Bolsover Hospital

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Bolsover Hospital provides rehabilitation services for patients admitted from home or following discharge from acute hospitals.

There are three wards at Bolsover Hospital. Linden and Rowan wards each offer 16 beds for rehabilitation services. Sherwood ward provides 19 beds but is only open for part of the year in response to NHS winter pressures. The in-patient units are staffed with multi-disciplinary teams including medical cover.

Care was planned for and delivered in a safe manner overall. Evidence showed that staff reported incidents on the trust's electronic reporting system and shared information and learning within the teams. Staff did not consistently follow the correct procedures in respect of people's advance decisions not to be resuscitated in an emergency.

Care was planned and delivered by a multi-disciplinary team who worked together to provide the best outcome for patients. Staff used evidence based guidance and good practice using nationally recognised assessment tools. Staffing levels were not always adequate.

Patients we spoke with told us they received good care from compassionate and kind staff who respected their dignity. Patients were involved in most decisions about the care they received. Discharge planning started as soon as people were admitted to the wards to ensure the rehabilitation they received prepared them to return to their homes or supported care. The team met daily to review the discharge plans for patients to ensure they remained appropriate.

There were governance arrangements in the Trust which were implemented at ward level. Staff were aware of the Trust's vision called the DHCS Way, and generally felt empowered to raise concerns if required.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

We saw that the care provided during our inspection was generally safe. Staff were confident about reporting adverse incidents and shared learning within their teams. People were assessed for risks on admission and appropriate measures were put in place when potential risks were identified.

Are services effective?

Care was effectively delivered through the use of evidence based guidance and nationally recognised recording tools. The wards provided effective rehabilitation services to support discharge home or if appropriate residential support. Discharge was planned from the time of admission and processes were in place to review the discharge planning regularly.

There had been significant staffing changes affecting one of the wards and we saw there were unfilled vacancies which necessitated the regular use of agency nurses. The staff we spoke with said having nurses who didn't know the ward or patients impacted on the care provided.

Are services caring?

Patients told us they felt involved in their care. All of the patients we spoke with said that staff treated them with respect. We observed staff speaking with people in a kind and compassionate manner. We saw patients' privacy and dignity were maintained during personal care. Patients were encouraged by staff to maintain their independence. Staff did not consistently follow the correct procedures in respect of people's advance decisions not to be resuscitated in an emergency.

Are services responsive to people's needs?

The multi-disciplinary teams worked together to meet the needs of patients. Full assessments of people's needs were completed on admission and were updated in response to changes in their health.

Patients we spoke with told us the staff had recognised and responded to their needs and supported them towards their discharge goals. The average length of stay in January 2014 was 22 days. People's discharge plans were discussed daily to ensure they remained relevant.

Are services well-led?

The wards were well managed by proactive staff. However, there had been significant changes with the staffing of one ward which had been challenging for all the staff. Information was shared with patients and their relatives through open and transparent processes. The Trust had governance processes in place which were well embedded at a local level.

Summary of findings

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

Community inpatient services

Staff were committed to providing high quality services to the patients on the wards at Bolsover hospital. Comments from patients, their relatives and representatives confirmed this. Care met the rehabilitation needs of the patients.

During our inspection we saw that the care provided was safe. Processes were in place to ensure any adverse incidents were reported and acted upon. Patients' risks were assessed on admission and reviewed regularly. Management plans were in place to reduce the identified risks.

The multi-disciplinary team worked effectively together to achieve patient discharge in a timely manner. The average length of stay per patient was 22 days in January 2014.

Patients and their relatives were happy with the care provided. We observed staff treating people with dignity and respect. Patients were involved in most decisions about their care and staff knew the people they cared for well.

Summary of findings

What people who use the community health services say

In April 2013 the Trust had implemented the Friends and Family Test which asks patients whether they would recommend the ward to their friends and family if they required similar care or treatment. Looking at quarterly results we saw that in October 2013 the Trust was placed in the top 25% for England.

Patients told us they were happy with the care they received. One person said, "I'm progressing nicely. Nothing to grumble about here". Another person said, "It's marvellous, they're very, very good".

Areas for improvement

Action the community health service SHOULD take to improve

- Ensure senior clinicians follow the Trust's policy on "Do Not Attempt Cardio-Pulmonary Resuscitation" (DNACPR) Decisions, by involving patients in the decisions, recording the discussions, and reviewing the decisions on a regular basis.
- Review the storage of clean equipment in a dirty sluice area.
- Improve staffing levels.

Action the community health service COULD take to improve

- Improve signage and environmental settings for people with dementia.

Good practice

- Multi-disciplinary teams worked effectively to ensure the best outcome for patients.
- Patient discharge was very well managed.

Bolsover Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance, Berkshire Healthcare Foundation Trust

Head of Inspection: Ros Johnson, Care Quality Commission

The team included a CQC inspector, a nurse specialist, a therapy specialist and an expert by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we inspected.

Background to Bolsover Hospital

Bolsover Hospital registered with the CQC in May 2011. The inpatient service provides rehabilitation services for adults in North East Derbyshire. Bolsover Hospital is registered to provide the regulated activities: Diagnostic and screening procedures; and Treatment of disease, disorder or injury.

The hospital is managed by Derbyshire Community Health services NHS Trust, which delivers a variety of services across Derbyshire and in parts of Leicestershire.

Bolsover Hospital has not previously been inspected by the CQC.

Why we carried out this inspection

This provider and location were inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

The inspection team always looks at the following core service area at each inspection:

Community inpatient services

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

Detailed findings

We carried out an announced visit on 25 February 2014. During our visit we held a focus group with matrons and ward managers. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We reviewed comment cards and survey feedback.

Community inpatient services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The inpatient wards were situated on the ground floor of Bolsover hospital and accessed via the main corridor in the hospital. The wards had same sex bays, adequate toilets and bathrooms and shared a therapy room. The areas we visited were free from clutter and obstacles.

The ward managers were employed by the Trust. Patients' needs were met by a combination of qualified nurses, healthcare support workers, doctors and therapists who made up the multi-disciplinary team.

During our inspection we spoke with patients and relatives. We spoke with the ward managers, an advanced nurse practitioner and two clinical practice facilitators. We held a focus group meeting with seven ward matrons.

We reviewed patient records, observed care being delivered and reviewed information we had received from the trust.

Summary of findings

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Patients we spoke with told us they received good care from compassionate and kind staff who respected their dignity. Patients were involved in most decisions about the care they received. Discharge planning started as soon as people were admitted to the wards to ensure the rehabilitation they received prepared them to return to their homes or supported care. The team met daily to review the discharge plans for patients to ensure they remained appropriate.

Community inpatient services

There were governance arrangements in the Trust which were implemented at ward level. Staff were aware of the Trust's vision called the DHCS Way, and generally felt empowered to raise concerns if required.

Are community inpatient services safe?

Safety in the past

The Trust used an electronic adverse incident reporting system. Staff were encouraged to report incidents to ensure inpatients in the hospital were kept safe from harm. Details about incidents recorded during the current month were displayed on a white board in the ward so that people using the service, their relatives and representatives could see what had been reported. The Trust reported 202 serious incidents in the 12 months December 2012 to November 2013, in line with other similar organisations nationally.

In 2013 there was a serious safety incident regarding the administration of insulin. The Trust had investigated this incident and put a staff training programme in place to help prevent it happening again. Staff we spoke with were aware of the serious incident and the training they were required to do.

Staff had attended appropriate training in safeguarding vulnerable adults and were able to explain how they would protect people from harm. Staff had recently identified a risk to a person and we were able to track the procedure they had followed to ensure the concern was escalated appropriately.

Learning and improvement

Processes were in place to monitor and report safety incidents. Staff were confident about using the reporting system and could give us examples of incidents they had reported. Incidents were discussed at the weekly ward team meetings and learning shared. A patient told us, "I have felt safe here. There's always someone around to assist me".

Details of any complaints received were shared with the team and actions taken. A ward manager told us, "We follow a 'you said we did' policy". The ward manager described how a patient had complained about the noise from the trolley disturbing them. We saw evidence that staff had resolved the problem in response to the comment.

Systems, processes and practices

Most of the staff we spoke with reported that the managers were supportive to them. Staff generally told us they felt

empowered to raise any issues with managers without concern. We saw that the wards had audit arrangements in place to monitor the quality of a wide range of services related to patient safety.

The wards had identified hand hygiene champions who were responsible for promoting hand cleanliness to reduce the risk of cross infection. We observed good practice during our inspection, such as:

- Staff washing their hands prior to providing care and following 'bare below the elbow' guidance
- Adequate hand washing facilities on the wards and in the main corridor of the hospital
- Access to and use of personal protective equipment, for example gloves and aprons
- Arrangements for storage and disposal of clinical waste

One room on the ward was marked "Dirty Sluice" but was the only sluice area available and contained clean equipment used for personal care. The cleaning of the room was completed by ward staff on a rota basis and all of the equipment we looked at was clean but could be at risk of contamination from dirty equipment brought in to the room. The risks posed by combined use had not been assessed.

We looked at the resuscitation equipment on the ward and found it was checked regularly to ensure it was ready for use in an emergency.

Each ward had a whiteboard in the office with detailed information about the patients on the ward. The information included the reason the patient had been admitted, any significant previous medical history, the date the care plan was due for review, history of falls, frequency of dressing and any investigations or appointments due.

Monitoring safety and responding to risk

Safe care assessments were undertaken on admission including risks associated with infection, dementia, falls, skin condition, nutrition, and moving and handling. The information was reviewed again within 48 hours. This meant patients at risk of, for example, falling or developing pressure ulcers were identified during this process and management plans identified.

Staff completed an early warning score assessment daily to measure people's vital signs such as blood pressure and pulse rate. The assessment included an information pathway to follow if the readings presented any cause for concern.

Patients were reviewed two hourly by a process called rounding which included checks on the patient's position in the bed or chair, addressing pain and personal needs and checking the environment for any risks to the patient's comfort or safety.

Information relating to patient safety, including staff training, details of incidents and staff absence levels was displayed on ward notice boards where it could be viewed by patients, their relatives and representatives. This meant there was an open and honest process in place.

Anticipation and planning

Staff told us they were aware of the training that was mandatory or essential for their role. Subjects included health and safety, moving and handling and infection prevention. Staff told us the majority of the training was provided as e-learning that they completed on a compute. We saw from the training matrix that most of the staff were up to date with their mandatory training. A ward manager told us, "It has been difficult because we're short of staff but we try to make sure staff are up to date with training".

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

The care provided for inpatients was evidence based and followed approved guidance from the National Institute for Health and Care Excellence (NICE). Nationally recognised screening tools were used, such as the Malnutrition Universal Screening Tool (MUST) to assess patients' nutritional requirements and the Waterlow pressure ulcer risk assessment to gauge the risk of developing pressure sores. The hospital had implemented a safe care booklet which was completed within 24 hours of admission and included person centred information and the goals patients wanted to achieve during their stay in hospital.

The staff we spoke with were clear about their roles within the ward. They said they had been able to offer

rehabilitation services more effectively since a separate ward had been opened to accommodate patients being discharged from the acute hospital due to winter pressures, who might have different and more complex needs.

Monitoring and improvement of outcomes

We saw there were processes in place to monitor the outcomes for patients and develop the care which was appropriate for their needs. There was involvement with other members of the therapy team to ensure people could meet their planned discharge goals. For example patients would attend physiotherapy sessions to increase their mobility. We saw patients involved in a chair exercise session supported by therapy and ward staff together. A patient told us, "I'm hoping to go home soon and I go to the physio in the afternoon to get me moving better".

There were comprehensive assessments of the key areas for patients' health including assessment of personal care needs, continence, the patient's ability to self-medicate, tissue viability, nutrition screening and risk assessments for falls and venous thromboembolism. We saw that care packages and equipment were organised in advance of the person's discharge.

Information on performance and the delivery of services was displayed on each ward in a public area where it could be reviewed by patients and their families. The information included updates on staff training, appraisals and sickness, the number and detail of incidents recorded and the average length of stay for patients on the ward.

Sufficient capacity

There had been changes to the ward provision at Bolsover Hospital. Rowan and Linden wards had originally been one ward. We were told that managing the size of the ward had been difficult and two separate wards had been created. Both wards provided re-ablement or rehabilitation services to offer short term, planned and intensive services designed to support people to remain independent. Another ward, Sherwood, was open on a temporary basis to support the local acute hospitals with their winter pressures. We were unable to visit this ward during our inspection because of an infection control risk. Staff told us they were able to provide more appropriate care to patients whilst Sherwood ward was open and admitting people with different needs.

We saw there had been recent significant changes with staffing. A ward at a neighbouring hospital had been closed. Staff and patients had been transferred to Bolsover and for some staff this had been a difficult transition. The ward manager told us that an away day had been organised to promote effective working relationship for staff. We saw there were unfilled vacancies on each ward and regular use of bank and agency staff. The ward manager and staff told us they tried to use agency staff who were familiar with the wards to lessen the impact on permanent staff but this was not always possible. We saw there had recently been two adverse incidents because of non-attendance of booked agency staff impacting on staffing levels. There was a process in place to report back to the agency positive and negative comments about the staff they provided and unsatisfactory staff would not be sent to the hospital again.

Multidisciplinary working and support

The wards had a multi-disciplinary approach to people's care. We saw from the care records that therapists contributed fully to the patient's support and planning for future care. There was a daily multi-disciplinary meeting to discuss discharge planning and ensure delays in discharge were kept to a minimum by working together to provide complex care packages. All members of the team had a clear picture of the discharge plan and their own role in achieving it.

Patient records were stored at the end of beds to enable all members of the team access to the information they required.

Are community inpatient services caring?

Compassion, dignity and empathy

Most of the patients we spoke with said they felt involved in the care they were receiving. We saw in patient care records that patients had been asked on admission what name they would like to be addressed by during their stay and if they had any preference on receiving routine personal care from male or female staff. We observed personal care being delivered in a discreet and timely manner. A patient we spoke with said, "I've only got to ring my bell and they're here like a shot". One patient told us there could be delays in call bell response first thing in the morning when the staff were very busy.

Involvement in care

We observed staff gaining people's consent prior to delivering care and treatment. The care records we looked

at contained signed agreements for care from patients, for example the photographing of wounds. Some information was stored by the patient's bed so they could have free access to the information. We saw, and patients confirmed, that they were involved in reviewing the information within the care record on a regular basis.

We were told it was the responsibility of the doctor or advanced nurse practitioner to discuss with patients what their wishes were in relation to resuscitation should they become seriously unwell. When appropriate, the senior clinician would complete a 'Do Not Attempt Resusciation' (DNACPR) form, which includes a record of discussions with patients and relevant carers. The Trust's policy describes the required involvement of patients and relevant carers, the importance of recording the decision and that decisions should be reviewed weekly. We saw that the forms were not always complete, accurate or reviewed appropriately. The ward staff told us this made it very difficult when a patient's condition deteriorated and they did not know if the person had expressed their wishes.

Trust and respect

Every patient we spoke with agreed that staff treated them with respect and we observed staff interactions were polite and respectful. We saw staff encouraging people to mobilise and maintain their independence in a positive and encouraging manner.

Emotional support

Relatives told us they had received support from the staff about arrangements for the patient's discharge. We saw one person was upset about the decisions they had to make about long term care. Staff noticed this person's distress and immediately went to them to offer support.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

Patients were admitted to the wards at Bolsover Hospital for rehabilitation. Care was provided by an integrated team who continuously assessed what was required to enable the patient to become independent. The average length of stay for people on the ward was 22 days in January 2014 and the team were working together to improve the discharge process to reduce this further.

There was medical cover in place for the wards; however this was only available until 5pm daily after which staff contacted the out of hours service for medical support. The trust had responded to this by employing advanced nurse practitioners (ANPs) to support the medical staff and provide a service until later in the evening. ANPs are nurses who have received additional training in prescribing medication and examining patients.

The notices and signage on the ward were in English. Staff told us they rarely needed to provide information in other languages which reflected the information we had seen about the ethnic mix in the community. Staff told us they knew how to access a translation service for anyone whose first language was not English and had previously used pictorial information to aid translation.

Patients told us they were happy with the food they were served at the hospital and said it was generally of a high standard with choices available. We observed patients being served their lunch in the dining room and saw they had access to condiments, napkins and a choice of drinks to accompany their meal. No one required help to eat but staff checked that everyone was able to cut their food and offered help where necessary. One patient did not want the meal they had chosen because they did not feel well. Staff responded to this by arranging for them to have a bowl of soup instead and knew which flavours the person preferred.

We saw the nurse administering medication wore a red tabard with a message on it asking people not to interrupt the medication round. This is common practice and a way of reducing the number of medication errors which can occur if the nurse is disturbed. The staff told us that members of staff from outside the ward environment did not always understand the reasoning behind the red tabard and would often interrupt them. We saw an email had been sent to the hospital staff requesting that they adhere to this policy.

Access to services

People were able to go to Bolsover Hospital for rehabilitation following illness or injury, such as a fall at home or suffering a stroke. They were referred from an acute hospital or by their GP for assessment. This meant that people did not have prolonged stays at an acute

hospital and were able to stay closer to home. One of the three wards at the hospital, Sherwood, was opened during the winter months to help manage the increased demand on hospital beds at this time.

Public access to services at Bolsover Hospital was good. Care is provided on one level and free car parking is available. Spaces for disabled drivers were provided close to the entrance.

Vulnerable patients and capacity

Arrangements were in place to ensure staff understood the requirements set out in the Mental Capacity Act 2005 and recognised their responsibilities when delivering care. We saw that staff attended mandatory training in safeguarding vulnerable adults, consent and mental capacity. All staff spoke with confidence about the categories of abuse and the actions they would take to escalate their concerns.

There had been a recent safeguarding concern regarding a patient who had been transferred to another hospital and we saw that staff had initiated the process correctly and speedily as soon as concerns were raised with them.

Leaving hospital

People's goals for discharge were discussed as soon as they were admitted to the ward. This meant the multi-disciplinary team could manage the person's expectations and plan together to put a support plan in place. We saw that information on each person's discharge pathway was displayed on a board in the ward office which meant everyone involved could add up to date information. People generally felt that the service provided them with the confidence to return to their own homes following a hospital admission or when their home support needed to be reviewed. Patients we spoke with told us discharge plans were discussed with them. One person told us, "I went to my home yesterday to make sure I can cope when I'm discharged. The visit went well and I feel reassured that I'll be ok".

Learning from experiences, concerns and complaints

There were posters displayed on the ward and around the hospital providing information for people if they wanted to raise a concern. Information regarding performance was displayed on the wards we visited, and was discussed at the ward team meetings so as to inform practice.

Are community inpatient services well-led?

Vision, strategy and risks

Staff we spoke with were aware of the Trust's vision the 'DCHS way.' Staff said the board and particularly the Chief Executive maintained a visible presence and were approachable. Information was cascaded to staff through a variety of channels including, emails, the trust newsletter 'The Voice', staff forums and face to face in team meetings.

Risks were reported by staff and we saw the detail of the incidents was shared with patients and their relatives. Incidents were discussed at the weekly team meeting so that lessons could be learnt.

Staff were fully aware of the serious safety incident regarding the administration of insulin and the training they were required to do.

The last assessment by the NHS Litigation Authority (NHSLA) was in 2012. The NHSLA handles negligence claims made against NHS organisations and assesses the processes trusts have in place to improve risk management .The trust was assessed at level 1 in 2012 which meant they had policies in place which described the actions staff were required to follow. We saw that staff were familiar with the incident reporting system and were confident that any incidents reported would be investigated.

There had been several changes within a short timescale at Bolsover Hospital and staff had struggled to cope with some of the staffing changes. We saw that the ward manager had worked proactively to lead the team to work together for the benefit of the patients. Staff spoke with confidence about the quality of local management within the hospital and generally felt supported.

Quality, performance and problems

The quality and safety of in-patient care was monitored at all levels within the organisation. The Board received regular reports and the results of audits undertaken to measure the quality of care being provided.

The NHS Safety Thermometer prior is used to monitor the four common harms to patients: development of pressure ulcers, falls with harm, urinary tract infections in people with a catheter and venous thromboembolism. The data

for the trust showed decreases in all areas of harm. Information regarding performance was displayed on the wards we visited. We observed that this information was also discussed at the ward team meetings.

Leadership and culture

Most of the staff we spoke with were aware of the members of the Board. Staff felt well supported at a local level that they could raise any concerns and were confident they would be listened to.

The delivery of care was led by the nursing staff. We saw there was effective communication between all the members of the multidisciplinary team to support patient centred care and rehabilitation. Staff told us there had been so many changes they were looking forward to a period of stability. A member of staff said, "There have been a lot of changes but I feel staff are now settling. There has been good team building".

Communication about changes in the Trust were cascaded to staff through a variety of routes. The Trust issued a monthly bulletin, The Voice, and the Chief Executive wrote a weekly update email to staff. There was a staff forum meeting at Bolsover Hospital and we were told updates were discussed at the ward team meeting. The team minutes we looked at included information for staff regarding the CQC inspection.

The majority of patients we spoke with were positive about the care they received. Patients and their families were provided with several opportunities to raise any concerns they had and the patients we spoke with told us they would speak to staff if they were unhappy.

Learning, improvement, innovation and sustainability

New staff received an induction into the Trust. Staff told us this had been improved recently because new staff attended induction before starting their job. This meant that staff had access to the IT system immediately they started. Staff told us they had good access to training. In addition to the mandatory training staff received they were able to access other training they identified to support their role.

The majority of training was provided through e-learning. Staff told us access to computers was sometimes difficult. We looked at the training matrix on the wards and saw there was a good uptake from staff on mandatory training.