

Lancashire Care NHS Foundation Trust

RW5

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RW5AQ	Longridge Hospital	Community Inpatients	PR3 3WQ

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated the community health inpatient service as 'requiring improvement' overall because:

- The ward had encountered issues with nurse staffing. In a three month period 1 June 2016 to 31 August 2016, 25% of shifts had been short of substantive staff. Sickness and vacancies accounted for the issues which were managed by bank staff or overtime.
- The ward did not participate in national audits to monitor outcomes of some of the conditions that were being treated, for example, hip fracture and sentinel stroke national audit programme. During the inspection there were two patients with these sub-acute conditions.
- The ward had input from pharmacists, physiotherapists, occupational therapist and an integrated therapy technician, however, the increased number of patients requiring rehabilitation meant the service was under pressure and some patients did not receive timely treatments.
- Although there was a gym on site, it meant leaving the ward with the patient and the time commitment to one patient would leave no time for any others. Consequently, the gym was not fully utilised.
- Equipment that was essential to monitor a patient's nutritional needs was broken and a replacement had not been ordered.
- Staff were unsure of the future of the unit and therefore the direction and strategy was also unclear. Some staff had been expected to continue to work on a month-by-month contract and long-standing well trained staff were looking for alternative roles.
- Due to the variable nature of the patients on the ward, patient outcomes were not routinely collected. Discharge plans were discussed from admission but were based on individual patient needs and did not follow any benchmarked outcomes.
- The management of the risk register was poor and changes had not been recorded, one risk was three years old and no changes to the register had been made.

However:

- The ward staff knew how to report incidents and as a result improvements were made to ensure patients were safe. Analysis of incidents was undertaken and changes were implemented across the team.
- All ward areas were visibly clean and clutter free. The ward was undergoing a deep clean during the inspection. Infection control audits and hand hygiene were regularly undertaken and results gave assurances of good compliance.
- We examined ten sets of health care records that demonstrated good care plans were in place. Patient's needs were assessed and patient centred goals were set. Regular reviews were done and treatment was delivered in line with evidence based guidance.
- The ward used nationally recognised assessment tools when monitoring patient's health. Pain, nutrition, hydration and skin condition was regularly assessed and treatment delivered following best practice guidance.
- Key staff had undertaken additional training to become specialist nurse champions. The ward had dementia, safeguarding, tissue viability, end of life and infection control champions. These staff were responsible for ensuring ward procedures were up to date and provided advice and support to their colleagues.
- Patients were well cared for on Longridge ward. We observed staff attending to patients in a kind and caring manner, with dignity and respect and this was confirmed with patient led assessment results being better than the national average in many areas. Staff told us how much they enjoyed their job, and caring for people from the local community.
- Patients at the end of their life were cared for well at Longridge. Staff had completed individualised care plans to document the patients' wishes. We saw guidance and procedures for caring for the dying

Summary of findings

patient and appropriate use of medicines. Relatives were encouraged to stay with their loved ones while they were cared for on the ward and a named nurse was assigned to the patient and family.

Summary of findings

Background to the service

The Longridge Community hospital is situated in the town of Longridge, eight miles from the city of Preston. Longridge ward is an established 15 bedded nurse led inpatient unit that provides step up, step down and end of life care. The unit is open 24 hours and medical cover is provided by GP's based at the two surgeries in Longridge. Out of hours medical cover is provided by the Preston out of hours service. Admission criteria was that patients must be registered with a Longridge GP. Their condition must be such that treatment at home is not appropriate or that post-surgical or medical care, rehabilitation or end of life care is required.

The community hospital also hosts clinic rooms for outpatient services. A large physiotherapy facility and kitchen assessment facility are available on the ground floor to enable rehabilitation to progress.

During the inspection, we visited the ward over two days. We spoke with 21 staff, five patients and reviewed 10 sets of health care records.

Our inspection team

The team was led by:

Chair: Neil Carr, OBE, Chief Executive South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Head of inspection: Nicholas Smith, Head of Hospital Inspection, Care Quality Commission

Inspection Managers: Sharon Marston and Nicola Kemp, Care Quality Commission

The team that inspected community inpatient wards included one CQC inspector, and a specialist advisor.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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 the inspection visit, we reviewed information that we held about these services, asked a range of other

organisations for information, and held focus groups with patients, carers and staff. We also conducted key interviews with executive, non executive and senior management team members.

During the inspection visit, the inspection team:

- visited the community inpatient unit at Longridge Hospital
- observed staff providing care and treatment to one patients on the unit
- spoke with five patients

Summary of findings

- spoke with 21 staff members individually; including doctors, nurses and occupational therapist
- looked at 10 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider say

Patients described the ward as “for recuperation it is the finest place you can come to” “wonderful, there is nowhere better” “all staff are amazing”.

Areas for improvement

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

The provider must:

Ensure all patients, with a sub-acute condition, using the service are assessed and treatment delivered in line with best practice guidance.

Staffing levels are sufficient to provide therapeutic assessment and input and health care assistants that continue therapeutic treatment have appropriate qualifications and training.

Provide staff with regular updated training to provide end of life care, basic life support and conflict resolution to maintain staff competencies.

Repair or replace chair scales to ensure correct weight measurements can be taken.

Routinely collect patient outcomes and ensure that discharge plans follow benchmarked outcomes.

Review the risk register to ensure it is a true and accurate record of the current identified risks. This should be kept up to date and be regularly reviewed.

The provider should:

Involve staff with the commissioning decisions in relation to the future arrangements for the unit.

Lancashire Care NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the community health inpatient service as 'good' for safe because:

- The ward had an excellent record of safety performance over time. Patient falls were the most common incident that occurred and there was evidence of lessons learned as a result of analysis. Staff were able to tell us about the system used for recording incidents and give us examples of what should be reported.
- The medicines management processes in place kept people safe. Regular GP visits and pharmacist input meant prescribing, acquisition and administration was appropriate to patients' needs. All medicines were stored and disposed of safely. Policies and procedures were adapted specifically for the ward.
- Staff received safeguarding adults training and could give examples of when to escalate safeguarding concerns.
- Risk assessments and regular monitoring was carried out to ensure that deteriorating patients were recognised and treated appropriately.

- Staffing levels were monitored and assessed daily to ensure patients were safe. At the time of our inspection, the staff sickness level was 14% for substantive staff, however safe staffing levels were maintained using overtime and bank staff.

However:

- The hours of therapist time commissioned for the ward did not meet the needs of the type and number of patients who were admitted.
- Staff mandatory training was good overall but the number of staff completing basic life support and conflict resolution training was lower than the trust target of 85%.

Safety performance

- The inpatient ward at Longridge Community hospital participated in the NHS safety thermometer programme which is a national 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 four key safety areas which are

Are services safe?

new pressure ulcers, catheter related urinary tract infections (CAUTI), venous thromboembolism (VTE) and falls. Although the ward had a harm free care noticeboard, the safety thermometer was not displayed.

- In a twelve-month period from August 2015 to July 2016, there were 15 incidents of pressure ulcers recorded on the safety thermometer. There were two grade four and two grade three pressure ulcers, according to the incident reports completed. The other eleven pressure ulcers reported were grade two. All other key safety areas had been recorded as zero. The rate of harm free care was recorded as a total and for the 12 month period was 91% which was worse than the England average of 94.2%. This could be explained by considering the average length of stay is higher than in an acute setting and therefore some patients with pressure ulcers may be present for several months.

Incident reporting, learning and improvement

- Incidents were recorded on the trust incident reporting system. All levels of staff we spoke with were confident using the system and gave appropriate examples of what should be recorded.
- From 1 September 2015 to 31 August 2016, there were 134 incidents reported on Longridge ward. The incidents were graded and ranged from 'no harm' to 'severe.' There were 109 incidents recorded as low or no harm. The highest category was level four, which was severe, of which there were six recorded. Four relating to pressure ulcers acquired prior to admission and two were incidents of assault of staff by patients who required mental health input. Analysis had been done and actions taken as a result of the incidents.
- There was evidence of lessons learned from analysis of incidents. A health care assistant told us that regular post fall audits were undertaken every three months and common themes or learning was discussed as a team to improve patients' safety.
- However, there were three separate incidents over a four-month period relating to injuries caused by opening or closing of windows on the ward. Despite the maintenance company being informed in March 2016 and again in June, there was a further incident in July 2016 causing harm.

- Senior staff were aware of their responsibilities relating to duty of candour legislation. Though there were no examples of its use on the ward, we were confident that the staff understood when it would be appropriate. 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.

Safeguarding

- All staff we spoke with had a good understanding of their responsibilities in respect of safeguarding and were aware of how to respond to protect vulnerable people. There was evidence in the incident report system that staff raised concerns when they considered patients to be at risk.
- Safeguarding and mental capacity training formed part of the trust mandatory training programme. Staff were trained to level two for safeguarding children and adults. The team at Longridge were compliant with training and 100% had completed safeguarding adults training and 95% had completed level two training for children.
- There was a link nurse with specialist knowledge in safeguarding who worked on the ward. Ward staff could approach this staff member for advice and support. This member of staff was responsible for keeping policies and procedures up to date in a file that was available to all staff.

Medicines

- Medicines were managed well on Longridge ward. Medicine policies were available electronically on the intranet and some specific guidance for the ward was available in paper format, for example, End of Life Prescribing Guidance. These were appropriate and up to date.
- Patient's medication was regularly reviewed by GP's who visited the ward from Monday to Friday. The out of hours GP service was utilised for requests in the evening and weekends. There was a specimen signature list of all staff who regularly prescribed and administered medication.

Are services safe?

- A part time dedicated pharmacist ensured patient's medication was appropriate and safe. She had responsibility for medicine reconciliation, which is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, checking for accuracy and any contraindications in prescribing. The pharmacist also provided guidance to staff and patients and participated in ward meetings including morning ward rounds and planned discharge meetings. She was also responsible for medicine audits on the ward and ensuring procedures were accurate and regularly reviewed.
- Medicines were obtained from a neighbouring acute hospital pharmacy and we were told there were very few problems with supply.
- There were four medication incidents recorded from 1 September 2015 to 31 August 2016, relating to supply or transfer from the acute hospital. Scanned emails were sent to the hospital to ensure there was an audit trail of requests.
- Patients' own medication was used if patients were admitted out of normal working hours and General Practitioners (GP's) could prescribe to local pharmacies if necessary.
- A weekly top up service, provided by the neighbouring trust, ensured the ward was kept stocked of the most frequent medicines used.
- During our inspection, we observed staff giving patients medications, including controlled drugs. Staff administered medication in accordance with local policy and professional standards including two people going to the bedside when administering a controlled drug. Staff wore red 'do not disturb' tabards while completing medication rounds to stop any unnecessary interruptions that may affect safety. This process has been introduced since the last inspection
- We checked the environment in which medicines were stored and disposed of. All medicines were stored appropriately in locked cupboards and were within expiry date. Medicines requiring refrigeration were stored in fridges that were locked and temperatures monitored daily. Staff knew what to do if the fridge went out of the specified range of between two and eight degrees centigrade. Temperature logs were all within range.
- Staff appropriately completed daily checks of controlled drugs (CD) record books. We saw staff had completed them appropriately as per trust policy. Staff recorded patients' own supply of CDs in a separate book so that these were not confused with the wards supply of CD medications. Samples were checked during the inspection and were found to be accurate.
- New bedside lockers had recently been purchased that could accommodate a patient's current medication. The locker had a specific storage drawer where prepared discharge medication could be kept along with any patient specific creams, ointments or sprays.
- Medication no longer required was disposed of using labelled sharps bins and controlled drug denature kits that were stored correctly in a locked cupboard.

Environment and equipment

- We saw an independent fire survey being carried out during the inspection. The inspectors were satisfied that the ward facilities were appropriate.
- We checked all electrical equipment on the ward to ensure it was safe and had been appliance tested. We found two pieces of equipment in storage that had passed its retest date. Senior staff were informed and maintenance staff retested the equipment the same day.
- There were kitchen facilities on the ward for staff and patient food storage and heating. One of the two fridges was broken and the room was clean but crowded, old and worn. The domestic supervisor told us an assessment had been completed and there were plans to refit the kitchen and add a larger fridge to accommodate the evening meals. No dates had been set for work to commence.
- There was sufficient and appropriate equipment to assist the moving and handling of patients. Mechanical hoists including the bath hoist, walking frames and wheelchairs were clean and serviced where appropriate.
- There was mobility equipment including hoists, wheelchairs and walking frames that were stored safely and had 'I am clean' stickers as appropriate. There was a good stock of clean linen and slings were tested with visible weight categories attached.

Are services safe?

- We were told that the chair scale had been broken for some months. It was reported as an incident in July 2016 and the action taken was to recalibrate the weighing facility on the beds on the ward. However, at the time of inspection, two nurses told us that the beds were still inaccurate and a patient had weighed 80kg in bed and 62kg when he stood. This is an issue when patients are undergoing continuous nutritional assessment.
- The ward had standardised resuscitation equipment that was checked daily and a checklist had been implemented since the last inspection. The trolley and equipment was clean, tidy and in good order. No emergency medication was available apart from a number of anaphylaxis drugs kept in the locked cupboard. We asked staff about the lack of arrest drugs and were told that this was in line with the trust resuscitation policy.
- Clinical and domestic waste was correctly segregated and in appropriate containers. Sharps were used and disposed of correctly and in line with trust policy.

Quality of records

- We reviewed the health care records of 10 patients on the ward during the inspection. The records were stored safely in a lockable trolley behind the nurses' desk. The ward used paper-based records that were tidy and legible.
- All 10 sets of records demonstrated evidence of thorough risk assessments, including nutrition and hydration, dementia, falls, pain and pressure ulcers. These were completed in a timely manner after the patient had been admitted and we saw evidence they were regularly reviewed.

Cleanliness, infection control and hygiene

- All areas we inspected at Longridge Community hospital were visibly clean and tidy. In the most recent patient led assessment of the care environment (PLACE), the ward scored 100% for cleanliness, which was higher than the national average of 98%.
- An audit had been performed in October 2015 that used a nationally accredited audit tool, produced by the Infection Prevention Society (IPS 2005) to assess and monitor the standards of infection control on the ward. The comprehensive audit measured against 167

statements. The results were excellent, showing 95% compliance with a four point action plan for improvements. The issues had been addressed. The ward participated in the 'Essential Steps' audits involving assessment of staff and facilities on the ward at regular intervals. We saw evidence of the last three assessments carried out in January, April and July 2016. The ward passed all aspects of the audit including hand hygiene, personal protective equipment and aseptic non-touch technique. In January 2016, 20 observations gave 100% compliance.

- We observed a ward deep clean in progress during the inspection. Patients were moved from the bay whilst a team of domestics ensured all surfaces were cleaned. This process was carried out every six months. All bedside curtains were clean and had been replaced in the last month.
- There was a notice board in the main corridor of the ward displaying infection prevention information. The names and contact numbers of trust Infection Prevention Control (IPC) team was displayed along with the IPC link nurses for the ward. There were leaflets demonstrating correct hand washing techniques and the World Health Organisation guidelines: Five Moments for Hand Hygiene.
- We saw a procedure for how to manage outbreaks of *Clostridium difficile*.
- Sanitizing hand gels were visible and in suitable locations at ward and patient room entrances, we saw both staff and patients using the gel. We saw personal protective equipment available for staff, where required, such as gloves and aprons. Hand sanitizer, and wash lotion were available at hand wash basins. Staff observed the trust policy of 'bare below the elbows'.
- The ward had rooms with several occupancy options and allowed patients to be segregated with known or suspected infectious conditions. There were three single rooms, two twin bedded rooms and two four-bedded bays. Each area had en-suite toilet facilities, which helped to prevent the spread of any infection.
- We saw an inpatient known to have Methicillin-resistant *Staphylococcus aureus* (MRSA) infection who was cared for in a single bedded side room and all appropriate precautions to prevent spread of infection was taken. On discharge, the patient's room was deep cleaned.

Are services safe?

Mandatory training

- The trust had a programme of mandatory training that all staff undertook on a regular basis. Training was delivered either in face-to-face sessions or via the intranet e-learning modules. Knowledge was refreshed either every one, two or three years, depending on the subject.
- Training included; infection control, resuscitation, health and safety, safeguarding and manual handling. Staff requirement to complete the training was dependant on their clinical input and job role.
- The compliance rate for staff working on Longridge ward was good. There was an overall compliance rate of 93%. Compliance was 95% or 100% for twelve mandatory subjects, but basic life support (BLS) was 82%, completed the annual BLS training and conflict resolution was only 67%. This was below the trust target of 85%. This had been a concern at the last inspection, yet we found only 16 out of 24 staff had completed conflict resolution training at the time of this inspection. This was a requirement every three years and access to the course appeared to still be an issue.

Assessing and responding to patient risk

- All patients were assessed on admission following key guidelines for assessment. This included risk of falls, tissue viability checks and nutritional screening. Patients were then given a bed based on their need for observation and higher risk patients were in plain sight of the nurse base. We saw assessments in all ten sets of records reviewed.
- The trust had a policy for monitoring patients and the use of an early warning score (EWS) tool was seen. Patients at Longridge were monitored at least 12 hourly and the frequency increased if the score suggested the patient was deteriorating. The EWS score was based on the patient's temperature, pulse and respiration rate.
- The policy for caring for a deteriorating patient was seen and had clear guidance for ensuring patients' safety. A resuscitation trolley, oxygen and suction were available but no emergency drugs because of resuscitation team guidance.
- We spoke with three staff who explained the process if a patient deteriorated. All staff knew not to delay calling

the emergency services if a patient deteriorated. Patients could be transferred to the neighbouring acute hospital if they were suspected of having sepsis or another condition requiring urgent care.

- The ward staff held handover meetings at the change of each shift. Each patient was discussed with key factors mentioned and updates on changes in their condition, including mobilisation, diet and discharge if appropriate. Multi-disciplinary team meetings were also held to ensure all key staff were aware of the patient's progress.

Staffing levels and caseload

- Since the last inspection, the ward had acquired an electronic safe staffing tool. Daily input of patient numbers and levels of care required determined the number of staff required to provide safe care. This was reported as Care Hours per Patient Day (CHPPD). The system also had a red flag system when the actual staffing numbers were insufficient and managers then had the ability to plan in advance. A situation report was provided to clinical managers twice a day to enable them to make decisions regarding staffing.
- During the period 1 June 2016 to 31 August 2016, the ward had a deficit of staff, according to the CHPDD tool, on 70 occasions from 277 shifts. This meant that 25% of the time the ward had staffing difficulties. The largest reported deficit on one shift was 20 hours. No temporary staff were used on this occasion and utilisation was 170%, which meant substantive staff worked additional hours.
- Temporary staff accounted for an average of 10% of the staffing numbers in the same three month period. They had been utilised on 158 occasions and attributed between 2% and 72% of the total nursing team on those shifts. There were two incidents recorded on the incident reporting system, when agency requests had not been fulfilled.
- At the time of the inspection, we were told that the ward was short of five substantive registered nurses due to sickness and vacancies. Two senior ward staff were on sick leave at the time of the inspection. The 'acting' ward sister was a temporary post and they had been unable to temporarily backfill her post. The nurse in charge provided staffing updates to the management team twice a day in a 'situation report'.

Are services safe?

- Three healthcare assistants were also working on temporary contracts that were being extended on a month-by-month basis due to the uncertain future of the unit. This had led to feelings of insecurity and staff applying for permanent posts elsewhere when they clearly loved working at Longridge.
- The shortfall in the number of therapists was listed on the risk register. The number of step down patients from the acute setting had increased since the needs of the ward had been assessed and staffing commissioned. The ward had visits from a physiotherapist 16 hours per week, an occupational therapist 15 hours per week and an integrated therapy technician for 22.5 hours per week. Dietician, speech and language and neuro-rehabilitation were available following a referral. Both nursing and therapies staff told us they could not meet the demand of the number of rehabilitation patients admitted to the ward. We saw two patients, during the inspection who required daily assistance, yet therapists were only available three days per week.

Managing anticipated risks

- Staff told us they felt particularly vulnerable at night when the downstairs clinic was unmanned and the only staff in the building were on the ward. Following a risk assessment the number of staff on duty through the night had been increased to four in order to adequately manage situations, for example, a patient became aggressive. Staff were to contact the police for support. Staff felt this was a last resort as confused patients sometimes became frightened or violent when they saw police officers on the ward. Sister told us it was important that thorough assessments were done and patients monitored and transferred appropriately, There were two examples of appropriate actions taken, recorded in the incidence log .
- The ward sister told us that most staff were from the Longridge area and local staff could be contacted in an emergency, such as adverse weather causing staffing disruptions.
- Similarly, when staffing numbers were low, the ward had a contingency plan to refuse any new patients until staffing levels were safe.

Are services effective?

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

Summary

We rated the community health inpatient service as 'requires improvement' for effective because:

- During the inspection there were patients whose treatment was not following current evidence based guidance and standards. The number of substantive hours of therapy staff was insufficient to provide treatment following National Institute for Health and Care Excellence guidance and pathways were incomplete.
- The ward did not participate in national audits to monitor outcomes of some of the conditions that were being treated, for example, hip fracture and sentinel stroke national audit programme.
- There was no formal training at induction or regular competency updates for nurses in the use of syringe drivers, a device used to administer medication to patients who were at the end of their life. A plan to address this was put in place during the inspection.
- Due to the variable nature of the patients on the ward, patient outcomes were not routinely collected. Discharge plans were discussed from admission but were based on individual patient needs and did not follow any benchmarked outcomes.

However:

- Care plans were evident in patient records to monitor patients for nutrition and hydration. Assessments to monitor risks of pressure ulcers, venous thromboembolism and falls were performed and patient's pain was regularly assessed and treated.
- There were established policies for treating patients at the end of their life and good processes were in place for provision of medicines.
- Catering services were on site and the ward had a dedicated chef to provide nutritional requirements of individual patients on the ward.

Evidence based care and treatment

- Patients' care records demonstrated that good care plans were in place. Patient's needs were assessed and patient centred goals were set. Regular reviews were done and treatment delivered in line with evidence based guidance. However, we inspected two patients' records where the amount of therapist input did not meet NICE guidance for their condition. The ward sister told us that treatment was continued by the nursing team but there was no evidence of staff formally trained to deliver this therapy.
- Home care packages and plans for discharge were identified at admission and goals were discussed with patients. Criteria for admission to Longridge was that patients require medical assessment or treatment that cannot be safely provided at home (step up), post-surgical or medical care, rehabilitation (step down) or end of life care. Some of the goals we saw in health care records that were set with patients were "to go home" or "to get some rehab(ilitation)"
- The inpatient ward participated in the trust audit programme with community adult services. A pressure ulcer audit and an end of life re-audit were undertaken in April 2016 and followed criteria in the NICE quality standards. Results demonstrated good compliance on most statements, recommendations and action plans had been developed from the results.
- Because of an audit for compliance with NICE Quality Standard 76: Acute Kidney Injury, a task and finish group was set up, in April 2016, to improve the assurance. Staff on the ward were involved with the group and told us about its progress.
- We saw evidence of a dementia assessment tool in one of the health care records we inspected. The nurse in charge told us this tool was also used on confused patients to assist staff to understand the level of care required.

Are services effective?

- The ward pharmacist created a folder of information relating to caring for end of life patients. We saw prescribing guidelines that followed regional strategic network guidance and protocols on anticipatory medicines including flow charts on the use of each drug.

Pain relief

- Pain relief medication was prescribed by a doctor from the neighbouring GP practice who visited the ward between Monday and Friday. Patients were reviewed as required and seen promptly. Out of hours medical cover was provided by a GP service based in Preston.
- There was evidence in healthcare records that patients' pain levels were regularly monitored, if appropriate, and a pain management plan was in place if the patient was at risk.
- We spoke with four patients who told us their pain was regularly assessed and well managed. A nurse told us the Abbey Pain Tool, a recognised tool for assessing needs, was used every two hours, where appropriate, during intentional rounding.
- The documentation used when caring for end of life patients contained evidence that pain relief was considered and part of a patients' care package. The Abbey Pain Scale was seen in the policy.
- We also saw evidence and discussed with staff the use of anticipatory medication when caring for patients at the end of their life. Prescribing guidelines were available and met recommended guidelines.

Nutrition and hydration

- The nutritional needs of patients at Longridge were managed well. Individual risk assessments were completed on all patients on admission (where appropriate) and we saw evidence of re-assessment in healthcare records. The ward used the Malnutrition Universal Screening Tool (MUST) when making assessments. The ongoing issue with the broken seated scales had created some problems monitoring patients accurately.
- The ward had access to dietician services that were provided by another trust. Telephone advice could be sought and referrals made to the service were usually seen. We saw evidence in one set of healthcare records that the dietician assessed the patient eight days after referral.

- All patients' diet and fluid intake was discussed at handover and vulnerable patients were discussed at length.
- Longridge community inpatients employed a chef and had a purpose built kitchen, on the ground floor, to provide nutritional meals for patients on site. Individual dietary requirements were catered for. The chef told us he prepared all the meals for the day and usually provided soup and sandwiches in the evening as he worked alone and could not cover all three mealtimes.
- The patient led assessment of the care environment (PLACE) audit undertaken in 2016 rated the food at Longridge as 92%, which was better than the England average of 90%.
- Mealtimes were protected on the ward and patients were not disturbed by staff or visitors. A patient told us how kind and gentle a member of staff had been when assisting another patient with their meal.

Patient outcomes

- During the inspection, we were informed that the patient dictated the pathway and therefore the length of stay. If a patient's goal was to go home and the patient was discharged to home then that was a measure of a successful outcome. The average length of stay in May 2016 was 19.8 days; however, this had increased to 26 days at the time of inspection. No explanation was offered for the increase in length of stay.
- Due to the variable nature of the patients on the ward, patient outcomes were not routinely collected. Discharge plans were discussed from admission but were based on individual patient needs and did not follow any benchmarked outcomes. The ward also did not participate in any national audits as the specific patient numbers were low.
- Longridge had admitted a patient who had not fit the criteria at the acute hospital for their stroke care pathway. We were told she was admitted for assessment for an increased package of care, however, due to her co-morbidities her recovery would be poor. The patient however made excellent progress and was making significant improvement in her mobility and was eating well. However, her therapy input from the physiotherapist and dietician was limited and did not follow the national stroke guidance.

Are services effective?

- The ward had cared for 28 patients at the end of their life who had chosen to remain at Longridge in their last hours of life in the previous 12 months. This number had increased since the previous inspection report
- An audit was undertaken, examining patient falls, every three months. Any common themes were addressed and learning shared via staff team meetings and notice board. For example, a reminder to check blood sugars was posted following the audit.

Competent staff

- All appropriate nursing staff had received clinical supervision four times a year following Royal College of Nursing guidelines for continuous professional development.
- Longridge had champions for specific services such as safeguarding, dementia, tissue viability, infection control and end of life. Staff participated in a package of training to develop education and knowledge in their specific area. The ward champions would then ensure policies were up to date, represent the ward on specific committees and provide advice and guidance to other ward staff.
- The data presented stated that only one member of staff had received an annual appraisal in the last 12 months. We spoke with the ward sister who explained that she did not have access to input the data on the system but that all staff appraisals were up to date. The staff we saw during the inspection had received an appraisal.
- As well as a dementia champion, 22 out of 23 additional staff had received training in caring for patients living with dementia. Nineteen of the 23 staff in the 12 months prior to the inspection, had received mental health level one and two training and additional training in treating pressure ulcers.
- There had been no annual updates to training in the use of syringe drivers since the introduction of new McKinley equipment three years earlier. When highlighted, the senior staff took immediate action and a three-point plan was put in place to re-train all staff.

Multi-disciplinary working and coordinated care pathways

- The nursing staff had excellent working relationships with the general practitioners from the practices in the Longridge area. Staff liaised regularly to discuss admission, care and discharge and kept community nursing teams and social care providers updated on progress, as appropriate.
- Patients care pathways and discharge plans involved all of the team involved with the patient including doctors, nurses, therapists and pharmacists. Pathways were regularly assessed and adjusted to suit the patient's progress.
- The end of life specialist nurse attended palliative care multi-disciplinary (MDT) meetings for patients who had stated their preferred place of care was Longridge. Liaison with the district nurse team and the specialist palliative care team ensured the ward provided effective care. The hospital used an individualised plan of care which identified the wishes and care needed at the end of life.
- We saw evidence of individualised care plans for each patient, based on the outcomes of risk assessments. Care plans had documented notes detailing the patient's progression or regression with their care, were up-to-date, and completed to a good standard in accordance with professional standards by both nursing and medical professional bodies.

Referral, transfer, discharge and transition

- Patients were referred to Longridge inpatients for step up care from their GP, step down care from the local acute hospitals or for end of life care. The criterion for admission was that all patients had to have a GP in the Longridge area. The ward was usually contacted directly by telephone, and if the ward had capacity, the patient's GP would have to approve the admission.
- We were told that, due to lack of security and the isolated nature of the ward, patients might be refused admission if they had previously displayed challenging behaviour.
- There were no beds set aside specifically for end of life patients as the ward had only 28 patients in the 12 months prior to our inspection, requiring end of life care and there had been no issues accommodating these

Are services effective?

patients. District nurses (DN) could refer over the weekend or out of hours if the patient was listed on the Gold Standard Framework (GSF). GSF is a systematic, evidence based approach to optimising care for all patients approaching the end of life.

- The pathway of patients was managed well on the ward. Daily meetings were held to discuss progress and realistic targets were set including estimated discharge date.
- Discharges were completed on any day of the week to the patient's own home. MDT worked well to ensure all paperwork and medications were completed in good time. Home assessments were done, including domiciliary visits by the integrated therapy technician to ensure the home was safe and the patient could manage post discharge. Communication with community teams and care facilities ensured smooth transfers.
- There were 16 patients readmitted within a 90-day period from 1 January 2016 to 30 June 2016, this was a rate of approximately 13% (based on discharge figures supplied). As the patient cohort was predominantly elderly and frail patients,
- We heard discharge care visits being arranged with the community teams 24 hours prior to a patient discharge. This was to ensure that services would be in place in time for the patient going home. Home assessments had already been completed and the patients' discharge medication was ready.

Access to information

- Staff had access to the most up to date trust policies and procedures via the intranet. All staff had personal access to trust information and contacts needed to assist in care provision.
- In addition, the most frequently used documents were in paper format and kept in relevant folders in the nurse

base. Folders included tissue viability, dementia, nutrition and hydration and palliative care. The nurse champion was responsible for updating folders and ensuring new information was shared with all staff. Maintenance and out of hours security details were also readily available and displayed.

- Each nurse attending handover received a printed-paper summary of the current patients and their status. This provided 'at a glance' information that assisted staff to care for patients.
- There was a whiteboard situated behind the nurses' station where daily jobs were allocated to each member of staff, for example medicines, fluids and housekeeping.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Mental health education was delivered via an e-learning package. Nineteen from a possible 23 Longridge clinical staff had undergone the training and understood the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- We saw evidence of DoLS applications being submitted in trust incident reporting data. Between August 2015 and September 2016, there were three applications made.
- We examined ten sets of health care records. Three patients had do not attempt cardio pulmonary resuscitation (DNACPR) forms completed appropriately in their notes. There was consideration of appropriate patient care documented and evidence of discussions with the family and next of kin in eight sets of records.
- Records also contained consent from the patients in all notes we inspected. We also observed consent being granted from a patient prior to commencing a treatment.

Are services caring?

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

Summary

We rated the community health inpatient service as 'good' for caring because;

- Patients spoke positively of the care and treatment they had received. We were told they were treated with kindness, compassion and dignity. Patients were involved in their care and discharge goals were written in patients' own words.
- The ward had a strong visible person centred culture. Staff knew patients well and treated them as individuals. We saw staff comforting and reassuring vulnerable patients.
- Staff facilitated home comforts, such as a regular hairdresser or manicures to promote positive well-being. Patient feedback was used positively to make changes, where appropriate.
- Feedback sessions were undertaken and responses from patients were extremely positive. Patients were asked as part of the August 2016 audit to use one word to describe Longridge. Words used included: "wonderful, quality, relaxing, restful and pleasant". Patients told us it was known locally as "Longridge Hilton".

Compassionate care

- All the patients we spoke with were overwhelmingly positive about the care and treatment they had experienced. They described the ward as "for recuperation it is the finest place you can come to" "wonderful, there is nowhere better" "all staff are amazing". All patients we spoke with gave positive feedback regarding respect and dignity.
- There was a strong, visible person-centred culture on the ward and all patients felt involved in their care. We also saw friendly interactions with patients where they were treated as individuals. Families were encouraged to stay with their loved ones who were at the end of their life.

- The ward had received 111 compliments in the last 12 months. We were told the staff were regularly mentioned in the local newspapers and thanked by bereaved relatives for the care that had been given.
- The ward also received a large number of financial donations from the local people and the manager gave us examples of how the money was spent improving the environment and providing benefit to patients. Each room had a television and radio and the staff were looking at purchasing tablet devices for the patients to use to talk to relatives.
- Feedback sessions were undertaken and responses from patients were extremely positive. Patients were asked as part of the August 2016 audit to use one word to describe Longridge. Words used included: "wonderful, quality, relaxing, restful and pleasant". Patients told us it was known locally as "Longridge Hilton".

Understanding and involvement of patients and those close to them

- Each patient had been assigned a named nurse and this was displayed on the care records. Patients were aware who their named nurse was.
- Each patient had an admission form completed in their health care records. The patient's reason for admission and discharge goal was written in their own words on the form, for example "Came here for rehab". Staff had responded to the patient's wishes, sought appropriate assessments and made plans.
- The trust facilitated monthly feedback sessions, known as 'Your Time'. Results for May, June and August 2016 the three months provided were extremely positive. All patients said privacy and dignity was respected. Staff provided calm, reassuring, kind and considerate care.

Emotional support

- During the inspection, we observed a member of staff offering reassurance to a distressed patient in a kind and supportive way.

Are services caring?

- We were told that patients were invited to have an assessment in the patient kitchen to evaluate their ability to manage at home. If they felt unready then there was no pressure to continue and the assessment was deferred until they could be encouraged to do so.
- A patient told us she felt scared and vulnerable when she sustained her injuries. On arrival to the ward, she began to feel safe and staff were amazing.
- As the hospital was in their home village, patients had access to their usual home services and staff facilitated appointments with local hairdressers and nail technicians to help the patient feel 'back to normal'.

Are services responsive to people's needs?

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

Summary

We rated community health inpatient service as 'good' for responsive because:

- The service was responsive to the needs of the local population and patients from out of the area, in times of need.
- Patients' needs were always a consideration in planning and delivering care and treatment.
- The ward was situated on the first floor of a two-storey self-contained building. There was access via stairs or lift and the ward had security key entry to keep patients safe. Staff had sight of four live security cameras from the ward nurse base.
- The ward environment and facilities were appropriate to provide nursing and rehabilitation care. The ward environment was clean, spacious and in good condition. Patient led assessment of the care environment (PLACE) audit data had scored 93% for condition, appearance and maintenance. The ward had a PLACE rating of 84% for disability and 80% for dementia. This was better than the national average of 74%.
- The community hospital had kitchen facilities and a chef to provide specific nutritional meals to meet the needs of specific patients. The chef could liaise with the dietician to ensure meals were appropriate. The PLACE rating for food was also above the national average.
- Patients at the end of their life had their needs met. Admission was prompt and there had been no examples of the ward being full. Appropriate compassionate care and support was provided by the multi-disciplinary team.
- The hospital had excellent gymnasium and kitchen assessment facilities. The gymnasium was large and very well equipped. Due to the limited number of hours the physiotherapy staff were contracted to work with community inpatients the facilities were under-utilised.

Planning and delivering services which meet people's needs

- The inpatient beds in Longridge were for patients registered with one of the eight Longridge GP's. The

ward had been commissioned as predominantly a step up facility, but we were told that patients were more often admitted for rehabilitation and step down care or palliative care from the local acute trust.

- The ward environment was clean, spacious and in good condition. Patient led assessment of the care environment (PLACE) audit data had scored 93% for condition, appearance and maintenance. The ward had a PLACE rating of 84% for disability and 80% for dementia. This was better than the national average of 74%.
- The hospital had good rehabilitation facilities with a large well-equipped gymnasium and a patient kitchen for home assessments. However, a therapist felt that she did not always meet the needs of rehabilitation patients due to the number of hours she was contracted to spend on the ward. Although there was a gym on site, it meant leaving the ward with the patient and the time commitment to one patient would leave no time for any others. Consequently, the gym was rarely used.
- The patients' lounge was clean and spacious. There was a television and a selection of books and activities. Patients were encouraged to eat lunch in the lounge to mix socially, but we were told that many patients preferred to stay in their own room.
- Facilities in the patient bays were good. All areas were clean and tidy and all patients had toilet and bathing facilities. Call bells and walking frames were all accessible and close to patients' beds.
- Patient information leaflets were available on the ward, however they were untidy and some were out of date.

Equality and diversity

- The facilities were accessible for people living with a disability. There was a lift from the ground floor to the ward and all areas of the ward were wide and spacious.
- Staff had undertaken equality and diversity training as part of their mandatory training package. Due to the demographics of the local area, there was low numbers

Are services responsive to people's needs?

of people from an ethnic minority background. Staff knew they could access patient information leaflets in other languages and could access a translator service, but told us they had not needed to.

Meeting the needs of people in vulnerable circumstances

- The inpatient ward did not record the number of patients who had chosen Longridge as their preferred place of death. However, 28 patients on an end of life pathway had died there in the 12 months prior to our inspection. The nurse in charge told us that only two patients had been discharged to die at home in the six months prior to our inspection.
- Staff knew of the wishes of the dying patient as individualised plan of care documents were completed. Patients were admitted with their anticipatory medicines prescribed and do not attempt cardio pulmonary resuscitation (DNACPR) in place. Relatives were encouraged to stay with their loved ones while they were cared for on the ward and a named nurse was assigned to the patient and family.
- The community hospital had kitchen facilities and a chef to provide specific nutritional meals to meet the needs of specific patients. The chef could liaise with the dietician to ensure meals were appropriate.
- The 2016 Patient led assessment of the care environment (PLACE) audit stated that the food at Longridge scored 92% which was better than the national average of 90%.
- A chaplain visited the ward weekly and spent time with patients who required their services. We were told other faiths could be provided for if required.

Access to the right care at the right time

- Between 1 June 2016 and 31 August 2016, the mean percentage bed occupancy was 78%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care. The ward had experienced short periods of high bed occupancy and staff vacancies but no incidents had been reported as a result.

- Between 1 May 2015 and 30 April 2016, the average length of stay was 19.8 days. During the inspection, we were told the length of stay had increased to 26 days and was closer to the target for discharge which was 28 days.
- We were told that the number of patients admitted to Longridge inpatients for rehabilitation had increased in recent years but the commissioned therapy services had not increased to meet demand. The ward had regular visits, three times per week from a physiotherapist, an occupational therapist and an integrated therapy technician. These allied health professionals (AHP) also provided domiciliary visits within their allocated hours.
- We saw two examples of patients who were not receiving sufficient therapy in accordance with National Institute for Health and Care Excellence (NICE) guidance during the inspection.
- Provision for dietician, speech and language and neuro-rehabilitation did not include any regular contractual visits. Senior staff told us that patients referred to the dietician could take up to one week to be seen as there were only two dieticians covering the area which included Preston, Chorley and South Ribble.
- The ward sister was able to give us an example of when a patient's medical fitness was unsuitable for admission to Longridge. The patient was clinically unstable and medical and nursing staff felt the admission was inappropriate.

Learning from complaints and concerns

- The inpatient ward had received no formal complaints since 2013. Senior staff were able to explain to us that they understood the process for dealing with complaints and concerns and how learning could be achieved.
- Staff told us they were aware of the complaints process but they would try to resolve any issues raised locally. If the patient or relative was still unhappy then the issue would be raised to the manager and the patient engagement lead.
- We were told that lessons from concerns were discussed with staff as a group and the harm free notice board was used to remind staff of any implemented changes.

Are services well-led?

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

Summary

We rated the community health inpatient service as 'requires improvement' for well led because:

- Some staff had been expected to continue to work on a month-by-month contract and long-standing well trained staff were looking for alternative roles.
- There had been no provision for cover of the two key senior nurse roles that were vacant due to long term sickness.
- The same risks were seen repeatedly on the risk register and although staff had responded well, no long term plans had been implemented to ensure safety.
- The management of the risk register was poor and changes had not been recorded, one risk was three years old and no changes to the register had been made.

However:

- In uncertain times, the ward had continued to provide good care for the local population.
- There was a clear process of managing incidents at a local level and examples of improvements were evident.
- The ward staff told us of a good team working culture. The team and senior nursing staff had managed in the ward manager's absence.
- Managers had submitted a proposal to commissioners to ensure the future of the inpatient ward.

Service vision and strategy

- The trust vision was 'to provide high quality care, in the right place, at the right time every time' was underpinned by values of excellence and high quality care. The strategy was on display in the staff area on the ward and staff we spoke with were aware of the vision.
- Staff were unsure of the future of the unit and therefore the direction and strategy was also unclear. Locally staff

were determined to continue to provide the best care possible. There would be a significant impact to the model of the ward and the staffing required if the bid to be the commissioned frailty unit was successful.

Governance, risk management and quality measurement

- There was a clear process for recording and managing risks. We were told that risks such as insufficient therapy staffing and gaps in training had been identified and recorded. The ward service manager was unable to assure us that the risk register was regularly managed with time scales and actions set.
- The risk register had five risks in total. There had been no improvement to the rating since the opening date. One risk was dated 13 August 2013 and identified no robust contracting process or governance arrangements for Longridge GPs.
- The safe staffing risk relating to evacuation in a fire had been addressed though the risk register did not reflect this.
- There were no effective measures of performance against targets and it was therefore difficult to assess standards and understand if improvements were required. The Service Manager told us that 'We provide good, honest care' and the ward worked to patient led outcomes 'patients go home when they are ready'. We found that the ward contributed to the National Audit of Intermediate Care 2015, though no information was provided during the inspection.
- Managers understood the risk to the service and had submitted a proposal to the community bed review. Commissioners were looking for provision of a frailty service in the region and the manager at Longridge was confident that the needs could be met.
- Staff told us the future of the ward was the main priority on their worry list. Staff all spoke positively about working at Longridge but temporary rolling contracts

Are services well-led?

meant their future home life plans were on hold until they knew their future Managers were unable to offer any information regarding the future of the unit to the staff.

Leadership of this service

- There was a clear structure of responsibility and staff knew who the managers were and how to access the management team.
- We were told that the staff did not feel isolated from managers or the trust, despite the remote location of the ward. There were regular visits from clinical managers and contact numbers were on display in the ward office should the need arise.
- At the time of inspection, two of the senior clinical staff were absent through sickness. The remaining ward sister worked additional shifts and was available for advice when off duty. This had led to difficulties as no authorisation had been given to access staff records or order valuable equipment. This had led to delays in replacing the seated scales.
- The ward sister told us she was extremely proud of the staff and felt lucky to be part of the team. She communicated her appreciation at informal staff huddles and often thanked the team members personally. This was evident during the inspection as staff were efficient but appeared happy and relaxed in their work.
- Staff told us they felt the local leadership of the ward was good and the team pull together to provide a good service for patients.

Culture within this service

- There was a real emphasis on teamwork at Longridge and a positive community spirit. Staff were supportive and assisted colleagues in their role. Staff created a caring atmosphere with patients, involving them in conversations and treating them with respect.
- The nurse in charge told us that staff willingly helped the ward and went the extra mile to help their colleagues. We were told “When I got the job here, it felt like I had come home”
- Staff had told us that they were upset by the current insecurity of their job roles since October 2015 as there had been rumours that the ward could close. Staff had

first read this in the local newspaper and when temporary contacts were reduced to one month at a time, staff feared the worst. Managers could neither confirm nor deny the information, which led so some staff seeking alternative employment.

Public engagement

- The hospital had received 111 separate compliments in the last 12 months.
- A monthly survey known as ‘Your Time’ had been introduced on the ward and gave patients the opportunity to feedback their feelings and opinions of their care. Anonymous feedback was given to the Ward Manager to action and implement change, where appropriate. We saw results from June, July and August 2016 and patients gave excellent comments and were positive about their care.
- The trust had an engagement process known as ‘You said, we did’. As a result of patient feedback the ward purchased a toaster so that patients could have toast and jam in addition to their regular meals.

Staff engagement

- Staff told us that communication with immediate line managers was positive. Staff spoke positively of the ward manager. The Ward Sister completed weekly huddles to keep staff up to date with training and changes to procedures.
- Management had not kept staff informed of the future plans for the unit and some staff had applied for other posts as they were unsure if the unit was to close.
- Staff spoke of a desire to change to a longer working shift pattern that was adopted in many acute settings. There were three shifts in place and staff said they would prefer 12 hour days. A member of staff said it had been raised with management but no decisions had been made.
- Staff participated in the NHS annual staff survey. The survey was anonymised and was reported as Lancashire care staff as a whole. The trust performed better than the national average for combined Mental Health/ Learning Disability and community trusts in the areas of staff satisfaction with the quality of work and patient care they are able to deliver, staff motivation at work and recognition and value of staff by managers and the

Are services well-led?

organisation. However, in the staff friends and family test 2015/16 the number of staff who would recommend the trust as a place to work was 55% which was lower than the England average of 62%.

Innovation, improvement and sustainability

- The project of providing a ward based blood monitoring service had still not reached fruition. This was discussed at the last inspection in April 2015 and we were told that although policies and procedures had been written, the delay was due to accessing training for staff.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The provider did not ensure that care and treatment was provided in a safe way for patients because:</p> <p>Not all patients with a sub-acute condition were assessed and treatment was not always delivered in line with best practice guidance.</p> <p>Staffing levels were not sufficient to provide therapeutic assessment of patients' needs</p> <p>Not all staff had the appropriate qualifications and training.</p> <p>Not all staff received regular updated training to provide end of life care, basic life support and conflict resolution to maintain staff competencies.</p> <p>Chair scales to ensure correct weight measurements could be taken were not accurate.</p> <p>Patient outcomes were not routinely monitored to ensure that discharge plans followed benchmarked outcomes.</p> <p>The risk register did not provide a true and accurate record of the current identified risks.</p> <p>This is in breach of Regulation 12 (1) (2) (a) (b) (c) (e)</p>