Braintree Community Hospital Ward

Quality Report

Braintree Hospital
Chadwick Drive (off Rayne Road)
Braintree
Essex
CM7 2AL
Tel: 01376 555900 787 273131
Website: www.provide.org.uk

Date of publication: 17/04/2014
Date of inspection visit: 21-23 January 2014

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

Summary of findings

Contents

Summary of findings

Overall summary

Braintree Community Hospital ward (Courtauld ward) is a 24 bedded facility with an additional four day-treatment beds within the site of Braintree Community Hospital. This inpatient service provides rehabilitation and end of life care for adults. It also offers day case admission for patients undergoing blood and medication transfusions.

We chose to inspect Braintree Community Hospital Ward as part of the first pilot phase of the new inspection process we are introducing for community health services. Braintree Community Hospital Ward was last inspected in April 2013 when we found it to be meeting the five standards we reviewed.

In general, we found that Braintree Community Hospital ward provided safe care. People were protected from abuse and avoidable harm. Whilst mechanisms were in place to monitor, report and learn from safety incidents, there were inconsistencies in staff practice, resulting in under-reporting. The staff skill mix was inadequate with a high use of agency staff.

Staff said that they had good training and development opportunities although clinical supervision arrangements were not as robust. Staff spoke with passion about their work and demonstrated commitment to provide the best care they could.

Patients and their families were central to making decisions about their care and the support they needed. The majority of patients and their relatives were positive about the care and treatment they had received, and we saw some good examples of staff delivering compassionate care to patients and their families.

Although most staff felt very well supported by their managers, we had concerns in regards to the quality of ward leadership and clinical supervision arrangements were not robust.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

In general services were safe because there were systems for identifying, investigating and learning from patient safety incidents and there was an emphasis in the organisation to reduce harm. However, we found inconsistency in the classification and reporting of incidents (other than falls) which meant under-reporting of overall incidents had occurred. Staff skill mix, including the ratio between substantive and agency staff, was inadequate with a high number of agency nurses being employed.

Are services effective?

Inpatient services at Braintree Community Hospital ward were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices. However, the arrangements in place in regards to clinical supervision were not robust.

Are services caring?

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

Are services responsive to people's needs?

Braintree Community Hospital ward was responsive to people's needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time.

Are services well-led?

There were organisational, governance and risk management structures in place. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns.

However, ward leadership was inconsistent and there was an absence of visible senior management support.

Summary of findings

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

Community inpatient services

Mechanisms were in place to monitor, report and learn from safety incidents. However, there were inconsistencies in staff practice in regards to the practical application of these systems, resulting in under-reporting. Staff skill mix, including the ratio between substantive and agency staff, was inadequate with a high number of agency nurses being employed.

Inpatient services at Braintree Community Hospital ward were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices; however, the arrangements in place in regards to clinical supervision were not robust.

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

Braintree Community Hospital ward was responsive to people's needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time.

Ward leadership was inconsistent and there was an absence of visible senior management support. There were organisational, governance and risk management structures in place. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns.

Summary of findings

What people who use the community health services say

The Friends and Family Test (asks a single, standard question: "How likely are you to recommend our ward to friends and family) was conducted at Braintree Hospital between April 2013 to September 2013. The results were consistently poor meaning that patients are less inclined to recommend the ward to friends and family.

The majority of patients we spoke with were complimentary about the care they received.

An internal customer survey was conducted at Braintree Community Hospital between May 2012 and March 2013.

A sample of 211 patient views were collected prior to their discharge, and the results were generally favourable. Negative findings included: "It would have been a 10 but there was a slow response to the call bell", "could not look out of the window as obscure glass was in place", "good food, satisfied with ward but unsure as to the treatment given" and "attitude of staff".

There have not been any patient comments through the NHS Choices or Patient Opinion websites.

Areas for improvement

Action the community health service MUST take to improve

- Ensure effective arrangements are in place to identify, assess and manage risks including 'near misses'
- Ensure sufficient numbers of suitably qualified, skilled and experienced persons are available at all times.

Action the community health service SHOULD take to improve

- Review agency staff use to ensure continuity of care
- Ensure staff are given the opportunities to receive clinical supervision and processes are in place to monitor these arrangements.
- Review staff allocation to enhance observational oversight of patients

Action the community health service COULD take to improve

- Review use of environment to ensure all areas are used effectively to enhance patient experience.

Good practice

- The care provided was person centred and based on evidence based guidelines
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.

Braintree Community Hospital Ward

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

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

Head of Inspection: Amanda Musgrave, Care Quality Commission

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

Background to Braintree Community Hospital Ward

Braintree Community Hospital opened in 2010 after consultation with local GPs and the public for health services closer to where they lived. Braintree Community Hospital ward (Courtauld ward) is a 24 bedded facility; with 16 single rooms and two four bedded bays. There are an additional four day-treatment beds within the site of Braintree Community Hospital. This inpatient service provides rehabilitation and end of life care for adults. It also offers day case admission for patients undergoing blood and medication transfusions. The £16.5m building is one of the first community hospitals to bring together public and private healthcare providers to deliver free NHS services.

These services are managed by Braintree Clinical Services Ltd, owned by Serco, who sub-contract services to Prime Diagnostics Ltd and Central Essex Community Services C.I.C. on behalf of the NHS. Central Essex Community Services C.I.C. run a number of clinics from this hospital, including:

- Adult Speech and Language Clinics
- Community Cardiac Services
- Community Dermatology
- Community Hospital Wards
- Integrated Orthopaedic Service
- Minor Operations (vasectomies / carpal tunnel and minor skin surgery injuries)
- Outpatient Physiotherapy and Occupational Therapy
- Podiatry
- Rapid Assessment Unit
- Podiatric Day Surgery

Why we carried out this inspection

This location was inspected as part of the first pilot phase of the new inspection process we are introducing for

Detailed findings

community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team looked at the following services:

- Services for adults requiring community inpatient services

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

We carried out an announced visit on 23 January 2014. During our visit we held focus groups with a range of staff, we observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the service. We visited community hospitals, health centres, community clinics and accompanied the provider's staff on patient home visits.

We carried out an unannounced inspection to Braintree Community Hospital ward on 23 January 2014. As part of the visit we looked at how services were operated out of hours and what staffing arrangements were in place, specifically around the use of agency staff.

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

Community inpatient services

Information about the service

Braintree Community Hospital ward (Courtauld ward) at Braintree Hospital is a 24 bedded facility with additional four day-treatment beds within the site of Braintree Community Hospital. This inpatient service provides rehabilitation and end of life care for adults. It also offers day case admission for patients undergoing blood and medication transfusions. A total of 632 people used the inpatient facility at Braintree hospital between November 2012 and October 2013. During our inspection, we spoke to approximately five patients and six staff.

Summary of findings

Mechanisms were in place to monitor, report and learn from safety incidents. However, there were inconsistencies in staff practice in regards to the practical application of these systems, resulting in under-reporting. Staff skill mix, including the ratio between substantive and agency staff, was inadequate with a high number of agency nurses being employed.

Inpatient services at Braintree Community Hospital ward were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices; however, the arrangements in place in regards to clinical supervision were not robust.

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

Braintree Community Hospital ward was responsive to people's needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time.

Ward leadership was inconsistent and there was an absence of visible senior management support. There were organisational, governance and risk management structures in place. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns.

Community inpatient services

Are community inpatient services safe?

Safety in the past

We found that community inpatients were protected from abuse and avoidable harm as staff were confident about reporting serious incidents and providing information to the ward matron or senior manager if they suspected poor practice which could harm a person. However, we found that some 'minor' incidents were not reported. For example, in one patient's records staff had recorded that the patient was bruised. No action had been recorded in regards to the cause or action taken in response to this observation, nor had this incident been recorded in the electronic reporting system. Staff we spoke with were aware of the safeguarding policy and had received training at the appropriate level with regards to safeguarding vulnerable adults. The 2014 mandatory training records reported 100% attendance at Safeguarding Adult and Children levels 1-3 at Braintree Hospital Ward.

Information highlighted by the NHS Safety Thermometer assessment tool (used by frontline staff to measure a snapshot of these harms once a month) identified an increase in pressure ulcers between April 2013 and June 2013 for the over 70's group. However, this snapshot figure is of all patients identified with a pressure ulcer and includes patients that may have been admitted with existing pressure damage as well as those patients that have developed a pressure ulcer whilst in hospital. The provider reported no occurrences of grade 3 or 4 pressure ulcers on the ward between April and November 2013.

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

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

We looked at the current medicines storage arrangements and found that medicines, including emergency drugs, in the ward were stored safely for the protection of patients. A comprehensive recording chart was available for the prescribing and recording of medicines. These charts were well completed, provided an account of medicines prescribed and demonstrated that patients were given their medicines as prescribed. However, we found that where people were given their medicines in the form of a skin patch, the site of application was not always recorded. This could result in damage to a person's skin if the same site was used repeatedly.

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

Learning and improvement

Fifty-one falls had been reported between April 2013 and December 2013 for the Ward. A root cause analysis (RCA) investigation was conducted for each of these incidents and the data was entered into Datix. The provider identified there was an increasing trend in the number of falls that had been reported during the six months to December 2013. As a result, the provider planned to conduct a review to monitor the incidence of patient falls in relation to the numbers of staff on duty, the ratio of agency staff and the location of staff on duty when falls had occurred.

Staff were familiar with the reporting systems for incidents; however, their knowledge of reporting was mainly around falls. The senior manager was identified as the person responsible for reporting incidents into the electronic Datix system. This person was not present at the time of this visit. Staff were not confident in regards to the identification of near miss incidents and as such near miss incidents were underreported. For example, one member of staff had been rostered to provide one-to-one support to a patient identified to be at high risk of falls. However, we observed two additional patients, both that had been addressed to be at high risk of falls, had been accommodated within the same bed bay area as this patient. As such the one-to-one support that the risk assessment management had indicated the patient required was not provided. Staff had not recognised this non-compliance with the risk management plan to be a risk and had not reported it into Datix. Staff told us that they did not report incidents that had been "resolved locally". This meant that senior staff had not been sighted in regards to the frequency of such events and were not able to take such information into account in determining future staffing requirements.

A customer experience report was produced on a monthly basis for the Board and provided an overview of customer

experience across all locations. This report included an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. Complaints were categorised as only concerns, moderate or severe. There were no severe complaints to date in November 2013 and 55 complaints attributed to the inpatient wards at all three sites. The report outlined individual complaints and how they were dealt with and the key learnings to be shared. One complaint related to a patient who had fallen on the ward.

Systems, processes and practices

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

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

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

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

We saw that all members of the multidisciplinary team were involved in root cause analysis investigations and action plans had been developed and implemented.

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

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

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

Monitoring safety and responding to risk

On the day of inspection, we found that staffing levels and skills mix did fully support safe practice. We noted that the November 2013 quality and safety committee board report identified a staffing shortfall of five full time equivalent qualified staff and a half full time equivalent healthcare assistant. The risk register noted that the ward management had been restructured and an advert placed for an additional one band 6 and one band 5 nurses to support the current team. Staff confirmed this; however, whilst this was positive, the current numbers were inadequate considering the high bed occupancy in this ward (reported 98% bed occupancy from April 2013 to October 2013).

There was a consistent high use of agency staff. One agency nurse had worked on the ward for three years. Both agency and substantive staff confirmed that agency staff were present on every shift. We looked at staffing rotas and found that a range of 75% to 86% agency staff were on duty on each shift on 22 January 2014. We noted a similar pattern of high use of agency staff throughout the week

beginning 20 January 2014 and other weeks in January 2014. Staff told us “Staffing levels at Braintree are not as high as they could be which is why we have to use agency staffing a lot."

The ward was 24 bedded with 16 single rooms. Patients were allocated to beds according to the level of observation they required. For example, patients who were identified to be at risk of falls were accommodated in beds closest to the nursing station so that they could be closely observed and monitored. However, we found that the ward layout resulted in poor staff visibility, particularly when staff attended to patients accommodated within single rooms. We also observed inadequate staffing arrangements to cover staff breaks. For example, we saw one qualified nurse go on a break, one nurse performing medication administration which left only one nurse responsible for all 24 patients. This resulted in frequent interruptions to those tasks the available staff were engaged in, including medication administration. We observed a patient in a side room who was in pain waiting for a long time before we advised staff that the patient was in pain and assistance was offered.

Information relating to patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents. The notice board reported that there had been no healthcare associated infections attributed to the ward in the previous six months, and a high compliance of over 90% on the cleanliness and hygiene audits.

A range of risk assessments were undertaken to ensure staff and patient safety, of which all the staff we spoke with were aware. These included: ward environment; lone working; manual handling; Control of Substances Hazardous to Health (COSHH); and ward security.

Anticipation and planning

The majority of staff we spoke with reported that they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The 2014 central log for mandatory training confirmed that nearly all staff on the ward had attended required mandatory training.

The systems and processes in place to identify and plan for patient safety issues in advance, such as staffing and bed capacity, were not always safe. Staffing levels had recently been revised and the number of staff increased. However, recruitment processes to meet the increased establishments had not been completed and the staffing shortfall was being met with agency staff. However, we noted that patient dependency tools were not used to calculate staffing ratios and staff told us that staffing shortfalls remained and that this compromised patient care. The provider told us that a project was underway to develop their own tool.

Where staff identified potential concerns relating to patient safety, these were assessed and recorded on the directorate risk register. The directorate risk register identified concerns regarding staffing arrangements on this ward and the actions that had been taken to mitigate the risks. The corporate risk register stated that an e-rostering project had been initiated at three sites (including Braintree) which should reduce dependency on bank and agency staff and better manage the staff mix in services.

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

Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, nutritional needs, and falls and infection control risks. Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care. We saw falls assessments being carried out within six hours of admission. Patient admission assessments were logged in a book and then entered on to the computer. Staff told us that the action was taken to ensure compliance with the six hour assessment process.

Are community inpatient services effective?

Community inpatient services

(for example, treatment is effective)

Evidence-based guidance

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

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

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. For example, we reviewed the records for one patient who had been assessed as lacking capacity to make decisions and for whom a decision had been made not to attempt cardio pulmonary resuscitation (DNACPR). We saw that the appropriate people, including relatives had been involved in the decision making process and that the decision had been clearly documented in the patient's notes. We also saw mental capacity act assessments had been carried out in all three sets of patent records reviewed.

Monitoring and improvement of outcomes

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

Medication administration records were not audited. A senior nurse told us that any errors or omissions would be picked up the next time they were used. There was no formal process for trend analysis of errors or omissions identified by staff responsible for the administration of medications. As such opportunities to improve practice are limited.

Staffing arrangements

Systems and processes to identify and plan any potential staffing and bed capacity issues were ineffective. This resulted in last minute requests for additional staffing when the staffing numbers on duty were deemed inadequate to meet patient demand. Interactions with patients was limited one patient told us "the staff seem helpful but I don't see them a lot of the time". We observed furniture being moved between various bay areas to accommodate together those patients who had been identified to be at high risk of falls. The action was taken to accommodate a patient that required admission on the ward. One member of staff told us "It was really manic just now. We just had an admission and moved everyone all around".

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

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

Staff told us there was access to mandatory training study days. They told us that the content was appropriate and included infection prevention and control, moving and handling, medicines management and health and safety. We looked at the mandatory training attendances as recorded by Central Essex Community Services C.I.C. in January 2014 and we found that overall an average of 93%

of staff have met their training requirements on the Braintree Hospital Ward. This showed the provider ensured staff had the right skills, experience and support to deliver safe efficient care.

Whilst some staff reported that they had received an appraisal within the last year, some staff had not. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. Although mechanisms were in place for staff to receive clinical supervision, there were inconsistencies in practice. Some staff had not received any clinical supervision and others expressed concern in regards to the lack of structure of the supervision they had received.

Information provided within the organisation's Learning and Development Quarter 2, 2013 report identified that only 27% of staff were receiving clinical supervision within this period. However it was noted that the provider had already taken action to improve their performance through the review and introduction of a revised clinical supervision policy. Further work was needed by the provider to ensure effective implementation and monitoring of compliance with the standards set within this policy.

Multidisciplinary working and support

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

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

Communication between staff was generally effective, with staff handover meetings taking place during daily shift changes. We heard staff handover discussions that included information regarding risks and concerns of each patient, discharge date and plans as well as any issues that required follow-up.

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

Medical staff cover was provided by local general practitioners, the only exception being out of hours cover, which was via an external agency. Staff told us that on occasions there had been delays in medical staff attendance out of hours. In those circumstances emergency services had been called. When asked, staff confirmed that delays in medical staff attendance were not consistently reported as 'near miss' incidents.

Are community inpatient services caring?

Compassion, dignity and empathy

We observed all staff treating patients and visitors with dignity and respect and taking extra time with patients who didn't have full capacity to fully understand the advice being given. One patient said "They do all they can. I have no complaints." A staff member told us "most staff will go the extra mile" and "Patients are well looked after here".

Compliance with same-sex accommodation guidelines was ensured through the designation of single sex bay areas and ample provision of toilet and bathing facilities. We observed curtains being drawn around each bed prior to delivery of care and discussions with patients in regards to their care.

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

We observed staff treating people with compassion and empathy. We saw a nurse speaking kindly and quietly to a patient whilst testing their blood pressure.

Involvement in care

Patients and their families were involved in and central to making decisions about their care and the support needed.

Community inpatient services

We found by looking at care plans, reviewing clinical guidelines and talking to families and staff that care was planned in accordance with best practice as set down by national guidelines.

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

Staff had a good understanding of consent and applied this knowledge when delivering care to patients. Staff had received training around consent and had the appropriate skills and knowledge to seek consent from patients or their representatives. On the majority of instances we observed positive interactions between staff, patients and /or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered.

A range of literature was available for patients, relatives and /or their representatives and provided information in regards to their involvement in care delivery from the time of admission through to discharge. This included: complaints processes, key contacts information and follow-up advice for when the patient left hospital.

On the majority of occasions we observed positive interactions between staff and patients, this was particularly the case at meal teams. We observed one patient's call bell had been buzzing for a couple of minutes. The patient told us "I'm waiting to get into bed." The healthcare assistant who arrived assisted in a nice and pleasant manner. However, we did observe a lack of involvement between staff and patients. A patient in a four bedded bay said "I'm happy but bored. I can't really chat to other patients and "staff don't have much time to chat".

Trust and respect

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

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care.

The mandatory training log January 2014 noted that 100% of ward staff had received equality and diversity training. Staff we spoke with confirmed that they had received this training and could demonstrate through the care planning process that they were taking into account each person's culture, beliefs and values. Staff described that there were no large ethnic minorities within their catchment areas. However, they were all aware where support could be obtained if it was required, for example, a translator if English was not the person's first language. There was a patient whose first language was Hindi but she could also speak some English. A nurse who also spoke Hindi was working on the ward and was talking to the patient.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. We observed positive interactions between staff and patients, where staff knew the patients very well and had built up a good rapport. We saw staff providing reassurance and comfort to people. One patient, who had recently had a leg amputated and was in a wheelchair for the first time, told us that staff had helped to manage their fears and stresses.

An advocacy service, provided by Age Concern Essex, was available providing additional assistance to patients in making any crucial decisions about their future.

The large patient communal day room / dining room was set up as a staff meeting room and staff told us that patients were not encouraged to use this facility. This meant that patients were afforded limited opportunities to socially interact with one another.

Community inpatient services

Are community inpatient services responsive to people's needs?
(for example, to feedback?)

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

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

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

Access to services
Accessibility to the ward was good as services were provided on the first floor level with lifts and stairs and ample free car parking available on site.

Patients could access the ward by referral from three main routes which were either from the onsite rapid assessment unit (RAU), from the rehabilitation wards at the acute hospitals or from the persons own GP. The system in place meant that patients with specific needs could be admitted in a timely manner to receive appropriate care.

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

Where patients lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. For example, we reviewed the records for three patients and saw mental capacity act assessments had been carried out with clearly documented decisions.

Staff told us, and we observed, that where possible patients who were vulnerable or confused were accommodated within the same ward area, with a member of staff specifically assigned.

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

Discharge planning commenced at the point of admission for all patients. The length of stay was between 12 days (admissions avoidance) or 28 days (rehabilitation). This timescale was flexible and increased or decreased according to the patient's progress. Information relating to the average length of stay and time to discharge was displayed on notice boards in the ward area and the provisional date was also displayed on a board behind each bed so patients, their representatives and healthcare staff were aware of the expected discharge date and could prepare accordingly. Staff told us discharge planning had improved in the last few months with the arrival of the new acting ward manager. And "realistic discharge dates are given".

Community inpatient services

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

If patients were medically fit for discharge but required an onward appointment which could be several weeks away, arrangements are made to support them at home in-between. Some staff expressed concern at delays in discharging patients that required continuing health care placements.

We saw that medicines prescribed on a "when required" basis, for example for pain relief, were offered and given to patients when they needed them. We also found that people were encouraged to look after and take their medicines themselves in preparation for discharge. Patients we spoke with told us they had been given enough information to be able to understand and take their medicines safely.

Discharge delays relating to equipment were rare. It was ordered quickly and arrived the next day. Longer term adaptations were organised by patients themselves via independent companies, with support put in place in the interim.

Learning from experiences, concerns and complaints

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

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

Patient Advice and Liaison Service (PALS) leaflets were available but these were not clearly visible.

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

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

Are community inpatient services well-led?

Vision, strategy and risks

Staff were clear about the organisation's vision and underwent a corporate induction which included the provider's core values and objectives for the organisation. Information relating to core objectives and performance targets were visibly displayed in the ward area.

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

The provider's priorities, as outlined in the Quality Account of June 2013, for 2013/2014 focused mainly around patient safety. Priorities that were applicable to the inpatient ward

were: working with other relevant organisations to develop a holistic and integrated frailty pathway; maintaining MRSA and Clostridium Difficile performance; and building on the pilot approach to Customer Engagement.

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

Quality, performance and problems

We saw that the Board received quality and safety reports every other month that included information such as staffing vacancies, numbers of falls and pressure ulcers, medications incidents, serious incidents and HCAI indicators by service level. We noted that discussion about quality indicators had become more detailed and focused in the last six months. The acting ward matron held weekly performance discussions with the manager of the social care facilitator who worked on the ward.

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

Leadership and culture

Ward leadership was weak. We observed reactive management of staffing and capacity concerns that impacted on the quality of interaction between staff and patients, and between nursing staff and other members of the multidisciplinary team. Senior managers were not visible and some junior staff were not aware how to access senior manager support out of hours.

Patient experiences and staff involvement and engagement

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

The Friends and Family Test (asks a single, standard question: "How likely are you to recommend our ward to friends and family) was conducted at Braintree Hospital between April 2013 to September 2013. The results were consistently poor meaning that patients are less inclined to recommend the ward to friends and family.

The majority of patients we spoke with were complimentary about the care they were receiving and the staff delivering care.

Learning, improvement, innovation and sustainability

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

A training matrix listed the courses that ward staff had completed and outlined what was required for each staff member. Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data demonstrated a 93% mandatory training completion rate for staff working at Braintree Community Hospital ward.

We noted that the majority of the training was done through e-learning; this is a computer generated way of learning. Staff watched a video or briefing and have to answer questions on a specific subject. The e-learning training included modules around dementia and safeguarding vulnerable adults, which also included managing patients with challenging behaviour. Other training such as manual handling was classroom based as staff needed to carry out practical tests to confirm competence.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not protected people by means of an effective operation of systems to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 10(1)(b) and 10(2)(c)(i)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Treatment of disease, disorder or injury

Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

How the regulation was not being met: The provider has not ensured that at all times there are sufficient numbers of sufficiently qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity.

Regulation 22