East Coast Community Healthcare C.I.C.

1-286186558

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)
1-2718482102	Laurel Ward	Laurel Ward	NR33 8AG

This report describes our judgement of the quality of care provided within this core service by East Coast Community Healthcare. 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 East Coast Community Healthcare and these are brought together to inform our overall judgement of East Coast Community Healthcare

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated community inpatient services as good. Safe, effective, caring, responsive and well-led all received good ratings, This was because:

- Clinical areas were visibly clean and staff complied with infection control procedures.
- Medicines were stored securely and staff completed appropriate checks of controlled drugs.
- Staff understood their responsibilities in terms of duty of candour (a regulatory duty that relates to openness and transparency) and in terms of reporting incidents and safeguarding concerns.
- Mandatory training compliance was good. We saw records to show that mandatory training for inpatient staff in October 2016 was 95.98%.
- Staff gave us examples of national guidance that was relevant to their practice and implemented these guidelines. For example, nursing staff completed a falls history for any patient over the age of 65 admitted to the ward. This was in line with National Institute of Health and Care Excellence (NICE) clinical guideline CG161 Falls in older people: assessing risk and prevention.
- Patients told us nursing staff managed their pain well. Nursing staff completed intentional rounding, which meant that patients were asked about their comfort and well-being a minimum of every four hours and more often if needed.
- Staff compliance with supervision and appraisal was good. We saw records to show that 100% of nursing staff on the ward had completed an appraisal in the last year.
- There were positive working relations between different members of the multidisciplinary team. There were formalised meetings in place for the multidisciplinary team to share information on patients' care.
- Results from the NHS Friends and Family Test were positive. From September 2015 to August 2016, there were nine months where there were sufficient patient responses received to calculate results. In six out of these nine months, the inpatient service scored 100% for the question "Would you recommend this service to friends and family?"
- Staff worked with other teams in the organisation and with the local acute hospital to improve patient flow and to make sure that patients received the right level of care in the right place. For example, senior staff told us how they worked with the local out of hospital team to ensure that patients were triaged appropriately to either the community hospital or to be supported at home.
- There was a robust process in place for handling complaints. Senior staff gave us examples of learning from complaints and shared this learning with staff at team meetings.
- There were governance processes in place for sharing information with staff on the ward and escalating information to executive level through the integrated governance committee.
- We saw a local risk register, which included identified clinical risks and actions to mitigate them.

However:

- There was no clear documentation of safety checks for the resuscitation trolley before 27 October 2016. Senior staff were aware of this and had put a new safety checklist in place to ensure that staff documented safety checks clearly. We followed up on this at our unannounced inspection on 17 November and found that staff had consistently completed the new safety checklist every day.
- The temporary inpatient ward (Laurel ward) was originally designed for patients with mental health needs. This meant that there were some features of the environment that were not ideal for patients using the community inpatient service. The layout and size of the ward also meant that there was very limited space to store equipment. We saw several pieces of equipment stored in corridors, including two transfer aids. This meant that there was limited space for

patients and staff to move through corridor areas. Senior staff were aware of the limitations of the environment and had put measures in place to reduce risks.

- The root cause analysis for a serious incident on the ward lacked a detailed analysis of the underlying causes of the incident. This meant that we were not assured that learning from serious incidents was always robust.
- Staff told us that there was a lack of engagement from senior leaders in the organisation.

Summary of findings

Background to the service

Information about the service

East Coast Community Healthcare (ECCH) provided a community inpatient service for adults in the Great Yarmouth, Lowestoft and Waveney area. The service provided inpatient care for patients who had been discharged from the local acute hospital and needed therapy assessments and discharge planning. Patients could also be referred from the community for therapy assessments or occasionally, for end of life care.

At the time of our inspection, the inpatient service had been temporarily moved from Beccles ward (a 21-bed ward at Beccles Hospital) to Laurel ward (a 12-bed ward at Carlton Court in Lowestoft). This was due to renovations being carried out at Beccles Hospital.

From January 2016 to October 2016 there were 222 admissions to the inpatient service at Beccles ward and Laurel ward.

We also visited the minor injury unit (MIU) which is based at Beccles community hospital. Although the service is called a minor injuries unit it operates in line with the clinical service provided by a GP practice nurse and will treat very minor injuries including bites and stings, sprains and minor cuts. Outside of this remit patients are referred to the local accident and emergency department. The local population were aware of the limits of the service provided and records showed that the service was used appropriately.

The unit treated 614 patients in September 2016 and total patients treated in 2016 at the time of our inspection were 5001.

Our inspection team visited Laurel ward. During our inspection, we spoke to six patients and one patient's relative. We also spoke to 10 members of staff, including managers, nurses, therapists, a pharmacist and a ward clerk. We reviewed seven sets of patient care records and prescription charts. We also reviewed local policies and guidance, minutes from meetings, incident investigations and audit data.

East Coast Community Healthcare C.I.C.

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 this service as good for safe because:

- Clinical areas were visibly clean. We saw staff carrying out infection control procedures, such as hand hygiene and the use of personal protective equipment.
- We saw positive results from an audit of hand hygiene compliance. From January 2016 to October 2016, staff compliance with hand hygiene was consistently 99-100%.
- Staff stored medicines securely and monitored controlled drugs appropriately.
- Staff knew how to report incidents using the electronic reporting database and could give examples of incidents they had reported.
- Most staff were aware of their responsibilities in relation to duty of candour. 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. We asked four members of staff about duty of candour and three of them were aware of their responsibilities.
- We saw information for staff on safeguarding adults. Staff knew how to raise concerns about safeguarding. Compliance with safeguarding adults level two training was 93% for inpatient staff in October 2016.
- Care records were stored securely and contained appropriate risk assessments and management plans.
- Compliance with mandatory training for inpatient staff in October 2016 was 96%.

However,

- There was no clear documentation of safety checks for the resuscitation trolley before 27 October 2016. Senior staff were aware of this and had put a new safety checklist in place to ensure that staff documented safety checks clearly. We followed up on this at our unannounced inspection 17 November and found that staff had completed the new checklist every day.

Good

Are services safe?

- The temporary inpatient ward (Laurel ward) was originally designed for patients with mental health needs. This meant that there were some features of the environment that were not ideal for patients using the community inpatient service. The layout and size of the ward also meant that there was very limited space to store equipment. We saw several pieces of equipment stored in corridors, including two transfer aids. This meant that there was limited space for patients and staff to move through corridor areas. Senior staff were aware of the limitations of the environment and had put measures in place to reduce risks.
- The root cause analysis for a serious incident on the ward lacked a detailed analysis of the underlying causes of the incident. This meant that we were not assured that learning from serious incidents was always robust.

Safety performance

- Managers monitored safety outcomes using the inpatient clinical dashboard. The organisation's clinical quality manager then collated safety outcomes into a monthly clinical quality report. This was presented to the integrated governance committee to provide an overview of risk management in the service.
- We reviewed the clinical dashboard for October 2016. This showed that from January 2016 to October 2016, no patients developed avoidable pressure ulcers under the care of the inpatient service on Beccles ward and Laurel ward. There were three unavoidable pressure ulcers in this period. The clinical dashboard also contained information on other safety measures, including venous thromboembolism (VTE) assessment and the number and severity of falls. The service did not set goals or targets in terms of safety outcomes.
- Senior staff told us that safety outcomes were discussed and analysed for learning. For example, staff discussed falls, pressure areas, urinary tract infections related to catheters and venous thromboembolism (VTE) at the monthly 'four harms meeting'. Senior inpatient nursing staff, community nursing staff, the organisation's quality manager and tissue viability specialist nurses attended this meeting.

Minor Injuries Unit

- In the minor injuries unit managers monitored outcomes and safety performance using the minor injuries unit clinical dashboard. This information was collated into a monthly clinical quality report. The data dashboard was collated by the service manager and distributed to the team monthly. Data showed no serious incidents attributed to the service.

Incident reporting, learning and improvement

- There was one serious incident reported on Beccles ward from 7 December 2015 to 23 May 2016. There were no never events reported in this period. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were 43 incidents reported on the inpatient ward from August 2016 to October 2016. We reviewed information about these incidents and found no trends in the types of incidents that took place.
- We noted that some incident reports about patient falls referred to three or four nursing staff 'assisting' patients back to bed after a fall. It was not clear from the incident reports whether staff had used equipment, such as a hoist to maintain the safety of patients and staff during this process. We asked a senior nurse about this and they told us that staff would use a hoist to assist a patient from the floor, if the patient was unable to safely stand up after a fall. This was in line with the organisation's moving and handling policy.
- Staff at all levels of seniority understood how to report incidents using the electronic reporting system that was in place. We asked five members of staff about incident reporting and all of them understood their responsibilities. Staff gave us examples of incidents they had reported. For example, one therapist told us about an incident where a patient had been verbally abusive. The incident had been reported appropriately and the therapist told us they had received feedback and support from managers after the incident.
- Managers shared learning from incidents at monthly staff meetings. We saw six sets of minutes from these meetings dated from May 2016 to October 2016. These showed that managers discussed incidents with staff.
- We reviewed the investigation for the serious incident that occurred on Beccles ward. The investigation

showed evidence of actions taken to keep the patient safe after the incident. However, there was a lack of analysis of the events leading up to the incident and no detailed explanation of the root cause of the incident.

Minor Injuries Unit

- In the MIU reporting systems were in place to ensure that incidents were reported and investigated. Incidents were reported via the Datix system. Staff could explain the process and gave examples of incidents that had been reported. Staff confirmed they received feedback around incidents and could give examples of action taken as a result of a reported incident**.**

Duty of Candour

- We asked four members of staff about duty of candour. Three out of four staff were aware of their responsibilities in relation to duty of candour. 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.
- Senior staff gave us examples of when they had used duty of candour and could explain what their responsibilities were. Two records reviewed showed that duty of candour had been adhered to following an incident. Patients had received an apology and were offered a meeting to discuss any concerns.
- However, in the minor injuries unit three members of staff we asked about duty of candour were unclear about the regulation and when it would apply.

Safeguarding

- Staff knew how to report safeguarding concerns and the staff we spoke to could name the lead for safeguarding.
- Inpatient staff compliance with safeguarding adults level two training was 93% in October 2016. We saw records showing extra local training given to inpatient nursing staff on safeguarding and deprivation of liberty safeguards (DoLS). We asked two staff members about safeguarding training and both said that they had completed safeguarding adults level two training in the last year.
- We saw information and contact details for the safeguarding team displayed in staff areas of the ward. There was a safeguarding handbook available in the ward office for staff to reference.

Minor Injuries Unit

- In the minor injuries unit five members of staff were able to tell us under what circumstances they would make a safeguarding referral. Staff demonstrated knowledge of the safeguarding guidance, what to do and who to contact should a concern be raised. All had level 2 safeguarding adults and children with the lead also being trained to level 3.
- Two members of staff in the department were named domestic abuse and female genital mutilation (FGM) champions and confirmed that they had received additional training to help identify concerns.
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Medicines

- Staff stored medications securely on the ward. Controlled drugs (CDs) were locked behind two doors and medication trolleys were kept locked when not in use. Two staff nurses held the keys to access medications.
- We checked the register of CDs from 11 May 2016 to 29 October 2016. This showed that staff checked the stock of CDs twice a week to ensure that all stock was monitored and accounted for.
- We checked the expiry dates on a sample of five medications. All the medications we checked were in date and stored appropriately. Staff had marked each medication box with the expiry date in large letters to make sure that medicines nearing their expiry date were easy to identify.
- We checked records for the medicines refrigerator from 1 September 2016 to 2 November 2016. The temperature had been checked on a daily basis by nursing staff. There was one occasion where the temperature fell outside the recommended range and a comment had been documented to explain why this was. We saw a notice for staff reminding them of what action to take if the refrigerator temperature fell outside the recommended range. This meant that medications requiring refrigeration were stored appropriately.

Good

Are services safe?

- At our unannounced inspection we reviewed 3 medicines prescription charts and found them to be complete with no gaps in recording.

Minor Injuries Unit

- Medicines were stored in a locked cupboard. Keys were held by the nurse on duty.
- All medicines in the cupboard that were checked on inspection were in date.
- There was a notice in the cupboard to say that for certain medications date opened must be recorded. This was not seen on an opened 120/5mls paracetamol box or an opened piriton packet.
- All six members of staff confirmed their understanding of Patient Group Directives (PGD's). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor (or dentist). All PGDs were in date and signed by the staff.
- There was no PGD in place for Ventolin + atravent yet it was possible that a patient with asthma could attend the department. We spoke to the pharmacy lead and they confirmed that a PGD had been considered and the risk assessed and it was concluded that a PGD was not necessary. GPs at the walk in centre were available to provide the prescription and this could be done verbally by phone. The appropriate drugs were available on the unit.
- Audit results showed that fridge temperature daily checks were completed. We saw that daily checks had been completed for August, September and October 2016.

Environment and equipment

- We checked the cleanliness of 10 pieces of equipment on the ward. All the equipment we checked was visibly clean and was labelled with green 'I am clean' stickers to indicate when the equipment was last cleaned. All of the stickers we saw were dated appropriately.
- We saw a cleaning log, which showed that daily cleaning of clinical areas was carried out consistently. Data provided showed that all equipment on the ward was appropriately tested.
- Resuscitation equipment was stored in an accessible location. We looked at records of safety checks for resuscitation equipment. The records had been completed daily from 27 October 2016 to 1 November 2016. However, there was no record of safety checks before 27 October 2016. We raised this with senior staff on the ward, who told us that the safety checks had previously been recorded on the cleaning record. The cleaning record did not show clear documentation that safety checks had been carried out. Senior staff told us that they had recently become aware of this problem and had immediately asked staff to complete a separate record of safety checks. We returned on 3 November and 17 November and saw that staff had continued to complete the new record of safety checks every day.
- The temporary inpatient ward (Laurel ward) was originally designed for patients with mental health needs. This meant that there were some features of the environment that were not ideal for patients using the community inpatient service. For example, there were no pull-cord bells for patients to use in bathrooms and the ward was made up of single, individual rooms. The layout and size of the ward meant that there was very limited space to store equipment. We saw several pieces of equipment stored in corridors, including two transfer aids. This meant that there was limited space for patients and staff to move through corridor areas. Senior staff were aware of the limitations of the environment and had put measures in place to reduce risks related to this.

Minor Injuries Unit

- Equipment was serviced through an external contractor. All equipment we checked had been serviced and electrical safety tested. Staff reported that the contractor was responsive and equipment that was broken was replaced in a timely manner
- The waiting room was visibly clean and uncluttered. During our inspection we saw that there was adequate seating for the number of patients attending.
- We observed five fire extinguishers which were within date for their annual check.
- There were three clinic rooms in which MIU patients were treated. One room was set up to treat children and had a child friendly wall mural. Clinic rooms were visibly clean and tidy. Blood bottles and swabs were all in date.
- The sharps bins in each clinical room were labelled and dated.

Good

Are services safe?

- The resuscitation trolley was checked weekly. We saw records that these checks had been completed since 27th August 2016 with no omissions. The oxygen cylinder was full and medication and equipment that we checked was in date.
- Staff told us that the provider health and safety lead could be called for advice. Staff gave an example where nurses were required to decant liquid nitrogen but had not received the appropriate training. The health and safety lead was very responsive and assessment was done and training delivered and staff were now trained to carry out this process safely.

Quality of records

- Patient care records were stored securely in locked cabinets in the staff office.
- Nursing and medical staff used paper records for all documentation. Therapy staff used an electronic system for recording notes. Therapy staff printed their notes and put these into the paper records on the ward so that the patient record on the ward was complete. Senior staff told us that they planned to train nursing staff on the electronic system so that the ward could move to an electronic patient record in future.
- We reviewed seven sets of patient records and prescription charts. All of the records we reviewed contained management plans and appropriate risk assessments.
- All of the patient records we reviewed contained documentation of patient observations.
- All of the prescription charts we reviewed were signed, dated and contained documentation of patients' allergies.

Minor Injuries Unit

- Patient records were recorded and held electronically on SystmOne.
- We reviewed 10 patient records. Clinical notes were completed appropriately with evidence of presenting complaint, completion of relevant medical history including medications, appropriate diagnosis and an evidence based treatment plan. Where appropriate there was evidence of referral to additional services including GP services and the eye clinic.

Cleanliness, infection control and hygiene

- All clinical areas we visited were visibly clean. We saw staff completing hand hygiene before and after contact with patients. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.
- Clinical staff were bare below the elbows and wore uniforms in line with trust policy. We saw three nurses wearing appropriate personal protective equipment when treating a patient.
- Results from a local audit of compliance with hand hygiene procedures were positive. From January 2016 to October 2016, staff compliance with hand hygiene was consistently 99-100%.
- There were no cases of Clostridium difficile or MRSA bacteraemia on Beccles ward or Laurel ward in the 12 months before our inspection.
- Staff stored clean commodes in the shower room. This was due to a lack of space in the sluice. Senior staff told us that they had consulted with the infection control team about this to make sure that this did not present an infection risk.

Minor Injuries Unit

- The department carried out a monthly hand wash observational audit. The results showed that compliance in May 2016 was 99%, June 100%, July 93%, August 100%, September 99%. Staff told us that results below 95% trigger the implementation of an action plan reminding staff of hand washing technique. We did not see an example of an action plan although the audit data showed that an action plan was implemented.
- There was an annual unannounced environment audit carried out by a member of the infection control team. The result for October 2015 was 99% and for October 2016 it was 100%.
- The department carried out an quarterly uniform audit. The organisations target was 100%. We saw that the result in March 2016 was 90% due to a member of staff arriving at work in uniform. Provider policy states that staff must not wear uniform outside of the unit. However changing facilities were not provided and nurses were required to change in the office or staff toilets.

Good

Are services safe?

- We saw that there was a daily cleaning rota carried out by the nursing staff on duty. We saw records of this being completed for September 2016 and October 2016 with no omissions.
- Hand gel was available in all the clinic rooms as well as at the entrance to the clinical area and in the waiting room.
- Personal protective equipment (PPE) was available in all rooms including latex free gloves and aprons.
- We observed staff washing their hands and wearing gloves and aprons during consultations. However we did observe one nurse opening a cupboard wearing gloves that she had worn to examine the patient. This is not good aseptic technique. The nurse did put on clean gloves when she treated the patient further.

Mandatory training

- Inpatient staff completed mandatory training, which included basic life support, conflict resolution, infection control, safeguarding and risk awareness, among others.
- Compliance with mandatory training for inpatient staff was good. We saw records showing that in October 2016, compliance with mandatory training for inpatient staff was 96%.
- We asked two members of staff about mandatory training and both said that they had completed mandatory training in the last 12 months.

Minor Injuries Unit

- Staff confirmed that they had received a range of mandatory training and training specific to their roles. Mandatory training includes Fire/ infection control/ Basic life support (BLS) and immediate life support (ILS)/equality and diversity/safeguarding/conflict resolution/fraud/record keeping/mental capacity/ health and safety/consent/PGD and immunisation.
- The provider target for mandatory training was 90%. At the time of our inspection the unit was 93% compliant with staff booked onto training that was outstanding.
- Individual staff members were responsible for booking their own training. Human resources notified staff via email when training was due to be updated. Training was delivered through a combination of face to face learning and computer based e-learning courses.

Assessing and responding to patient risk

- All seven patient records we reviewed contained appropriate risk assessments, including Waterlow scores (for assessing risk of pressure areas), falls history and venous thromboembolism (VTE) assessment.
- Staff used a modified early warning score (MEWS) to identify changes in patients' observations. This meant that staff had a standardised way of identifying patient deterioration.
- Staff completed a handover at 7am and 9am each day. We saw a handover sheet, which included information on each patient's mobility status, allergies, mental capacity and management plan. This meant that staff had up to date information on each patient's clinical condition.
- Senior staff knew how to respond if a patient's condition deteriorated. A GP visited the ward twice daily and could be contacted via telephone between 8am and 6.30pm if a patient needed further review. Staff had direct telephone access to a GP out of hours service overnight.
- Staff told us that in an emergency they would call 999 and the patient would be transferred to the local acute hospital via an ambulance. Senior staff could give us examples of when this had occurred and how the situation had been managed. Senior staff told us that nurses were trained in early recognition of sepsis and would call an ambulance to request a transfer to hospital within four hours if a patient was suspected of having sepsis.
- All patients were cared for in individual rooms. This meant that nursing staff had limited sight of patients who were at risk of falls. Nursing staff had put in place measures to reduce risk. For example, staffing had been increased and we saw a patient receiving one to one supervision in order to maintain their safety. The ward had purchased six 'high-low' beds in order increase safety for patients at risk of falls.

Minor Injuries Unit

- Patients were triaged according to their presenting complaint recorded by the reception staff. Nurses would triage the patient using the Manchester triage system. The large majority of patients fell within the fourth (standard) and fifth (non urgent) triage group which meant that they were in the lowest risk category.

Good

Are services safe?

- Due to low patient numbers patients were almost always seen within 15 minutes of arrival and presented with low risk conditions.
- Receptionists received informal red flag training to recognise conditions like chest pain or shortness of breath and would alert clinicians immediately.

Staffing levels and caseload

- We saw planned and actual numbers of nursing staff displayed on the ward. The actual number of nursing staff matched the planned number on the two days we visited the ward.
- There were 13.6 whole time equivalent (WTE) registered nursing staff in post and 15.7 WTE support staff in post at the time of our inspection.
- There were no vacancies for nursing staff from Band 2 to Band 6.
- There was one vacancy for a Band 7 team lead on the ward. The matron was covering this role in the interim.
- GPs visited the ward twice a day to provide medical input for patients. There were no other medical staff employed on the ward.
- A pharmacist was available on the ward for 15 hours per week.
- Physiotherapy and occupational therapy was provided by community therapists, who worked part-time on the ward, from Monday to Friday. One physiotherapist and one physiotherapy technical instructor were available four mornings per week and two physiotherapy technical instructors were available on the remaining morning. One occupational therapist and one occupational therapy technical instructor were available on a Monday morning, a Friday morning and all day on a Wednesday.
- Therapy staff and senior managers told us that the lack of full time therapy staff limited the level of rehabilitation that could be provided to patients on the ward. Senior staff told us that a business case had been put forward to increase therapy staffing and that this was awaiting approval.
- Turnover for inpatient staff was 46.81%. We asked senior staff about this and they said it was due to changes in commissioning, which had resulted in the recent closure of three inpatient units. Senior staff told us that staff affected by this had been re-allocated to other roles in the organisation.

Minor Injuries Unit

- The unit was led by a band 7 emergency nurse practitioner and a part time band 6 minor injuries nurse.
- There were 2 full time band 5 minor injuries nurses and 2 part time band 5 nurses supported by a full time health care assistant. It had been identified that additional staffing was required and 2 posts had been advertised but recruitment was on hold at the time of our inspection.
- Each shift was staffed by a minimum of 2 nurses. On average the unit treated 15 patients a day.
- The unit only treated patients with minor injuries including minor cuts for suturing and dressing, bites and stings and sprains. The local population were aware of the service provided and records showed that the service was used appropriately.
- Staff did not treat children under one and children aged one to two were treated at the nurse's discretion.
- The department policy stated that there should not be band 5 nurses working without a senior member of staff. Staff told us that on several occasions band 5 nurses had been working alone in the department. The off duty rota demonstrated this. Dating back to 19th September we saw 15 shifts where band 5 staff were on duty and the senior nurses were off duty. However staff told us that senior team members were happy to be called at home if the staff had any queries. The out of hours GP surgery also offered support as did the local NHS Trust and a local minor injuries unit.

Managing anticipated risks

- Senior staff were aware of the risks related to the limited space on Laurel ward and had sought advice to manage the risks. Senior staff had consulted the infection control team to make sure that risks were managed correctly. For example, managers had installed portable handwashing basins to make sure that staff had enough facilities for handwashing and had sought advice on infection control in relation to storing commodes in the shower room
- We did not see any evidence of staff training on responding to major incidents and emergencies.

Good

Are services safe?

Minor Injuries Unit

- The provider made the decision to reduce the opening hours of the service due to staff shortages to ensure that the unit could be staffed safely.
- Lone working adjustments had been implemented since the inpatient ward on the site had temporarily relocated. This had meant that staff in the unit would be the only member of staff in the building after five o'clock. Two members of staff were now rostered to cover all shifts.
- There were alarms in each clinical room and staff carried personal alarms. The alarm sounded in the reception area as well as in the clinical areas. Reception staff confirmed that they were aware of the procedure if the alarm was triggered.

Good

Are services effective?

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

Summary

We rated this service as good for effective because:

- Staff were aware of national guidelines that were relevant to their practice.
- Staff knew how to access policies. The policies we saw reflected national guidance and were version controlled and within date for review.
- Patients told us that their pain was well managed. Nursing staff completed intentional rounding, which meant that patients were asked about their comfort and well-being a minimum of every four hours and more often if needed.
- Staff compliance with supervision and appraisal was good. We saw records to show that 100% of nursing staff on the ward had completed an appraisal in the last year.
- The staff we spoke to reported positive working relations between different members of the multidisciplinary team. There was a weekly multidisciplinary team meeting, which was attended by GPs, nurses, therapists and a social worker.
- Senior staff monitored outcomes, including length of stay and clinical outcomes such as falls, urinary tract infections and pressure ulcers.
- Staff were trained in mental capacity assessment and Deprivation of Liberty Safeguards.

However:

- Although we saw evidence that an audit of clinical notes in the minor injuries unit was carried out no audit tool was used. This meant that the audit was not replicable and outcomes may not have been consistent.
- With exception of the minor injuries nurse lead the nursing staff on the unit did not hold a Royal College of Nursing accredited minor injuries training qualification.

Evidence based care and treatment

- Staff knew how to access policies via the staff intranet. Policies were based on national guidance. For example, we viewed the CPR policy, which referenced the Resuscitation Council recommendations, 2010 and we saw the policy for the safe and secure handling of medicines, which referenced the Nursing and Midwifery Council Standards for medicines management. The policies we saw were version controlled and were within date for review.
- Two staff told us that they received updates on any changes to policy via the 'weekly update'. This was emailed to staff and was available on the staff intranet.
- Staff were aware of relevant national guidelines. For example, a senior nurse told us about how they used the National Institute for Health and Care Excellence (NICE) clinical guideline: Falls in older people: assessing risk and prevention, 2013 and a therapist told us about guidelines that were relevant to her practice, for example the National Service Framework for older people, 2001.
- Staff completed local audits on areas including record keeping, hand hygiene and completion of observation charts. The inpatient annual clinical audit calendar contained information on the frequency of audits and goals for compliance with each audit.
- Staff completed audits of the clinical care provided to patients. We saw a clinical audit and service evaluation calendar for 2016, which included audit of areas including dementia care, completion of patient observations and completion of Do not attempt cardiopulmonary resuscitation (DNACPR) forms.
- There was a central department within the organisation where audit data was collated and interpreted. This department informed the matron of areas where goals were not met and where action plans to improve outcomes were required.
- Audit of the care provided to patients living with dementia showed positive results. We saw audit data from October 2016 which showed 100% compliance with required care standards.

Minor Injuries Unit

Good

Are services effective?

- Policies had recently been updated in line with best practice and National Institute of Health and Care Excellence (NICE) guidelines. We saw examples of policies including the Clinical protocol for management of minor head injury dated 18 October 2016 and the clinical protocol for the management of human and animal bites date 18 October 2016. These were being ratified by the provider policy team.
- The policy for development and implementation of PGDs was in date and in line with best practice.
- Patient leaflets containing information about their condition and treatment were in line with national guidance.

Pain relief

- Patients told us that their pain was well managed. We asked two patients about pain management and both of them said that staff regularly offered them pain relief.
- Staff used 'intentional rounding' to check on patients' well-being and comfort. This meant that nursing staff proactively checked on patients' pain a minimum of every four hours.
- The records we reviewed contained a pain assessment tool and documentation of actions taken to manage patients' pain.
- We asked one therapist about management of patients' pain in relation to their progression with rehabilitation. The therapist told us that there was good communication between therapists, nursing staff and GPs in terms of pain management.
- Medicines records showed that pain relief was given according to prescription in a timely way.

Minor Injuries Unit

- Pain relief was available to patients if required. Patient group directions were used to allow staff to administer some simple analgesia. There was no use of controlled medicines in the Minor Injuries Unit.

Nutrition and hydration

- Records contained nutritional assessments, for example the Malnutrition Universal Screening Tool (MUST). This is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. These were completed and actions taken in response to the scores.
- We asked five patients about the food and drink provided on the ward. All of the patients we asked were satisfied with the food and drink they had been given. One patient commented, "It's rather nice food".
- We saw a staff handover sheet, which contained information on patients who required encouragement or support with diet and fluids.
- There was no face-to-face input from a dietician or speech and language therapist to support management of patients' nutrition. Senior staff told us that staff could seek advice from a dietician or speech and language therapist at the local hospital via telephone if needed under a service level agreement. Further support was available via referral by the GP.

Patient outcomes

- Senior staff monitored patient outcomes, including average length of stay, delayed discharges, falls and the number of inpatient deaths.
- Senior staff told us how they analysed information on delayed discharges so that learning could take place and patients could be discharged to their preferred place of care more quickly. Senior staff gave us examples of how they had worked with the out of hospital team to provide support to patients waiting for care at home so that they could be discharged from hospital more quickly.
- Staff did not audit re-admissions to the ward. Senior staff explained that this was because patients who needed re-admission for medical reasons following discharge would usually be admitted to the local acute hospital rather than to the community inpatient ward.
- Staff did not audit whether patients achieved their rehabilitation goals. Therapy staff told us that their input in terms of setting and monitoring achievement of rehabilitation goals was limited by the lack of full-time therapy staff on the ward.

Minor injuries unit

- An audit of clinical notes was carried out every six months. The audit looked at 10 sets of patients' notes. For each staff member the audit assessed recording of clinical presentation, arrival at correct diagnosis and treatment and appropriate discharge. Feedback was

given to individual nurses and learning shared formally at staff meetings, although staff told us that feedback was given daily due to the fact that the team was small and they all worked closely together.
- The audit was carried out by the lead emergency nurse practitioner but no formal audit tool was in place. This meant that the audit was not replicable and outcomes may not have been consistent.
- The lead nurse told us that where there were discrepancies, feedback was given to the staff member and reflection and additional training was given where required.
- We saw that a PGD audit had been carried out. This audit checked that the correct PGD had been used; medication had been recorded correctly, lot number and expiry date recorded and allergy check carried out on SystmOne. Audit result showed 100% compliance.

Competent staff

- Compliance with annual appraisal for nursing staff on the ward was 100%, which was excellent. We asked two nursing staff about appraisal and they both told us they had completed their annual appraisal.
- Therapy staff were line managed by community teams. We asked two therapy staff about appraisal and both staff said they had completed their annual appraisal.
- We asked three members of staff about supervision and they all said that they received regular clinical supervision.
- Senior staff told us that all new support staff from Band 1 to 4 were required to complete the care certificate within four months of starting. The care certificate is a set of standards, which aims to equip health and social care support workers with the knowledge and skills they need to provide safe, compassionate care.
- We saw evidence of local training sessions provided for staff. This included teaching sessions on wound care, safeguarding and end of life care.
- We saw an induction checklist for agency and bank staff, which included training on infection control, fire safety, incident reporting and information governance. Senior staff showed us a completed checklist for a member of staff currently working in the service.

Minor Injuries Unit

- 100% of staff were up to date with their appraisals and staff confirmed this. They also told us that they received monthly one to one meetings with their manager which gave the opportunity to raise concerns and receive feedback.
- The minor injuries unit lead nurse was an accredited emergency nurse practitioner.
- The deputy lead had undertaken a minor injuries nurse training course which included classroom session and in situ training at the minor injuries unit of the local NHS trust. This course was not Royal College of Nursing accredited.
- The band 5 staff members had undertaken local training in minor injuries including treating the sick and injured child and assessment of the older person and suturing. Band 5 staff had many years practice by experience.
- All staff we spoke with said that the training department was very supportive and would make every effort to help staff access available training.
- The unit did not use agency staff as it was difficult to get staff with the appropriate skills. Staff short falls tended to be covered by bank staff that had previous or current experience of working at the unit.
- Staff competencies were monitored and updated where required. We saw individual staff competency folders and saw that they were up to date.
- A GP out of hour's service was based on the site and provided medical support when required.
- Staff also had access to support via telephone from the local A&E department as well as a local minor injuries unit.

Multi-disciplinary working and coordinated care pathways

- Staff carried out a handover meeting each morning at 9am. We attended a morning handover meeting, which was attended by nursing and therapy staff. This included handover of important information, for example discharge plans for patients and updates on patients' medical conditions.
- Staff attended a multidisciplinary team (MDT) meeting every Wednesday. Staff told us that this meeting was attended by therapists, nurses, GPs and a social worker. Staff said there was good communication between different professionals at these meetings. For example, one therapist said "the GPs listen to you."

Good

Are services effective?

- We saw documentation of MDT meetings in patient records. This documentation included discharge plans and referrals that were needed. However, we noted that there was no personalised, multidisciplinary care plan to reflect patients' individual goals and rehabilitation plans.
- Nursing staff on the ward had monthly meetings. We viewed the meeting minutes from May to October 2016. These showed that meetings were attended by nursing staff of all levels and included discussion of serious incidents, audit, infection control and complaints. However, we noted that therapy staff did not attend these meetings.

Minor Injuries Unit

- Staff described strong multi-disciplinary team working both within the organisation and with other providers.
- Strong links were described with local NHS Trust and a local MIU that offered training opportunities as well as advice around patient care.
- Staff described strong links with the community services including district nursing and health visitors. Staff felt they could refer patients if they were concerned about their health care needs.
- The unit had an effective working relationship with the GP out of hour's service based on the site.

Referral, transfer, discharge and transition

- Referrals were taken via the organisation's single point of access. Referrals to the ward were accepted from any healthcare professional. Admission criteria for the ward were patients over the age of 18, who needed therapy assessments or support with discharge planning. Patients requiring therapy and care assessments could also be referred from the community. Senior staff told us that patients could also be referred for end of life care, if the community hospital was their preferred place of care, but that this was not common.
- Patients who needed escalation of care due to deterioration in their condition were referred back to the local acute hospital and were transferred by ambulance. There were no formalised protocols in place for the transfer of patients from the community hospital to the local acute hospital, however staff told us the arrangements via the GP were in place worked well. Any urgent transfers were made by emergency ambulance.
- We asked two patients about the plans and timescales for their discharge from the ward and both patients had been well informed about this by staff.

Minor Injuries Unit

- Although staff at the unit would see anyone who walks in to use the service the staff only treated minor injuries. Staff explained they signposted patients to appropriate services including their GP and local accident and emergency department.
- We observed that there were arrangements in place for the onward referral of patients to other services where required. For example during out inspection we observed a patient treated that had an eye complaint. We saw that the nurse organised a referral for the patient to the eye clinic and gave the patient the relevant information.
- Patients' clinical information was accessed on SystmOne which could be accessed by the patient's GP. The system notified the GP that the patient had attended the unit and if further follow up was required. A copy of the patient's discharge letter was also sent to the GP. The system notified the health visitor or school nurse if a child was treated at the unit.
- We observed a patient consultation and saw that the patient was given wound care advice and information about signs if infection. The patient was given an information leaflet and a contact number if the patient had any questions or concerns.

Access to information

- Staff had access to all relevant information about each patient's care as this was documented in patient records on the ward. Blood and other test results were sent directly to the GP responsible for the patient.
- We saw incident reports, which showed examples of staff taking appropriate action when information had not been received from other healthcare organisations. This meant that staff took action to ensure they had all the information needed for patients' ongoing care.

Minor Injuries Unit

- Staff had access to a wide range of policies and guidance via the hospital intranet; all staff we spoke with said that the system was easy to used and used it frequently.

Good

Are services effective?

- Staff could access datix the electronic incident reporting tool to review incidents and learning on incident management in order to develop their own practice and share learning with other staff across the hospital.
- Patient records were held on SystmOne. This was accessible from each desk top computer so staff had ready access to patient information.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Information for staff on mental capacity assessment and Deprivation of Liberty Safeguards (DoLS) was displayed in the staff office. This included a flowchart for assessing mental capacity and a flowchart for assessing when application for DoLS authorisation was required. Both of these flowcharts were based on legislation, including the Mental Capacity Act 2005.
- Staff were trained in mental capacity assessment as part of their mandatory training. We asked two members of staff about mental capacity assessment and they could both explain when mental capacity assessment would be appropriate and how best interests decisions would be made for patients who lacked capacity. Compliance with mental capacity and DoLS training was 100% for inpatient nursing staff. There were no patients subject to a DoLS at the time of our inspection.
- Information on patients' mental capacity was included in the daily handover discussion.
- The provider had a policy on DoLS. This was version controlled, dated July 2016 and was within date for its next review. The provider had a policy on the Mental Capacity Act, which was dated December 2014. This was version controlled and was within date for its next review.

Minor Injuries Unit

- We spoke with three staff about their knowledge and understanding of the Mental Capacity Act (MCA: 2005) and Deprivation of Liberty Safeguards (DoLS: 2009). All of the staff were able to explain the core principles of the MCA and DoLS and how this would apply in practice.
- One member of staff gave an example of how they supported a patient with dementia and how they had liaised with the patient's family offering appropriate guidance to gain the patient's consent to treatment
- Within the 10 sets of notes that we reviewed we saw that consent had been gained for treatment in all cases.

Good

Are services caring?

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

Summary

We rated this service as good for caring because:

- Results from the NHS Friends and Family Test were consistently positive.
- The patients we spoke to were positive about the care staff gave them. One patient said, "I'd recommend anyone to come here…it's been wonderful" and another said, "Everything is good here."
- Staff showed respect for patients' privacy and dignity and we saw staff interacting positively with patients.
- Staff supported patients' emotional needs. For example, one therapist told us about how she was working on anxiety management strategies with a patient.
- Patients' relatives and loved ones were included in care planning. However, one member of staff told us that involvement of relatives and loved ones in rehabilitation sessions was a "missed opportunity" because the working hours of therapists on the ward did not coincide with visiting times.

Compassionate care

- Results from the NHS Friends and Family Test were positive. From September 2015 to August 2016, there were nine months where sufficient patient responses were received to calculate results. In six out of these nine months, the inpatient service scored 100% for the question "Would you recommend this service to friends and family?". There was approximately 300 responses across childrens and adult services monthly.
- We saw examples of compliments from patients displayed in the reception area of the ward. One comment said "Thank you to all the wonderful staff for your kindness" and another said, "I will look back at my time on Laurel ward with gratitude to you all."
- We saw staff interacting positively with patients. For example, we saw one member of staff sitting with two patients in the day room and engaging them in conversation.
- Staff showed respect for patients' privacy and dignity. For example, staff closed patients' doors while care was taking place.
- The patients we spoke to were positive about the care staff gave them. One patient said, "I'd recommend anyone to come here…it's been wonderful" and another said, "Everything is good here."
- A patient's wife told us the care had been "lovely" and said she knew her husband was cared for on the ward.

Minor Injuries Unit

- Results from the friends and family tests showed that 100% of patients that used the service and responded to the questionnaire in August, September and October 2016 would recommend the service to friends and family. 100% said they were satisfied with the service they received over the same period.
- We spoke with a teenage patient who said that they had received good treatment and the staff were very kind and caring.
- We observed four patient consultations and saw that patients were treated in a caring way and that their dignity and privacy was respected.
- During our inspection we observed that all staff were courteous and polite to service users. We saw a member of the reception team taking an elderly patient to the waiting area as they were unclear where to go.
- Staff introduced themselves to patients and explained their job role.

Understanding and involvement of patients and those close to them

- We spoke to a patient's wife who told us she had been included in plans and said that staff were always available. The patient's wife also told us that she felt able to raise any issues about the patient's care with staff.
- One patient we spoke to said that staff had talked to his family when discussing plans for him going home.
- Therapy staff told us that they talked to patients' relatives and loved ones over the phone about rehabilitation and discharge plans. However, one

Good

Are services caring?

member of staff told us that involvement of relatives and loved ones in rehabilitation sessions was a "missed opportunity" because the working hours of therapists on the ward did not coincide with visiting times.

Minor Injuries Unit

- We observed a member of staff supporting a patient to access a clinical room; the nurse was courteous and took time to explain what was happening.
- We observed staff explain what they were doing and checking that the patient was comfortable and understood the treatment that they were receiving
- The parent of a child that was treated told us that they had used the service on a number of occasions and the care was always excellent. She said that she felt that she was kept informed and was involved in the treatment that her child was receiving

Emotional support

- A therapist told us about how she was working on anxiety management strategies with a patient as this had been identified as something that would be beneficial to the patient.
- We saw that staff discussed patients' cognitive and mental health needs at their daily handover meeting.
- Patients told us that their loved ones were able to visit them on the ward at that visiting times could be flexible if required.

Minor Injuries Unit

- One patient told us following their treatment staff had been very understanding of a personal problem and had taken time to listen and they felt that they had been supported and their needs considered.
- We observed one patient who was very nervous about their treatment and the nurse caring for them was very calm and supportive and put the patient at ease.

Good

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 this service as good for responsive because:

- Staff worked with other teams in the organisation and with the local acute hospital to improve patient flow and to make sure that patients received the right level of care in the right place. For example, senior staff told us how they worked with the local out of hospital team to ensure that patients were triaged appropriately to either the community hospital or to be supported at home. We saw a flow chart, which clearly outlined this triage process.
- At the time of our inspection, Beccles ward was being renovated in order improve the environment and facilities that were available for patients.
- Patients were supported to communicate their needs. A translation service was available for patients who did not speak or understand English and staff had access to patient information leaflets in British Sign Language and braille.
- We saw staff supporting the needs of vulnerable patients on the ward. For example, we saw staff providing one to one care for a patient who needed constant supervision in order to maintain their safety.
- There was a robust process for handling complaints. Senior staff gave us examples of learning from complaints and shared this learning with staff at team meetings.
- However, we saw that all patients were cared for in individual rooms on Laurel ward, which was the temporary location of the inpatient service while renovations were carried out on Beccles ward. Staff and patients' relatives told us that this meant vulnerable patients were more isolated.

Planning and delivering services which meet people's needs

- Senior staff told us how they worked with the local out of hospital team to ensure that patients were triaged appropriately to either the community hospital or to be supported at home. This meant that staff supported patients in the local community to receive the right level of care in the right place. We saw a flow chart, which outlined the triage process.
- Senior staff told us that they had a daily teleconference with the local acute hospital in order to discuss patient flow and the availability of beds. The ward clerk sent updates on availability of beds to managers at the local acute hospital twice a day. This meant that staff monitored patient flow so that resources were used more effectively.
- Senior staff had identified a need to increase the level of rehabilitation provided by the inpatient service. Senior staff had submitted a business case to increase therapy and nursing staffing in order to meet this need. This plan was in line with the views of nursing and therapy staff we spoke to.
- At the time of our inspection, Beccles ward was being renovated in order improve the environment and facilities that were available for patients as well as an increased number of beds that were available at Laurel ward.

Minor Injuries Unit

- Local people were aware of the service offered by the unit and it was used appropriately with patients attending with very minor complaints.
- At the time of our inspection the commissioning of minor injuries services in the area was under review. The outcome of this review may impact the services offered by the unit.
- Staff worked with other teams in the organisation and with the local acute hospital to improve patient flow and to make sure that patients received the right level of care in the right place. For example a service user told us that they used the service because it was local and the waiting time was shorter than the local accident and emergency department.

Good

Are services responsive to people's needs?

- Staff demonstrated knowledge of referral pathways for patients who may require further medical attention or follow up. Staff were able to explain the chest pain pathway as well as ear nose and throat (ENT), plastics and orthopaedics and eye pathways.

Equality and diversity

- Information was displayed about communication support available to patients. This included signposting on how to access information in formats including easy read, British Sign Language and braille.
- Staff had access to translation services for patients who did not speak or understand English. This included telephone translation and face-to-face translation services.

Minor Injuries Unit

- The unit had access to a telephone translation service if required. One member of staff we spoke with had used the service and found it responsive.
- The unit was on the ground floor of the building. The entrance was wheelchair accessible and toilets with access for disabled people were available.

Meeting the needs of people in vulnerable circumstances

- Information offering patients a chaperone was displayed in the reception area of the ward.
- Staff were trained on how to care for patients living with dementia. Training was provided to staff by an admiral nurse (a specialist nurse for dementia). From March to June 2016, 92% of staff had completed this training. We spoke to two care assistants who confirmed that they had completed this training.
- An audit of care for patients on the ward living with dementia showed positive results, with a score of 100% in October 2016.
- On Laurel ward, the temporary location of the inpatient ward, all patients were cared for in individual rooms. One member of staff told us that this meant vulnerable patients were more isolated. One patient's relative told us that their relative was "quite isolated in a single room". Senior staff were aware of the limitations of the temporary ward environment. We saw nursing staff checking on patients' wellbeing frequently and we saw nursing staff providing one to one care for a patient who was vulnerable and required constant supervision to maintain their safety.

Minor Injuries Unit

- The team were aware of the need to refer patients to further services if it was felt that a patient was vulnerable and required more support. They told us that they would refer to the out of hospital team and the district nursing team as well as to the patient's GP.
- A chaperone service was available for patients when required. We saw information offering patients a chaperone in the reception area.
- Staff had received dementia awareness training. A member of staff told us about a gentleman who had attended the unit who was living with dementia and how they involved his family to ensure that he would receive the appropriate after care for his injury.
- One staff member told us about an elderly patient who had a minor injury to her back that had left her incapacitated. Referral was made to the out of hospital team and social care to ensure the patient had support whilst they recovered.

Access to the right care at the right time

- There were 20 delayed discharges from Beccles Ward from 1 January 2016 to 30 June 2016. Senior staff monitored delayed discharges and were aware of the reasons for delays in discharges. Senior staff could give examples of how they had responded to delays in patient discharges. For example, the matron gave us an example of how she had escalated a delayed discharge to the inpatient lead in order to make sure the patient was discharged to their preferred place of care in a timely way.
- Staff monitored the average length of stay for patients. The average length of patient stay on Laurel ward ranged from 13 days to 24 days from June to October 2016. Senior staff told us that they aimed to discharge patients from the inpatient service within three weeks (21 days) of admission.

Good

Are services responsive to people's needs?

- Senior staff did not record the number of readmissions within 90 days of discharge. This was because patients requiring re-admission would usually be re-admitted to the local acute hospital not the community inpatient ward.

Minor Injuries Unit

- The unit had recently reduced its opening hours due to a shortage of staff and was now open daily from 10am to 6pm where previously the service had been open 8am to 8pm.
- Patients told us that they appreciated the short waiting times in comparison to local accident and emergency departments.
- There was no appointment system in place. Patients were triaged within 15 minutes using Manchester triage system. However due to the low volume of service users patients were often seen within 15 minutes of arrival. The safety dashboard indicated that between January and September 2016 100% of patients were discharged within four hours. The percentage of patient's triaged within 15 minutes was greater than 95% except in August (93%) and September (93.3%). Staff told us that this was due to the department being busier over the summer period.
- Reception staff told us that urgent cases were given appropriate prioritisation and they would notify nursing staff if a patient was unwell in the waiting area.
- There was no diagnostic imaging available at the site and staff were not able to refer patients for x-ray. If a patient required diagnostic imaging they would have to attend the local accident and emergency department.

Learning from complaints and concerns

- There were three complaints regarding inpatient care on Beccles ward from January 2016 to October 2016. We saw action plans related to these complaints. The action plans included identified areas for improvement, and actions with assigned responsibilities and dates for completion.
- Senior staff gave us examples of learning from complaints. For example, they told us about a complaint relating to the way a member of staff had communicated with a patient. This was addressed with the staff member and they were supported to attend a study day on communication to help improve their skills.
- Senior staff told us that information on complaints was shared with staff at team meetings. We saw a clinical quality report, which documented the dates when complaints and action plans were shared with staff at team meetings.
- Contact details for the Patient Advice and Liaison Service (PALS) were displayed in the reception area of the ward. We also saw comment cards for patients and their visitors in the reception area. This meant that patients and their loved ones had access to information on how to make a complaint.
- We saw a clinical quality report dated August 2016, which showed that from September 2015 to August 2016, there were 117 compliments received from patients and their loved ones about the inpatient service.

Minor Injuries Unit

- The unit had received two complaints in the previous 12 months. We saw that both complaints had been fully investigated and nurses involved had been given feedback. We saw evidence of reflection and shared learning. Staff we spoke with us were able to tell us about these two complaints and the outcome of the investigations.
- Learning from complaints within the organisation were shared at team meetings and via a monthly newsletter sent from the MIU manager. We saw minutes from two team meetings and saw that complaints were a regular agenda item.

Good

Are services well-led?

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

Summary

We rated this service as good for well-led because:

- Senior staff told us about their vision for the future of the inpatient service. This involved the re-design of the inpatient ward at Beccles hospital and proposals to develop this into a more rehabilitation-focused ward. The therapy and nursing staff we spoke to were aware of the proposed developments.
- There were governance processes in place for sharing information with staff on the ward and escalating information to executive level through the integrated governance committee. We saw evidence of senior staff sharing information on incidents and complaints with staff at ward level.
- We saw a local risk register, which included identified clinical risks and actions to mitigate them.
- There was a positive culture in the service and staff gave positive feedback about local leaders.
- However, staff told us that there was a lack of engagement with staff from senior leaders in the organisation. For example, staff told us that senior leaders did not always consult with them in a timely way on changes to services or seek their involvement in these changes.
- We saw an investigation into a serious incident. This lacked analysis of the root cause of the incident and did not contain interpretation of whether clinical practice in the lead up to the incident was of good quality. This meant we were not assured that learning from incidents was always robust.

However,

- Staff felt that there was lack of engagement from the executive team.

Leadership of this service

- The community hospitals lead and the community hospitals matron led the inpatient service. There was a vacancy for a Band 7 team lead on the inpatient ward at the time of our inspection. The matron was covering this role in the interim.
- The matron was responsible for day-to-day management of the ward and line-managed nursing staff. Staff were positive about local leadership and told us that leaders were visible on the ward.
- Therapy staff were managed separately under community therapy teams. This meant that leadership of inpatient nursing and therapy teams was not integrated. For example, therapy staff did not attend ward staff meetings.

Minor Injuries Unit

- The staff at the unit was very complimentary of the leadership from the minor injuries lead nurse. They said the manager was very supportive and worked hard to provide the best service to patients.
- However, staff told us that there was a lack of engagement with staff from senior leaders in the organisation with the exception of the executive director of adult services who staff described as very visible.

Service vision and strategy

- We saw the organisation's values of "Attitude, Behaviour, Competence, Delivery" displayed in the staff office on the ward. The staff we saw showed these values in their interactions with patients.
- Leaders told us about their vision for the future of the inpatient service, which included the re-design of the inpatient ward at Beccles hospital and proposals to develop this into a more rehabilitation-focused ward. The therapy and nursing staff we spoke to were aware of the proposed developments.

Minor Injuries Unit

- We saw the organisation's values of "Attitude, Behaviour, Competence, Delivery" displayed in the lead nurses' office.

Good

Are services well-led?

- There was a vision for the future of the service described by the lead nurse and the leadership team. However the implementation of this strategy was on hold whilst the review of services by the clinical commissioning group (CCG) was concluded.

Governance, risk management and quality measurement

- We saw evidence of a local risk register, which included two clinical risks. The risk register contained actions to mitigate these risks, with timelines and updates on actions.
- There were processes in place for sharing information with staff through team meetings and handover meetings. Standing items on the team meeting agenda included review of the clinical dashboard, complaints, NICE guidelines, serious incidents, review of the risk register and audit. We saw evidence that managers shared information on learning from incidents at team meetings. Therapy staff were not included in these meetings because they were line managed separately and were only part-time on the ward.
- Senior staff told us that information was escalated to executive level through the integrated governance committee, which took place every two months. Staff working on the ward were not aware of this forum for sharing information at executive level. We asked two members of staff about these meetings and neither of them were aware of the meetings.
- Staff received communications from senior leaders of the organisation through a weekly communications newsletter. Two staff told us about this newsletter.
- We saw evidence of an investigation into a serious incident in the inpatient service. However, there was a lack of analysis of the events leading up to the incident and no detailed explanation of the root cause of the incident. This meant we were not assured that learning from incidents was always robust.

Minor Injuries Unit

- We saw evidence of a local risk register, which included two clinical risks around staffing levels and staff training. The risk register contained actions to mitigate these risks, with timelines and updates on actions although these were on hold pending the outcome of the service review. Staff we spoke with were aware of the risks identified on the hospital risk register that specifically related to the minor injuries unit.
- There were processes in place for sharing information with staff through team meetings and team briefings sent via email. Items on the team meeting agenda included review of the clinical dashboard, complaints, NICE guidelines, serious incidents, review of the risk register and audit.
- Senior staff told us that information was escalated to executive level through the integrated governance committee, which took place every two months. The lead nurse on the unit was aware of this escalation process but band 5 nurses we spoke to said that they were not aware of this.
- Staff told us that the senior executive team shared information through weekly blogs. Staff said that on the whole these were well received although a member of staff told us that some content was ill judged as some members of staff were facing uncertainty about the security of their jobs.

Culture within this service

- There was a positive culture in the inpatient service. Staff said that the multidisciplinary team worked well together and said they felt confident to raise any concerns. We saw staff working positively together on the ward.
- The sickness rate for staff on Beccles ward in the last 12 months was 4%. We did not see a target in terms of sickness rates for the organisation.

Minor Injuries Unit

- Although the unit was facing an uncertain future we found that the team were very supportive of each other and motivated to deliver the best possible service to their patients.
- All members of staff that we spoke with said that they were proud of the service that they offered. They described a close, supportive team with a positive attitude.

Public engagement

- We saw comment cards for patients and relatives displayed in the reception area of the ward. We saw posters encouraging patients and their loved ones to

Good

Are services well-led?

give feedback on the service through PALS and to CQC inspectors. The service used the NHS Friends and Family test, which gave patients a chance to give feedback on the care they received.

Minor Injuries Unit

- There had been a recent public engagement process around the review of services provided by MIU to the local area. Staff told us that members of the public had been very supportive and wanted to keep the service provided at the unit.
- Patients were encouraged to complete a patient satisfaction survey. We saw boxes in the waiting area for patients to leave feedback questionnaires and were told that reception staff would hand out surveys. The boxes were empty at the time of our inspection.

Staff engagement

- Staff were positive about local leadership of the service. One member of staff said local leaders were “brilliant”.
- However, staff were less positive about executive level leadership. One member of staff said they would like “more presence” from senior leaders and another commented on the lack of staff engagement from senior leaders.
- Staff said they had not been engaged by senior leaders of the organisation in terms of how the inpatient ward facilities should be re-designed.
- Two members of staff we spoke to told us they were shareholders in the organisation. One member of staff was positive about this and said it meant they could “get involved” in the organisation while another felt that being a shareholder did improve engagement between senior leaders and staff.

Minor Injuries Unit

- At the time of our inspection staff were waiting to hear the outcome of a review of services provided by the unit. The MIU manager told us that they tried to keep the staff up to date with information but they were still waiting for confirmation.
- Staff at the minor injuries unit told us that although there direct line manager had been very supportive they felt that more support from the senior management team would have been beneficial.
- Staff were aware of the shareholder council that staff were invited to attend to give input to the services provided by the organisation although none of the members of staff we spoke with had attended.
- The provider held monthly staff awards ceremony and the minor injuries team had been nominated for an award the previous month.

Innovation, improvement and sustainability

- Senior staff told us that they had visited an intermediate care facility in order to get ideas on how to develop the inpatient service. The inpatient ward at Beccles hospital was being refurbished to improve facilities for patients at the time of our inspection.
- Senior staff had opened up the Band 7 team lead vacancy to nurses and therapists in order to improve the chances of recruitment and to fit with the vision of a rehabilitation-focused ward.