct the call to the appropriate local SPA. There were seven local SPAs spread across the county. All calls would then be answered and triaged by a clinical navigator, who was a band 6 clinician who referred the caller to the most appropriate service.
- Referrals to the Derby city community nurse team were made through the district nurse liaison service. The district nurse liaison service acted as a telephone call centre, taking referral details and passing on to the

community nurses by fax or telephone as they had no access to the electronic patient record system. Nurses reported that this led to messages been missed, or incomplete information been received. Nurses told us that patients would also ring the district nurse liaison service, and would be kept waiting for their calls to be answered. We asked the trust to provide information regarding this service including the number of calls answered, the time taken to answer calls or if there had been any incidents related to calls been handled inappropriately. The trust were unable to provide this information, but did inform us they were planning to incorporate this service into the SPA.

- The SPA clinical navigators also provided an 'in-reach' service with a local acute hospital provider. The clinical navigators completed assessments of patients' need in the acute hospital, in both ward and emergency areas and identified the most appropriate setting in the community for the patient to be cared for.
- The trust was working closely with another acute hospital provider to improve patient transfer to community nursing services. This was a local CQUIN, which was developed by commissioners.
- Patients attending cardiac rehabilitation were referred, as appropriate, to other support service such as smoking cessation clinics.
- Patients could self-refer to some services for example the continence team, podiatry, physiotherapy, brain injury team and cardiac rehabilitation.

Access to information

- All the localities we visited used an electronic patient record system, except for the ICT based at Cavendish Hospital, the Derby city team of community nurses and the cardiac rehabilitation team. Teams at Cavendish Hospital and Derby city confirmed that they would be soon be transferring over to the electronic system, with training for this starting in June 2016. The cardiac rehabilitation team used paper based records.
- Staff had access to the electronic records via computer terminals in offices, or via the use of 'Toughbook' laptops, which could be used in patients' homes. In areas where connectivity was poor, staff could still input information into the Toughbook, which would automatically be uploaded to the live system as soon as connectivity was established.
- Some paper records were left in patients' homes, for example care plans to aid communication with families and other care agencies such as the night community nursing service, which was provided by a separate organisation.
- Podiatry staff Ashford Therapy Unit did not have the use of a Toughbook. This meant that staff needed to write on paper notes following the interaction with each patient and then transfer the written notes to the electronic system when they returned to base, which duplicated their work.
- Staff spoke positively about the electronic patient record, as it created a single patient record that was accessible by all staff with in the ICT. Staff told us that this aided communication between the different professions. In most cases, GPs also used the same system, which further enhanced communication and access to information. In GPs surgeries where a different electronic system was used, community nursing teams were still able to access this patient record as well.

Consent, Mental Capacity act and Deprivation of Liberty

- We observed staff gaining verbal consent before providing care and saw patient consent forms had been signed by the patient when appropriate.
- The electronic patient record contained a prompt, which ensured patients' consent was obtained in order to share records with other professionals.
- Staff had a good understanding of the Mental Capacity Act (MCA) although had not had much experience of completing a 2-stage capacity assessment. Staff told us they would seek support from the GP if they had concerns about a patient who lacked the mental capacity to make decisions. We observed a multi-disciplinary team meeting, where the mental capacity of a patient had been considered.
- Staff demonstrated good knowledge of the Deprivation of Liberty Safeguards (DoLS).

Good

Are services caring?

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

We rated community health services for adults caring as good because:

- We spoke to patients using the services and all of the feedback was positive about the care they received.
- Patients and carers told us they were treated with compassion, dignity and respect and were included in the planning and delivery of their care.
- The interactions we observed between patients and staff were consistently respectful and compassionate, with staff taking time to support, listen and reassure patients.
- Results from the NHS Friends and Family test (FFT) were consistently above 97%.

Compassionate care

- We observed care being delivered to 28 patients, either in their own homes or within clinics. In every case, we saw staff providing kind and compassionate care.
- We spoke to a further 25 patients, who said that the staff were friendly, polite and caring. Without exception, the patients we spoke with were very complementary about the care and treatment they had received.
- Staff were gentle in their approach when they carried out assessments and procedures and took time to support, listen and reassure the patients.
- The dignity of patients was maintained at all times by staff ensuring curtains were pulled round in clinic settings and ensuring curtains were drawn in patients' homes.
- Although we observed busy services, this was not apparent to the patients using them, who reported feeling well cared for without being rushed.
- At the cardiac rehabilitation service, one patient who had attended an assessment reported that staff had shown him dignity and respect and had been friendly and informative. We saw kindness and compassion from staff when patients needed to cancel or re-arrange appointments. Patients were reassured that a cancellation was not a problem and that a new appointment would be made.
- The trust used the NHS Friends and Family test (FFT) to obtain feedback from patients. The FFT is a single question survey, which asks patients whether they would recommend the NHS service to their friends and family. Between January 2015 and January 2016, results of the FFT were consistently above 97% for this service, which is above the England average of 95%.

Understanding and involvement of patients and those close to them

- We saw staff taking time talking to patients and listening to any concerns about the care planned or being received. Clear and simple language was used to explain the care to make sure patients understood what was going to happen.
- Care was delivered in a calm and thoughtful way involved relatives and carers.
- We also observed therapists supporting patients in their own homes to make changes with exercise plans or changes to their home environment. This was clearly discussed in simple easy to understand language and information leaflets were left for patients and relatives to refer to.
- We spoke to patients and relatives using the services who reported that they were well prepared for the treatments and knew what to expect. One patient reported that he had been well informed of the end of life care provided to his wife before she died, and had been supported well by the staff.
- Podiatry patients told us that the staff were friendly, polite and took the time to discuss their care with them. In one clinic a patient was asked which dressing was preferred and the follow up appointment was discussed and made with the patient preference taken into account.
- We saw one patient actively involved in the care received and we noted they passed surgical tape to the nurse during a dressing change.
- Home visits were planned at times convenient to families, so they could be included in discussions about care arrangements.

Emotional support

- Staff consistently helped patients and those close to them to cope emotionally with their care and treatment. They were supported to manage their own health and care, where possible, to maintain independence.

Good

Are services caring?

- We saw staff discuss holistic care in team meetings and the emotional impact this had on their patients.
- We saw staff provide empathic support and reassurance to a patient and their family who were anxious. Patients were complementary about the emotional support they had received.
- We observed a home visit where a supportive approach was taken as it was the anniversary of the death of the patient's wife. The staff fully supported the patient at this difficult time.
- During home visits staff tailored care and support to meet the needs of individual patients, their families and other carers emotionally and physically. One district nurse told us that they felt it was very important to support patients holistically including emotional support to get the best outcomes for the patients.
- All staff we spoke to told us that it was important to them to provide emotional support to patients as part of the holistic care provided

Good

Are services responsive to people's needs?

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

We rated community health services for adults as good for responsive because:

- Services are planned and delivered to meet the needs of people.
- Patients were seen in a timely manner and care was provided locally.
- Community health services were provided by integrated community teams (ICT), which ensured patients received 'joined-up' care.
- Community matrons were available to co-ordinate the care of patients with long term conditions and specialist services were available.
- Staff ensured care was provided for those people in vulnerable circumstances and that care was accessible to all.
- There was a proactive approach to responding to patients complaints.

However:

- The continence advisory service was not accessible to all patients in the community.
- The time taken for patients to be seen by community staff once a referral had been made was not monitored, so there was no assurance that patients were seen in a timely manner.

Planning and delivering services which meet people's needs

- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways.
- Community health services were provided by integrated community teams (ICT), which ensured patients received 'joined-up' care.
- Community matrons were available to co-ordinate the care of patients with long term conditions who required advanced nursing care management, thereby improving quality of life and reducing unplanned use of services avoiding unplanned hospital admissions.
- Specialist services were available for patients such as a cardiac rehabilitation programme for patients who have had heart attacks of have long term condition such as heart failure and the brain injury services, which provided support and rehabilitation to patient following a brain injury.
- The musculoskeletal service was staffed by staff who had extended their scope of practice in order to provided specialist assessments, diagnose and directly refer patients for diagnostic tests. Additionally they provided speciality treatments such as joint injections. This meant patients could access these services in local clinics rather than be referred to acute hospital services.

Equality and diversity

- Staff we spoke with were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant that staff could communicate effectively with all patients.
- We saw that patient information leaflets from the British Heart Foundation were available in multiple languages.
- Staff in the continence advisory service gave us examples of arranging for patient information leaflets to be translated into Greek and for obtaining information in Braille.
- The cardiac rehabilitation service tailored exercise programmes to meet individual needs taking in to account age or disabilities. This meant, for example, that those patients who were wheelchair users could still participate in the programme.

Meeting the needs of people in vulnerable circumstances

- The service provided for those patients in vulnerable circumstances. For example, the brain injury team provided patients with credit card size cards, produced by a national charity. The cards stated that the patient had a brain injury and may have problems with memory speech or actions, and asking for patience and help.
- We saw the NHS friends and family test (FFT) survey form was available in a format suitable for patients with a learning disability.
- Since April 2015, the 3D's (Dementia, Delirium, and Depression) had been included within the trust's Essential Training for nurses. We saw that a 'recognizing delirium, depression and dementia' guidance had been

Good

Are services responsive to people's needs?

produced and this had been discussed and circulated at ICT meetings. Staff were able to give us example of caring for people living with dementia and the adjustments made, for example, taking time to talk to patients, using simpler language and involving carers.

Access to the right care at the right time

- Patients requiring physiotherapy, occupational therapy and podiatry services where seen in a timely manner. As of March 2016, 93% of patient waited less than 6 weeks from referral to treatment (RTT) in the Amber Valley and Erewash and the High Peak and Dales regions. In the Chesterfield region 91% of patients waited less than 6 weeks from referral to treatment.
- Between January and March 2016, the single point of access (SPA) handled an average of 543 calls per month. We asked the trust to provide details of the time taken from referral being made to the patient been seen, but they were unable to provide this information. This meant the trust were unable to provide assurance that patients were seen in a timely manner. The outcome of each of the calls, for example, if a hospital admission had been avoided, was not consistently recorded by the trust.
- Staff were able provide care for patients in their own homes, or for those patients who were more mobile, care was provided in local clinics.
- The service had taken steps to ensure care was more accessible to the local farming community by providing a clinic, with community nurses, podiatrist and physiotherapists at a weekly market.
- Community nurses provided a range of services at the Oakland Village. Oakland Village is a community village providing a range of accommodation from long term residential care beds to individual apartments. A dedicated team of community nurses were based at Oakland, which provided continuity for those patients needing community nursing. Nurses also provided a clinic at Oakland, which saved patients travelling to the health centre.
- The rapid response care team (RRCT) provided care to patients who required a social care package in order to prevent hospital admissions or to facilitate an earlier discharge from hospital. The team responded within two hours of receiving a referral and were available 8am to 10pm, seven days per week. The RRCT provided support for patients until a care agency could be identified. The majority of patients remained with RRCT for between 10-25 days.
- The cardiac rehabilitation service had monitored the demand for the service and in February 2016 had run an extra rehabilitation programme in order to meet the identified increase in demand.
- For the Erewash area, the trust monitored the number of patients who avoided a hospital admission as a result of been seen by either a community matron or an advanced nurse practitioner. For the six months, between November 2015 and April 2016, there were 1045 occasions when a hospital admission of a patient was avoided.
- However, we saw that the continence advisory service was not accessible to all patients in the community. This service provided specialist advice and support for all patients except for those living in Derby city area. This meant that these patients were cared for by community nurses, rather than receive specialist continence advice.This was because the service was commissioned differently between the city and county, however the trust were working with the commissioners to ensure an equitable service.

Learning from complaints and concerns

- Staff told us they would always try to address complaints informally in the first instance. One matron, for example, told us how they had visited a patient at home with another colleague to allay concerns and discuss problems early, before they escalated into a full formal complaint.
- We saw information about the patient experience team displayed on notice boards in all the clinics and health centres we visited and staff left information leaflets detailing how to raise a concern or complaint in patient homes.
- We saw evidence from minutes that complaints were discussed at meetings such as the ICT and the band six community nurses meetings.

Good

Are services well-led?

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

We rated well led as good, because

- Whilst there was no overall vision or strategy for the community service for adults, staff were familiar with the trust's vision and the 'Derbyshire Community Health Services (DCHS) Way' and consistently demonstrated the trust's values in their day-to-day work.
- There was positive feedback from all staff about the chief executive, and they appreciated the way in which she tried to communicate with staff to keep them up-to-date with trust information.
- There were effective governance arrangements in place. Local managers were aware of the risks in their areas and could discuss the actions being taken to reduce these risks.
- Local leaders were visible and staff told us that they felt supported and valued. Staff said managers were approachable and they felt able to raise concerns. Staff felt listened to and able to influence service delivery.
- Staff spoke positively about the organisation; were proud to work for their team and enjoyed their role.
- The trust, along with other health and social care organisations across Erewash, was selected as one of the first wave of vanguard sites across the country. The vanguard initiative aims to develop new ways of providing care for patients registered with 12 GP practices across Erewash.

However:

- A minority of matrons expressed lack of clarity about the future of the role of the matron.
- Morale was low with some community nursing staff in the Derby city team, who felt unsupported the local leadership.
- There was no strategic approach to monitoring or auditing the quality of the service or outcome measures for patients in order to improve the quality of the service delivered.
- There was an inconsistent approach to obtaining feedback from the public in order to shape and inform the services being delivered.

Service vision and strategy

- There was no overall vision or strategy for the community service for adults.
- However, staff we spoke with were familiar with the 'Derbyshire Community Health Services (DCHS) Way' which was the trust's pledge to staff and patients which promises how they will govern and manage the organisation. The DCHS way had three elements; Quality Service, Quality People and Quality Business, and we saw these used as a framework for recording minutes of meetings and in appraisal documentation. The trust pledge was displayed throughout the clinics and staff bases we visited.
- Without exception, all staff demonstrated the trust's values in their day-to-day work, both when caring for patients and their families and when interacting with colleagues.
- There was some uncertainty amongst some community matrons regarding their role. Matrons told us their roles had changed over time and they were now seeing patients with long term conditions only until the patient was stable. Once the patient had stabilised, care would be provided by a support role with their oversight. We were told that one clinical commissioning group (CCG) was proposing to remove the matron role and replace with the advanced clinical practitioner role.

Governance, risk management and quality measurement

- We found there was a system of governance meetings, which enabled the escalation of information upwards and the cascading of information from the senior management team to frontline staff.
- Most of the community health services for adults sat within the Integrated Community Based Services (ICBS) division. ICBS governance meetings were held monthly.
- Staff told us that governance issues were cascaded down and were routinely discussed at local meetings. We reviewed the minutes of various meetings and found they included information on incidents and complaints. Staff confirmed that if they were unable to attend a

meeting, minutes would be emailed to them. However, there were no arrangements in place for learning from incidents and complaints across the seven different geographical areas.

- Pressure ulcer incidence and the work being undertaken to support teams across the county was reported monthly to the quality service committee. We reviewed the minutes from these meeting and saw evidence that the incidence of pressure ulcers, the themes from root cause analysis and actions taken were discussed.
- Whilst local managers could talk to us about their risks, there were no locally held risk registers. We reviewed the trust wide risk register and saw that some of the risks the managers spoke about were on the trust wide register, for example the risk of patients developing pressure ulcers in the community, and the risks associated with the vacancies within Derby city community nursing teams.
- There was no consistent approach to monitoring and auditing the quality of the service or outcome measures for patients in order to improve the quality of the service delivered. However, some audit activity took place, for example, the monthly patient records audit. Some outcomes measures were being monitored, for example, the Erewash ICT was using the Derby outcome measure (DOM).

Leadership of this service

- Not all staff where knew who the chief nurse was. We asked 35 members of staff of varying grades, 15 knew the name of the chief nurse. However, one member of staff told us the chief nurse had spent a day with them in order to gain insight in to community role.
- All staff were familiar with the chief executive and many spoke positively about her. They valued the weekly email the chief executive sent, saying it was informative. One manager we spoke with had had the opportunity to spend time shadowing the chief executive in order to gain further understanding of management and leadership at a senior level.
- Staff were able to give specific examples of when members of the executive team had supported them with challenges they faced. One staff member spoke of a senior member of the team who had “opened doors” to enable collaboration with a neighbouring trust. Another had gained support to help resolve IT issues.
- The trust supported leaders to develop their leadership skills, with 21 out of 25 integrated care team leaders and integrated care managers completing the developing leader’s course.
- Local team leadership was effective. Staff we spoke with said they were supported from their line managers and that local leaders were visible and approachable. We observed effective local leadership during a team meeting.
- However, there were a small localised group of community nursing staff within the Derby city team, who expressed concerns about the local leadership and felt unsupported.

Culture within this service

- Generally staff spoke positively about the organisation, saying the trust was a good one to work for, and was focused on providing high quality care.
- Staff were supportive of each other within and across teams. We saw evidence of effective teamwork, with staff volunteering to help each other out or to take on additional visits to support each other.
- Staff said they were proud to work for their team and enjoyed their role. Staff we spoke with told us that caring for patients and helping patients to remain at home was the best part of their job.
- Staff generally reported a positive culture in community services, they felt valued, listened to and able to speak up if they had concerns.
- The trust had a lone worker policy and staff we spoke to were familiar with this. We were given examples of how staff were kept safe. For example, risk assessments were carried out if required staff would ‘double up’ for visits.

Public engagement

- The trust sought feedback from patients using the NHS friends and family test (FFT). Patients receiving care in their own homes were given free return postage, so they could complete the FFT cards and remain anonymous, rather than having to return the card to a member of staff.
- Whilst feedback from public was not consistently gained in order to shape and inform the services being delivered, we did see some examples of patient’s feedback being obtained.

Good

Are services well-led?

- Feedback had been sought from patients undergoing the cardiac rehabilitation programme, and this had led to leaflets being produced to support the education programme.
- The brain injury service promoted its service with the public by providing education to GPs on brain injury and were being actively involved in fundraising events in conjunction with the charity Headway.

Staff engagement

- We saw that teams held regular team meetings and we reviewed the minutes of these. This meant there were opportunities for staff to meet formally to discuss issues relevant to the running and development of their service.
- Staff participated in improving the services, for example, we heard how a community nurse had influenced a review of diabetic care, which lead to changing the timings for visits to those patients requiring insulin.
- The trust had an initiative that enabled staff to share their ideas with the executive team. They called this the dragons den. We saw evidence that a community matron had submitted an idea to trial new ways of working with two residential care homes, and was waiting the outcome.
- The trust had a quality people sub-board whose objective was to ensure quality people were recruited by the trust. We heard from a recently qualified occupational therapist who was a member of this group, and how they had been supported by the manager to attend this.
- We spoke with a junior physiotherapist who had developed an education leaflet to support patients to safely use their walking aids. The leaflet was now used trust wide and the member of staff was nominated for a 'rising star' award.

Innovation, improvement and sustainability

- In January 2015, the NHS invited individual organizations and partnerships to apply to become 'Vanguard' sites for the new care models programme, one of the first steps towards delivering the 'Five Year Forward View', which supported improvement and integration of services. The trust and other health and social care organisations across Erewash, were jointly selected as one of the first wave vanguard sites across the country. The initiative aims to develop new ways of providing care for those patients registered with 12 GP practices across Erewash.

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
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(g) The provider must ensure the proper and safe management of medicines. The provider did not ensure there was proper and safe management of medicines. Staff did not maintain a record of serial numbers for prescription pads. Staff did not transport medicines in securely sealed or tamper evident containers.