Central Manchester University Hospitals NHS Foundation Trust

RW3

Community health inpatient services

Quality Report

Trust Headquarters, Cobbett House
Manchester Royal Infirmary
Oxford Road
Manchester
M13 9WL
Tel: 0161 2761234
Website: www.cmft.nhs.uk

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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)
RW3	Intermediate Care Wards - Gorton Park Nursing and Residential Home	Community health inpatient services	M13 9WL

This report describes our judgement of the quality of care provided within this core service by Central Manchester University Hospitals NHSFoundation 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 Central Manchester University Hospitals NHSFoundation Trust and these are brought together to inform our overall judgement of Central Manchester University Hospitals NHSFoundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community inpatient services at Central Manchester University Hospitals NHS Foundation Trust as 'good' overall because;

There was a proactive approach to incident reporting and safety performance within the service. There was a positive culture of learning from incidents and changes had been made to improve quality and reduce patient risk. Care and treatment was delivered in line with evidence-based guidance. Multidisciplinary working was embedded throughout the service. Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance with clear evidence of action to resolve concerns. The leadership was knowledgeable about quality issues and priorities, understood challenges, and took action to address them.

There were systems in place to enable staff, and patients and their carers to give feedback on the service to enable improvements. There was a strong focus on continuous learning and improvement and innovation was supported and rewarded.

The service responded to times of additional pressures and had purchased additional beds to increase services to patients during the period of winter pressures. Care and treatment was coordinated with other services to ensure continuity of care and a seamless transition when patients were returning to the community setting.

Summary of findings

Background to the service

Central Manchester University Hospitals NHS Foundation Trust (CMFT) provides community inpatient services for the population of Central Manchester. There are 35 inpatient beds available at two rehabilitation wards based at Gorton Parks Nursing and Residential Home. The home is owned by a private provider. The service is available 24 hours a day, seven days a week, according to patients' needs. The Intermediate care team provide care and support to both of the units.

The delamere unit has 23 residential beds available for inpatients requiring rehabilitation therapy. The unit is staffed over 24 hours with care support workers that are employed by the private provider. The intermediate care team provides therapy and nursing intervention to the patients in the unit 7 days a week at intervals between the hours of 8am to 8pm.

The debdale unit has 12 nursing beds available for patients requiring 24 hour nursing care and therapy interventions. This unit is staffed by CMFT nurses daily over 24 hours and in addition, CMFT staff provide therapy intervention during the day. Care support workers employed by the private provider give care support to patients in these 12 beds daily over 24 hours.

Referrals are accepted from health or social care workers along with self-referrals. Admissions are taken as a step down from hospital for patients not ready to return to their own home and in need of rehabilitation, or as a step up from community for patients requiring rehabilitation, but not requiring hospital admission.

The intermediate care team is a multi-disciplinary team and includes: physiotherapists, occupational therapists, nurses, advanced nurse practitioners, assistant practitioners, support workers, rehabilitation assistants, general practitioners (GPs), a consultant in elderly medicine, pharmacists, and a social worker. The intermediate care team work with patients and those close to them to achieve identified goals to enable patients to become as independent as possible.

Between April 2014 and March 2015 the service offered 13,038 occupied bed days out of a possible total of 13,411, representing 97.2% bed occupancy for the year. Most patients (72%) using the service were over the age of 75 years old however, the service was available for adults over 18 years of age.

We carried out an announced inspection of both units on 13 November. We also carried out an unannounced inspection on 26 November 2015. As part of our inspection we reviewed data provided by the trust and spoke with ten members of staff including therapists, nurses, doctors and pharmacists. We spoke with four patients and observed care and treatment. We reviewed 12 medication records and ten sets of comprehensive patient records.

Our inspection team

Our inspection team was led by:

Chair: Nick Hulme, Chief Executive, The Ipswich Hospital NHS Trust

Team Leader: Ann Ford, Care Quality Commission

The team inspecting community inpatients services included two CQC inspectors (one with previous experience of working in community services and an occupational therapist specialist advisor.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of Central Manchester University Hospitals NHS Foundation Trust.

Summary of findings

How we carried out this inspection

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

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

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

We carried out an announced visit on 13 November 2015. During the visit we held interviews with a range of staff who worked within the service, such as nurses, doctors and therapists. We observed how people were being cared for and reviewed treatment records of people who use services. We met with people who used services, who shared their views and experiences of the core service. We also carried out an unannounced visit on 26 November 2015.

What people who use the provider say

We observed results from a patient survey conducted from May 2015 to September 2015, we spoke to four patients, and we saw case studies provided by patients.

Patients said "It's a lovely home and there is some lovely staff that have been really helpful", "its helped me with my confidence, the nurses are fantastic", and "staff were very nice they listened to me"

Patients had identified the respect and courtesy they received from staff as excellent or good.

100% of responses to the patient survey identified that patients were likely or extremely likely to recommend the service to their friends or family.

All comments received via comments boxes we left in the community service locations were positive about the standard of care received.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The service should:

- Ensure adherence to the documentation policy
- Ensure all staff attend mandatory training
- Ensure all staff adhere to the falls policy to reduce the risk of harm to patients in relation to falls.

Central Manchester University Hospitals 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

We rated community inpatient services as 'good' for safe because;

Intermediate care units were visibly clean, tidy, and clutter free and all staff followed infection control principles. There was sufficient, visibly clean and well maintained equipment available. Systems were in place to identify patients at risk and patient risk assessments were completed. Reporting and learning from incidents was well managed and staff received feedback from incidents at team meetings and training sessions. Improvements had been made from lessons learnt following incidents that had reduced the risk of harm to patients in particular in relation to pressure ulcers. Medicines management was generally good with pharmacist support for both units. Medication administration charts were legible and systems were in place for safe storage and administration of controlled drugs.

Nurse staffing levels met the requirements of the service and sickness within the service was being proactively managed. Medical cover was available during the week by GPs and a consultant in elderly medicine. Out of hours medical cover was accessed from the local GP out of hour's service. Staff were offered training in relation to safeguarding and were aware of safeguarding principles and procedures. However, attendance to training was lower than the trust target of 90%. Therapy and nursing staff contributed to the patients' care and a single patient record was available.

However, it was difficult to determine which part of the patient record held the latest relevant information. All parts of the patient record were not securely attached which could result in a loss of information. Work was on-going to reduce the risk of falls. However, we found that staff did not always adhere to the policy in relation to supporting patients that were identified as high risk of falls. Staff were reminded during team meetings to change the patients risk level indicator on the patients mobilising equipment as their risk of falls changed.

Safety performance

Good

Are services safe?

- The occurrence of pressure ulcers, patient falls, catheter acquired urinary tract infections (UTIs) and venous thromboembolism (VTE) was monitored. The matron participated in quality rounds which involved reviewing and speaking with patients. When an incident occurred the staff completed a harm free care form along with an incident form and the data was collated monthly by the matron.
- There had been no reported VTEs or catheter acquired UTIs since April 2015.
- There had been no health care acquired infections reported since April 2015 such as methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C-Diff).
- Between April 2015 and October 2015 there had been one reported pressure ulcer that a patient had developed on the unit. Pressure ulcers were classified on a scale of one to four with grade one being the lowest level of harm. The pressure ulcer reported was classified as a grade one.
- There had been 103 falls reported between April 2015 and August 2015. The falls were graded on a scale of one to five with level one being the least harm. Of the 103 falls, 91 were recorded as level one and 12 were recorded as level two.
- The service had responded to the number of falls reported and had made several changes to reduce and manage the risk which included: review of additional equipment, medication review for each patient and monitoring when a fall took place to identify any gaps in care. Falls were discussed at the harm free care meetings and minutes from these meeting confirmed discussions and learning from incidents took place.
- There were two serious incidents requiring investigation reported during the period August 2014 to April 2015. One incident was in relation to a grade three pressure ulcer. A root cause analysis (RCA) investigation had taken place with actions identified based on the findings. A number of initiatives were introduced to reduce the incidence of pressure ulcers which included a training package for staff, reviewing equipment provision, improving documentation, and referring to podiatry services.
- The second incident occurred in March 2015 and was in relation to a patient being found unresponsive in bed and bleeding from a surgical graft site. The patient was transferred to hospital for surgery but later died. The cause of death was confirmed as a haemorrhage from the femoral vessels and samples were taken to investigate the cause of the bleed. We saw evidence within the RCA that duty of candour had been implemented, and an action plan was developed with evidence for shared learning across several services within the organisation. The matron advised us that changes had been made in response to the incident which included: improved information sharing particularly for patients admitted over the weekend, and removal of the private provider's defibrillator from the unit.
- The service had experienced a high level of pressure ulcers during April 2014 to March 2015. Since April 2015 to October 2015 one pressure ulcer had developed on the unit. The adult intermediate care team had received an award from the trust in October 2015 for the most improved divisional area in relation to pressure area care.

Incident reporting, learning, and improvement

- Incidents were reported using the trust electronic recording system and staff were able to describe how and when to report incidents.
- Data provided by the trust showed there were 111 incidents reported by community inpatient services between April 2015 and September 2015. The majority of incidents reported were low level incidents which were suggestive of a positive reporting culture.
- Learning from incidents was shared across the team. This took the form of case studies and 'back to basics' training every two weeks. At the time of our inspection we observed a patient case study in relation to falls which was used as learning from the incident. The team had identified some issues with back and leg braces and invited the company that provided the braces to present and educate the staff at a 'back to basics' learning session.
- Staff were familiar with the principles of the duty of candour process and used these principles in practice. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safeguarding

- Staff received mandatory training for level 1, 2 and 3 safeguarding adults and children. Completion of safeguarding level 1 and 2 training in community

Good

Are services safe?

inpatient services was just below the trust's target of 90%. Data provided by the trust identified that 88.8% of staff had completed the mandatory annual corporate training and 88.5% of staff had completed the mandatory annual clinical training. Completion of safeguarding level 3 mandatory training for children and adults was poor with 26.9% compliance. The matron advised us that she was now reviewing training and ensuring staff were booked on to improve compliance.

- Staff understood the processes in place for identifying and reporting safeguarding concerns and allegations of abuse. The private provider who owned the service took the lead on safeguarding issues within the unit and any issues were reported to the service manager. Staff advised us that they could contact the trust's safeguarding team to discuss any issues and seek advice if required.

Medicines

- Medication was stored in locked wall pods in each patient's room. We reviewed a sample of medication and found the stock was within its expiry date.
- Controlled drugs were stored separately in a locked metal, wall mounted cupboard in a clinical area. We reviewed the controlled drugs record book and found that entries were dated and all medication that had been dispensed was signed for by two staff in line with best practice.
- Fridge temperatures were monitored and recorded. Records showed temperatures were within the acceptable safe range.
- There were six low harm near miss incidents reported in relation to medication between July 2015 and August 2015 which included drugs not being available and incorrect dose supplied. Within the incident reporting the near misses had been identified by the pharmacist when performing medication checks. At the time of our inspection we observed a nurse having a telephone conversation with hospital staff as a patient had been sent to the unit without all the discharge medication. The nurse informed us she would be reporting this as an incident.
- We looked at 12 medication administration records, and found them all to be legible and all had allergies documented. However, the date of administration had not been documented on one record for one day. There were medications that had been omitted on three of the twelve prescriptions. The reason for these omissions was not documented.

Environment and equipment

- Both units had access to a defibrillator, oxygen and an emergency prophylaxis medication kit.
- Daily machine and battery tests for the defibrillation machines were completed. Records of the checks were fully completed and showed the battery life was within the range required. The oxygen and emergency prophylaxis kit were stored securely.
- Electrical equipment was appropriately tested. The items we reviewed all had an in date portable appliance test sticker in place which indicated that annual maintenance checks for equipment were in place.
- A wide range of therapy and mobility equipment was in use. Equipment was visibly clean and in good condition.
- Clinical waste was segregated and stored appropriately and in line with best practice guidance. Specimens were labelled and stored appropriately in a separate fridge in the clinical area.
- All areas accessible to patients were visibly clean and clutter free.

Quality of Records

- Patients' records were stored in the patient's own rooms.
- There was evidence of multidisciplinary working within the patient record. Records included nursing and therapy assessments and risk assessments.
- An audit was completed in March 2015 and included ten sets of records. The audit identified five sets of records had loose documents within the files, the name of the person making an entry was not printed, and the designation of the person making the entry was not entered on any of the ten records. The matron had developed an action plan to address the issues which included the use of stamps which had the name and designation of staff in print form.
- We reviewed ten sets of records during our inspection however; we found them difficult to follow and did not fully understand how records were laid out. It was difficult to determine which part of the record had the latest relevant information. One member of staff told us

they knew where to find information in the records but it could be better structured. Another member of staff showed us and told us they knew which part of the record to go to for different information.
- Of the ten sets of records we viewed, four sets had loose documentation that was not secured. The key worker for the patient was not clearly identified on any of the ten records. Only two records had a planned discharge date recorded at the time of admission.
- When patients were discharged from the unit records were securely stored in locked cabinets prior to being sent for archiving.

Cleanliness, infection control and hygiene

- Areas within the inpatients units were visibly clean and tidy.
- The provider who owned the service was responsible for the cleaning of the wards which included common areas, bathrooms and general cleaning of patient rooms. The unit manager was responsible for ensuring cleaning of beds and deep cleans took place.
- Staff complied with the trust's policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidelines. Hand gel was readily available in all the clinical areas and we observed staff and visitors using it.
- There were ample access to hand washing facilities and personal protective equipment such as aprons and gloves.
- Mandatory training records identified that all but one member of staff had completed infection control training.
- Records showed that monthly hand hygiene audits were in place with high compliance rates of 94% and above since April 2015.
- A patient survey took place during May 2015 to August 2015 and 19 responses were recorded. Patients described the cleanliness of the location as good or excellent. In July 2015 80% described the cleanliness as good or excellent with 20% stating it was fair.

Mandatory training

- We were informed by four clinical staff that they were given protected time to complete mandatory training. Staff received an email when training was due.
- Mandatory training was spilt into corporate mandatory training and clinical mandatory training. Data provided by the trust identified that 88.8% of staff were compliant with the corporate mandatory training and 88.5% were compliant with the clinical mandatory training. The compliance rates were slightly below the trust's target of 90%.

Assessing and responding to patient risk

- Staff had access to a defibrillator, oxygen and anaphylaxis medication. The majority of staff had attended resuscitation update training.
- We were informed by two clinical staff that all patients admitted had their observations recorded daily for the first three days of admission which included blood pressure and pulse rate, to enable comparison should a patient deteriorate. A modified early warning score was used and staff knew to escalate concerns to enable the patient to go to hospital if required. Our review of ten sets of patient's records showed that all ten patients had their observations recorded for the first three days of admission. The early warning score had been completed in all ten patient records.
- Staff handover took place daily at each shift change. The nursing unit recorded the handover on an electronic record to maintain a record of discussions.
- Patient risk assessment tools were available and were used to assess the patient risk of pressure ulcers, nutrition and hydration, falls, and moving and handling. At the time of our inspection we looked at ten sets of patient records and found that nine had nutrition and hydration assessment on admission, nine had a pressure ulcer risk assessment completed, and nine had a falls risk assessment. All the patients that had pain relief medication prescribed had a pain assessment completed.
- There was an electronic white board easily visible to staff which highlighted all patients at risk of falls, and when their next assessment was due. A training package had been introduced to ensure staff were competent to manage falls effectively. At the time of our inspection, a total of five staff (19.2%) had attended the training and a further six staff had a place booked over the next three months.
- Patients identified as being at high risk of falls were categorised as red and needed assistance to mobilise. Patients at medium risk were identified as yellow and needed supervision to mobilise. A coloured tape was placed on the patient's zimmer frame which matched their level of risk.

Good

Are services safe?

- At the time of our inspection we observed two patients identified as red mobilising by themselves. We observed staff supporting two patients identified as yellow to mobilise. We asked an additional two patients that had red tape on their zimmer frame if they knew what it meant and neither of them was aware. We were not assured that the policy in relation to minimise the risk of falls was always being followed.

Staffing levels and caseload

- Therapy and nursing input was provided on the Delamere unit based on patient need, and staff were available to provide input daily between the hours of 8am and 8pm.
- The Debdale unit had 12 nursing beds and nurses provided cover over 24 hours daily. Nursing cover consisted of two nurses Monday to Friday during the day and one nurse overnight and at weekends.
- At the time of our inspection we observed the rotas for October 2015 and all shifts were covered with the identified skill mix. There had been no agency, or bank staff used and no additional hours were worked by staff. The private provider who owned the home provided one care support worker to the nursing unit overnight and two care support workers during the day.
- At the time of our inspection there was one whole time equivalent (WTE) band five vacancy.
- A band six nurse was on long term sick, and one WTE nurse was on a return to practice course with the intention to fill the WTE band 5 nursing vacancy.
- The team were currently managing staffing by rotating staff from the community intermediate care team into the units. The shift start and finish times were changed to meet the needs of the service and to ensure patients remained safe.
- At the time of our inspection two members of staff told us there was no nursing cover during the night shift for the nurse to take their unpaid break. There was also a risk on the register in relation to the nurse on nightshift ringing in sick and no staff being available to cover. We saw evidence in meeting minutes that this had been discussed and alternative options were being considered.
- Medical cover was provided for four hours a day, Monday to Friday. At weekends and out of hours staff could contact the GP out of hours' service. There was a part-time consultant for elderly care. An advanced nurse practitioner was also available.
- The sickness rate for the whole intermediate care team during the period October 2014 to September 2015 was on average 4.2% which was higher than the trust's target of 3.6%. However, this had reduced significantly since August 2015 to 0.8% and below.

Managing anticipated risks

- Patients experiencing falls had been identified as a high risk for the service. Additional training, patient compliance, and a review of equipment were in place to manage this risk.
- We observed in the minutes of a contract monitoring meeting held in October 2015, and a joint governance meeting between intermediate care and the private provider who owned the service, that a workforce issue had been identified at night time. At night there were two carers on duty on the debdale unit who worked to cover both the CMFT inpatients and the private provider's inpatients. When a patient in the private provider's side of the unit needed assistance from two carers, the CMFT nurse was left to work on their own placing them at risk. A twilight shift between 8pm and 11pm was identified as an option and this was being considered by the private provider. We did not see this issue identified on the risk register at the time of our inspection.
- There were systems in place to manage fluctuating demands. We were told that if the hospital was under pressure due to a lack of available beds they would consider if any patients could be discharged with additional support at home. Discussions took place daily with the private provider with regards to dependency of patients and staffing. The private provider made the final decisions on how many patients they were able to support based on dependency.

Major incident awareness and training

- Staff had attended fire training as part of their mandatory training.
- The service responded to winter pressures by offering additional beds in the unit. In the previous year four additional beds were purchased but these were in different units within the private provider's care buildings. Some lessons learnt from winter pressures last year had resulted in additional beds being considered in the nursing unit only to reduce the risk of fragmented care.

Good

Are services effective?

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

We rated community inpatient services as 'good' for effective because;

People had a comprehensive assessment of their needs from multi-disciplinary-professionals within the team using nationally recognised risk tools. Staff worked collaboratively to understand and meet the range and complexity of people's needs. Information about people's care and treatment, and their outcomes, was routinely collected and monitored. Outcomes for patients were positive and consistent. The service used National Institute of Health and Care Excellence (NICE) best practice guidelines to support the care and treatment provided for patients. The service participated in local and national audits to enable them to benchmark their outcomes and practice. Staff were qualified and had the skills they needed to perform their roles.

Staff were supported to deliver effective care and treatment through appraisal, weekly huddles, and learning from incidents and staff and patient feedback. There were systems in place to ensure safe discharge of patients back into the community with information shared to support continuity of care for the patient.

Evidence based care and treatment

- The service used National Institute of Health and Care Excellence (NICE) best practice guidelines to support the care and treatment provided for patients.
- National risk tools were in use which included: the Waterlow score to assess risk of pressure ulcers, Malnutrition Universal Screening Tool (MUST) to assess nutrition and hydration, and the Barthel Score had been adapted to determine patient outcomes.

Pain relief

- We checked ten sets of patient records and found that pain relief was assessed, prescribed appropriately, and monitored for efficacy. Patient's confirmed their pain relief was well managed. A review of each patient's pain management was documented in the patient's notes, on the MDT meeting sheet and also on the medication administration chart by the prescriber or pharmacist.

Nutrition and hydration

- The ten sets of patient records we reviewed included a nutrition and hydration assessment. Fluid balance and food charts had been completed and supplements were prescribed where indicated. Two records however, showed patients had not had a reassessment a week after initial assessment which is deemed as best practice.

Patient outcomes

- The service had a quality dashboard to record and monitor quality performance and patient outcomes and the service took part in the National Audit of Intermediate Care (NAIC).
- From April 2015 to September 2015, the trust data identified that 74% of patients were discharged to their own home with 34% of these patients not requiring a package of care at home. This was better than the findings in the 2014 NAIC, where 65% of patients receiving bed based services returned to their own home. This was indicative of effective care and treatment being received.
- The average length of stay during April 2015 to September 2015 was 33 days in the nursing unit and 38 days in the residential unit. The service had experienced some delays in discharge due to complex social care requirements. This was improving with the recent addition of the social worker working in the team. From July 2015 to September 2015 the average length of stay in the nursing unit had reduced to 21.6 days which was better than the NAIC 2014 findings.
- Staff were involved to monitor and improve patient outcomes as part of the care planning. We reviewed ten patient records and saw that improvements to patients' mobility and health was documented within the record. However, due to the lay out of the records it was not always clear what the key goals were.
- The skin bundle assessment tool was used to reduce the risk of pressure damage to the skin. We saw one patient's assessment record had a documented risk with action and treatment to reduce the risk; the treatment

had been prescribed on the prescription chart. However, we did not see a review of the actions and outcomes documented on the following skin bundle assessments.
- Changes made following learning from incidents in relation to patients developing pressure ulcers had resulted in no pressure ulcers developing on the units since April 2015.
- Assistance required with transfers was monitored pre and post admission. Data from April 2015 to September 2015 identified that 179 patient's required assistance to transfer at the time of admission. This reduced to 79 patients requiring assistance at the time of discharge which showed a positive result for patients and was reflective of effective therapy input from the service to improve patient's independence.

Competent staff

- Staff were able to identify learning needs through the trust's appraisal process. Data provided prior to our inspection identified that 82.6% had received an appraisal in the last twelve months. However, since the data had been submitted an additional three appraisals had been completed raising compliance to 96%.
- The staff participated in 'back to basics' training sessions fortnightly. Staff gave us examples of sessions recently attended which included presentations from ophthalmology services, and care and management of leg and back braces.
- A GP informed us how they were supporting an advanced practitioner to maintain their skills. The GP had identified a learning need in relation to escalating recordings of fast heart rates and had provided training on the issue to the team.
- Training needs were also identified through learning from incidents. Additional training in relation to managing the risk of pressure ulcers had reduced the occurrence of pressure ulcers developing on the units.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary meetings were held weekly and included a GP, social worker, pharmacists, and nursing and therapy staff.
- There were communication processes in place with services in the community that patients were known to, which supported the patients' care pathway by providing continuity of care.
- There was a named key worker identified for each patient whilst admitted to the unit and this was clearly identified on the whiteboards in the staff office. The key worker had the overall responsibility for the patient's care.
- The support workers from the private provider attended handover meetings which enabled a co-ordinated approach

Referral, transfer, discharge and transition

- Discharge planning began at the time the patient was admitted to the unit. A planned discharge date was written on the staff whiteboard and on the electronic whiteboard in the staff office however, we did not see this documented in six out of 10 patient records we reviewed.
- GPs were informed of discharge by the electronic patient record system and by letter. Referrals were sent to inform other community services via fax which included a contact assessment including: what treatment the patient had received, what their ongoing needs were, any risks or allergies and a copy of all the patient's discharge medication. This enabled continuity of care for the patient when leaving the unit.

Access to information

- Care records and prescription charts were available to staff for all patients on the unit. The records we reviewed were comprehensive however, they were not clearly laid out and staff needed to access many parts of the record for up to date information.
- The team had limited access to the EMIS system and told us they used it to inform the GP when a patient was discharged.
- There had been occasions when all the appropriate admission information had not been provided when a patient was admitted to the unit. The matron had addressed this by improving the triage system when a patient was referred.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff were aware of their responsibilities in relation to consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Data provided by the trust identified that 80% of staff had completed the relevant training. This was below the trust's target of 90%.

Good

Are services effective?

- Where patients lacked capacity staff involved relevant professionals and relatives/carers to ensure decisions were made in the patient's best interests.
- In a patient audit performed during April 2015 to August 2015, 100% of patients stated they had been asked for their consent prior to treatment. Six of the seven patient records we reviewed had patient consent clearly documented.

Good

Are services caring?

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

We rated community inpatient services as 'good' for caring because;

Patients were happy with the care they received, they felt supported, and thought that staff were responsive to their needs. At the time of our inspection we observed people being treated with dignity, respect and kindness. Feedback was received from patients and those close to them using a variety of processes including the matron's quality round, the discharge questionnaire, patient surveys, and patient stories. Feedback received was mainly positive.

We saw staff interacting with patients in a friendly and compassionate manner. People were provided with emotional support and their privacy and confidentiality was maintained. Patients told us they had been given options about their care and their views were taken into account, and this was reflected in the feedback from a patient questionnaire. There was professional support for patients discharged home to provide on-going assessment and support to maintain their independence.

However, meetings to discuss patient goals did not always take place with the patient present and some patients were not aware of plans in place to reduce their risk of harm.

Compassionate care

- We spoke to four patients who told us they were happy with the care they received from the staff. They told us they felt supported by the staff and that staff were responsive to their needs. During our inspection we observed patients to be appropriately dressed, with a clean and well maintained appearance.
- One GP told us they would be happy for their own parents to receive care from the service.
- As part of our inspection we observed staff talking to patients in a friendly, compassionate manner.
- The matron performed quality rounds to get feedback from patients to enable the service to make improvements. The concerns that patients raised were mostly in relation to meals. We saw evidence in meeting minutes that these comments had been discussed with the private provider who provided the catering service.
- A patient feedback survey from May 2015 to August 2015, found that patients had identified the respect and courtesy they received from staff as 'excellent' or 'good'. In June 2015 and July 2015 100% of responses identified that patients were likely or extremely likely to recommend the service to their friends or family.
- All the staff we spoke to were passionate about providing good care to the patients.
- We saw three patient stories from patients that had used the service. When describing the service they had received they said: **"**It's a lovely home and there is some lovely staff that have been really helpful", "its helped me with my confidence, the nurses are fantastic", and "staff were very nice they listened to me"

Understanding and involvement of patients and those close to them

- During July 2015 and August 2015, 100 patients surveyed all said their views were taken into account when planning their care. At the time of our inspection, one patient told us all their needs were being met and that they had been offered options about their care.
- In July 2015 and August 2015 more than half of patients in the aforementioned survey said they had not attended a meeting where their goals were discussed or did not know if they had attended.

Emotional support

- One patient's story described how staff had provided them with emotional support due to a recent bereavement. The patient described how she was listened to and taken to a private area maintaining her privacy, dignity, and confidentiality.
- When a patient was discharged home from the unit they could be referred to the home pathway service. The home pathway service visited patients in their own home following discharge and continued to assess the patient's ongoing level of independence and provided additional support.

Good

Are services responsive to people's needs?

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

We rated community inpatient services as 'good' for responsive because;

Admission criteria was clear and all referrals were triaged by a lead therapist or nurse who made the admission decision. The therapy and nursing staff worked flexibly to meet the needs of the patient. The average waiting time to access a nursing or residential bed was less than three days. The service had experienced some delays in discharging some complex cases. However, improvement had been noticed since July 2015 following the addition of a social worker to the team.

The service had purchased additional beds to increase services to patients during the period of winter pressures. Lessons had been learnt with regards to winter pressures and plans were in place to improve the service to ensure patients were kept as safe as possible and received the care they required to meet their needs. Care and treatment was coordinated with other services to ensure continuity of care and a seamless transition back into the community setting. Staff had worked with community services to support vulnerable patients with a safe discharge home.

Nursing, medical and therapy care all revolved around patient rehabilitation and reablement. There were processes in place for staff to communicate effectively with patients whose first language was not English. The unit received few written complaints but when they did they were received with a positive problem-solving attitude, policy was followed, and plans were in place to discuss and learn from the feedback from patients and their carers. We observed evidence in minutes of meetings that the service used complaints as a process for learning and improving services.

Planning and delivering services which meet people's needs

- Admission criteria was clear, patients must be medically fit, stable, and agree to rehabilitation. Patients were assessed in acute or community settings prior to admission. Nursing and therapy staff were aware of the admission criteria. The majority of referrals were from CMFT hospitals via the complex discharge team. Information regarding the reason for admission was available to staff before the patient arrived to the unit.
- Daily reviews took place between the unit manager and the service provider to determine the dependency levels of the patients and the number that could be safely admitted. For example to safely manage dependency of patients they were assessed to determine if they were able to move up into a nursing bed or move from a nursing bed into a residential bed. Therapy and nursing staffing levels were flexed to some degree depending on patient need.
- The intermediate care team providing care in the community was based in the same building and staff rotated across inpatient and community intermediate care services. We observed rotas where shift patterns had been altered to ensure safe levels of staffing on the units.
- The matron told us that patients were placed on a waiting list and based on their needs; they could be expedited for admission.
- On arrival to the ward a nurse, occupational therapist, and a physiotherapist assessed the patient and provided a joint care plan. This care plan was shared with staff that provided care for the patient. A key worker for the patient was agreed and discharge planning started at the time of admission.
- Three staff told us they had difficulties arranging care packages for some complex patients which could delay discharge. However, recently a social worker had joined the team; this had improved social care knowledge within the team and the social worker was able to assist with the coordination of discharges.
- When a patient was discharged home to other services a referral was faxed across to the service with all the detailed information and medication. The electronic patient record system was used as well as sending a letter to inform the patient's GP. This was to ensure information was shared across services to enable continuity of care for the patient. The patient also received a copy of the discharge letter.
- The service had responded to winter pressures by purchasing additional beds to increase services to patients in the past and plans were in place to improve the provision of this service. Previously winter pressures beds were located on different units within the home

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and patients were not always reassessed or discussed at handover. Plans were in place to ensure any future additional beds were all within the debdale nursing unit.

Equality and diversity

- Translation services were available for those patients where English was not their first language. Staff could request telephone translation or book an appointment for a translator to attend. Staff knew about the translation services and were able to describe the process to us at the time of our inspection.
- Two staff informed us that flashcards were also available to support them to communicate with patients whose first language was not English.

Meeting the needs of people in vulnerable circumstances

- Staff attended dementia training as part of their clinical mandatory training and there were nominated staff who were dementia champions for the service.
- The environment provided on the units offered comfort, routine and social opportunities to support patients living with dementia. This included a small dining area with small tables, private rooms for the residents where they could take some of their own familiar belongings, and clearly marked toilet areas.
- At the time of our inspection staff told us that on occasions patients with mild learning disabilities were admitted to the ward. Staff gave an example where they had previously made contact with the learning disability team to communicate and share care planning with the patient's key worker in the community to enhance continuity of care.

Access to the right care at the right time

- Between April 2015 and September 2015 the average waiting time for a nursing bed was 2.2 days and 2 days for a residential bed. This was slightly better than the findings in the NAIC (2014) where patients waited 2.7 days from referral to treatment for intermediate bed based services. The NAIC collates data from intermediate care providers across the country to enable benchmarking to take place.
- On receipt of referral, information was triaged by the lead therapist or nurse on the unit, care staff were informed and a room was allocated and made ready for patients before arrival. We were shown the referral form which requested key information on patients including: major risks, do not attempt resuscitation status, infections status, mental health and any information relating to wound products or catheter care.
- The average bed capacity utilisation for the period April 2015 to September 2015 was 97.8%.
- If demand for a bed was high staff reviewed patients to identify if they were able to be safely discharged with additional support via the community intermediate care services or if patients could be moved across the units if their needs had changed.

Learning from complaints and concerns

- At the time of our inspection the matron was aware of one complaint that was processed through PALS. This was in relation to bowel care and waiting times when calling for assistance. The service provider had provided evidence that calls were responded to via the call system data and a meeting with PALS and the family had been arranged for December 2015.
- Complaints were discussed at team meetings and any identified learning was shared.

Good

Are services well-led?

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

We rated community inpatient services as 'good' for well-led because;

Staff were able to articulate a clear vision centred on promoting independence for the patient. There were systems in place to monitor progress and quality of care. There was a strong sense of teamwork and collective responsibility to report incidents, improve care, and reduce risks to patients.

There was an effective process in place to identify, monitor, and understand current and future risk. Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance with clear evidence of action to resolve concerns. The leadership was knowledgeable about quality issues and priorities, understood challenges, and took action to address them.

There were systems in place to enable staff, and patients and their carers to give feedback on the service to enable improvements and reduce risks. There was a strong focus on continuous learning and improvement and innovation was supported and rewarded.

Service vision and strategy

- The trust vision to improve the health and well-being for patients and the trust values were borne out by staff in their own words and actions at the time of our inspection. Nursing, therapy, and medical care all revolved around patient rehabilitation and reablement.
- There was no written strategy for the service that highlighted priorities and progress against priorities available at the time of our inspection. However, the trust's 2014-2015 annual report clearly identified the service priorities in a development plan. The service performance was clearly articulated and the service specification identified what had been commissioned from the service and identified the key performance indicators.

Governance, risk management and quality measurement

- Clinical effectiveness and governance was led and monitored by the monthly intermediate care and clinical effectiveness meeting. This meeting reported to the adults and specialist community directorate clinical effectiveness meetings. There were several sub working groups generated from the meetings to embed culture and procedures throughout the workforce by engaging staff.
- At the time of our inspection, risks that were identified and escalated for the service included: failure of computer systems, lack of available wheelchairs, and potential lack of nursing cover for the nursing bed unit if staff were sick. The service had controls in place to reduce the risks which included: whiteboards and paper held records, and flexible staffing rotas. We saw evidence via minutes of meetings that all these risks were discussed and options to reduce the risks further were being explored.
- As part of our inspection we reviewed minutes from the clinical effectiveness meetings which identified discussions had taken place in relation to the risk register, clinical audit, and safeguarding.
- The service provider staff and trust staff had different sets of policies that they worked to. Joint governance meetings took place with the service provider every fortnight. We reviewed meeting minutes from October 2015 and staffing, health and safety, policies, documentation and falls were discussed. Two staff told us that some policies were now joint policies across both teams and the fire policy was given as an example.
- Information from meetings was shared with staff during team meetings. The matron was responsible for sharing information back to the staff.
- Patient falls were a concern and the existing falls policy was being reviewed. Fortnightly falls meetings were in place, when falls occurred reviews took place to determine if any alternative action could be taken to reduce the risk.
- Internal clinical audit processes were in place and monitored which included harm free care and infection control.
- In the service development plan, winter resilience plans were identified to enable the service to open additional beds during the winter pressures period. There had been lessons learnt from the previous year and work

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between the trust and the service provider was ongoing to enable additional beds to be on the same unit as the nursing beds to ensure patients receive the appropriate care.

Leadership of this service

- Nursing, therapy, and medical staff told us they felt supported by the leaders of the service and found them to be approachable.
- Nursing and therapy staff told us that it had taken a long time to feel integrated with the trust but that this was improving. Staff were invited to meetings in the hospital and the service was now included on the website. Senior staff including the head of nursing and clinical service leads had been visible on the unit during the last six months.
- The allied health professional (AHP) lead led a professional support drop in session once a week for AHPs to attend.

Culture within this service

- As part of our inspection we asked nursing, therapy and medical staff what they were most proud of. Teamwork was identified by all three staff groups. We were told "staff go the extra mile", and "all staff are patient centred". There was recognition of each other's professional strengths within the multi-professional team.
- The service promoted the safety and well-being of staff and staff informed us they had a lone worker policy in place, mobile phones were carried either out in the community or held on the units and if risks had been identified two staff were made available to attend to the patient.
- There was an open culture that supported the reporting of incidents to improve care and reduce the risks for patients. This was observed at the time of our inspection across a range of different professionals delivering care within the unit.
- Working relationships between the service provider and trust staff were valued by the matron and there was a strong sense of partnership working.

Public engagement

- Patient feedback questionnaires were given prior to discharge from the service, the friends and family feedback cards were also available. In June 2015 and July 2015 100% of responses identified that patients were likely or extremely likely to recommend the service to their friends or family.
- Patient and public feedback was mostly positive however, some patients raised issues with the repetition of the food menu.

Staff engagement

- Staff told us they had the opportunity to raise issues and give feedback to improve the service. Weekly huddles were in place where staff could discuss issues and generate ideas in a safe environment; staff one to ones were identified and the trust had a staff survey.
- Staff told us they felt supported to raise concerns and report incidents.

Innovation, improvement and sustainability

- The team had implemented improvements in relation to reducing the incidence of pressure ulcers which included: a 6 month action plan, training for staff, and equipment review. Since implementing these changes there had been no incidences of pressure ulcers reported on the unit since April 2015. This work resulted in recognition by the trust and a financial reward was offered by the division which the team were using to purchase equipment to reduce the risk of falls.
- The matron had directed improvements within the service by looking at incidents and risks and was monitoring improvements made in these areas which included falls, pressure ulcers and reduced length of stay.