Ilkeston Hospital

Quality Report

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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.

Overall rating for this service

Community inpatient services	
Other services	

Summary of findings

Contents

Summary of findings

Overall summary

Ilkeston Hospital provides general rehabilitation, end of life care and post-operative rehabilitation for adults following discharge from acute hospitals or from home. There are two 22 bedded inpatient wards, Hopewell and Heanor. Elective care services are provided at the Diagnostic and Treatment Centre.

Systems were in place to keep patients safe. Staff were confident about reporting serious incidents and poor practice. Learning took place as a result of serious incidents, and staff described changes that had come about following a significant medicines incident. Patients were assessed on admission and risk identified and managed appropriately, although some records were not accurately completed.

Although care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care.

There was a good staff mix of skill and experience. In the diagnostic and treatment centre there was a clinical practice facilitator, who supported staff with learning and development and provided monthly supervision.

Patients and their relatives were positive about the care and treatment they had received. Patients and relatives were treated with dignity and respect, and involved in making decisions about their care and the support needed.

We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working ensured people were provided with care that met their needs, at the right time.

Staff were aware of the Trust's vision, the 'DCHS Way'. There was good communication within teams. Most staff we spoke with felt well supported at a local level. They felt they could raise any concerns and were confident they would be listened to.

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 safe. Staff were confident about reporting serious incidents and providing information to the senior staff on duty if they suspected poor practice which could harm a person. Patients were assessed for risks on admission and appropriate measures were put in place when potential risks were identified, although some records were not accurately completed.

Are services effective?

Care was effectively delivered through the use of evidence based guidance and nationally recognised recording tools. Care plans and risk assessments were reviewed and updated as required. However, we saw that tools used to assess the risk of pressure ulcers and medication records were not always accurately completed. Effective rehabilitation was provided to facilitate discharge back into the community. Sufficient staff were provided to care for patients.

Are services caring?

Most of the patients we spoke with were very happy with the care and treatment at Ilkeston Hospital and said they felt involved in decisions about their care. Patients and relatives were treated with dignity and respect.

Are services responsive to people's needs?

The multi-disciplinary team (MDT) worked effectively to support the planning and delivery of patient centred care. Weekly MDT meetings ensured patients' needs were fully explored. The discharge and transfer of patients was well managed. Effective systems were in place to ensure that discharge arrangements met the needs of patients.

Patients attended the wards as outpatients to receive intravenous antibiotics. This meant that patients were able to remain in their own homes whilst receiving treatment, rather than being admitted to an acute hospital. Patients were referred to the diagnostic and treatment centre by their GP and could use the "choose and book" system to arrange their appointment.

Are services well-led?

Staff were aware of the Trust's vision, the 'DCHS way' and were able to describe what this meant in practice. There was good communication within teams. Staff told us they were well supported by managers; they felt they could raise any concerns and that they were listened to

Summary of findings

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

Community inpatient services

Systems were in place to keep patients safe. Staff were confident about reporting serious incidents and poor practice. Learning took place as a result of serious incidents, and staff described changed that had come about following a significant medicines incident. Patients were assessed on admission and risk identified and managed appropriately, although some records were not accurately completed.

Although care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care.

Patients and their relatives were positive about the care and treatment they had received. Patients had been asked their preferred name on admission and we observed staff respecting this. Patients and their families were involved in making decisions about their care and the support needed.

We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working ensured people were provided with care that met their needs, at the right time.

Staff were aware of the Trust's vision, the 'DCHS Way'. The Trust Board members were visible and the Chief Executive communicated weekly via email with all staff. The majority of staff we spoke with felt well supported at a local level within the ward and the hospital. Staff felt they could raise any concerns locally and were confident they would be listened to.

Other services

Elective care services

Patients we spoke with and received feedback from were very happy with the care and treatment they received at the diagnostic and treatment centre.

Elective care services were safe, with effective incident reporting and learning from adverse events. Appropriate evidence-based guidance was followed. Staff were mindful that medical cover was not always available. They were aware of the safety limits, and told us patients had to meet defined criteria to be sutiable for day case surgery.

There was a good staff mix of skill and experience. Staff were up to date with training and had annual appraisals. This gave them an opportunity to discuss their personal and professional development with their manager. There was a clinical practice facilitator, who supported them with their learning and development plan, and provided monthly supervision.

Usually people did not have to wait too long for treatment and they could use the "choose and book" system once referred by their GP. We heard some concerns from a local organisation that the centre was under-used and not working to full capacity.

Staff felt well supported by managers, though some felt a little isolated due to the unique nature of the services provided. There was good communication within teams and staff felt able to raise concerns and that they were listened to.

Summary of findings

What people who use the community health services say

Derbyshire Community Healthcare Trust had implemented the Friends and Family Test in April 2013. We reviewed the most recent figure for October 2013 which placed the Trust's inpatient scores in the top 25% for England.

Patients were satisfied with the care and treatment they received. Most patients felt they were involved in the care they were receiving.

Areas for improvement

Action the community health service SHOULD take to improve

- Ensure that medicines administration records provide an accurate record that patients have received their medication as prescribed.
- 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.

Good practice

Our inspection team highlighted the following areas of good practice:

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

Ilkeston Hospital

Detailed findings

Services we looked at:
Community inpatient services; Elective care

Our inspection team

Our inspection team was led by:

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

Head of Inspections: Ros Johnson, Care Quality Commission

The team included two CQC inspectors, community nurses 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 Ilkeston Hospital

Ilkeston Hospital is managed by Derbyshire Community Health Services NHS Trust which delivers a variety of services across Derbyshire and in parts of Leicestershire. It was registered with CQC as a location of Derbyshire Community Health Services NHS Trust in May 2011. Ilkeston Hospital is registered to provide the regulated activities: Diagnostic and screening procedures, Surgical procedures and Treatment of disease, disorder or injury.

There are two wards, Hopewell and Heanor, both with 22 beds. These inpatient services provide general rehabilitation, end of life care and post-operative rehabilitation for adults following discharge from acute hospitals or from home.

We also visited the diagnostic and treatment centre which offers a range of elective care interventions including orthopaedic, hand surgery, ear, nose and throat, ophthalmology, gynaecology, general surgery, urology, and endoscopy. All patients are admitted as day cases and usually referred by their GP.

Ilkeston Community Hospital has not previously been inspected by the CQC.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

The inspection team looked at the following core service:

- Community inpatient services

The inspection team also looked at:

- Elective care

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the provider. We circulated an electronic survey to community and voluntary organisations in the area of the Trust. We also sent comment cards to be distributed around Trust locations.

We carried out an announced inspection to Hopewell and Heanor wards and the Diagnostic and Treatment Centre on 26 February 2014. We looked at how the inpatient and elective care services operated.

During our visit we held focus groups with staff , we observed how people were being cared for, talked with carers and/or family members and reviewed personal care or treatment records. We reviewed all the information received in this way and information sent to us by patients and local people following a press release and publicity about our inspection. We also reviewed information from comment cards completed by people using the services

Community inpatient services

Information about the service

Hopewell and Heanor Wards are both 22 bedded facilities within Ilkeston Community Hospital. These inpatient services provide general rehabilitation, end of life care and post-operative rehabilitation for adults following discharge from acute hospitals or from home.

Both wards are located on the ground floor of the hospital and are easily accessible. Equipment was stored along the sides of corridors, although care was taken to ensure it did not obstruct access.

During our inspection we spoke with 10 patients and one relative. We held a focus group meeting with eight qualified staff from four community hospitals within the Trust.

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

Summary of findings

Systems were in place to keep patients safe. Staff were confident about reporting serious incidents and poor practice. Learning took place as a result of serious incidents, and staff described changed that had come about following a significant medicines incident. Patients were assessed on admission and risk identified and managed appropriately, although some records were not accurately completed.

Although care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care.

Patients and their relatives were positive about the care and treatment they had received. Patients had been asked their preferred name on admission and we observed staff respecting this. Patients and their families were involved in making decisions about their care and the support needed.

We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working ensured people were provided with care that met their needs, at the right time.

Staff were aware of the Trust's vision, the 'DCHS Way'. The Trust Board members were visible and the Chief Executive communicated weekly via email with all staff. The majority of staff we spoke with felt well supported at a local level within the ward and the hospital. Staff felt they could raise any concerns locally and were confident they would be listened to.

Community inpatient services

Are community inpatient services safe?

Safety in the past

Staff were encouraged to report incidents through the Trust's electronic reporting system to ensure patients were protected from harm. The Trust reported 202 untoward incidents between November 2012 and November 2013, which was in line with other similar organisations nationally.

Information highlighted by the NHS Safety Thermometer assessment tool (used to measure a snapshot of avoidable harms once a month) showed fluctuation in the number of new pressure ulcers between December 2012 and December 2013 for the over 70's group. However, the percentage of patients with new pressure ulcers has tended to fall in line with the national trend. The provider reported no occurrences of grade 3 or 4 pressure ulcers on the wards between December 2012 and November 2013.

Learning and improvement

Staff were familiar with the reporting system for all incidents, and told us all staff were responsible for reporting incidents and completing the electronic records. Staff were aware of the importance of reporting incidents and told us they were actively encouraged to do so. Root cause analysis investigations were undertaken when incidents occurred and action plans developed and implemented as required. Staff told us they received feedback about reported incidents, both in relation to their inpatient area and from across the Trust.

Staff shared with us the learning that had taken place following a serious medicines incident when insulin was not given safely. They told us following this incident, additional training had been provided, and the procedure for drawing up and administering the medication had changed.

Systems, processes and practices

Most staff reported that their managers were supportive. They told us they were able to raise issues without fear of negative consequences. The Trust had policies and processes in place regarding incident reporting which were available for staff to refer to. On the ward, staff were routinely monitoring quality indicators such as falls and pressure ulcers through the NHS safety thermometer, known as the 'four harms'.

The 2013 - 2014 Pressure Ulcer Prevention Plan acknowledged there was still progress to be made to address the delays in reporting grade 3 and 4 pressure ulcers and completing the action plan within the set timescales.

Patient records were stored at the end of beds to enable all members of the team access to the information they required. We were able to follow and track the patient care and treatment easily as the records we reviewed were well kept, up to date, and accurately completed.

Monitoring safety and responding to risk

The organisational risk register was held electronically. This meant it was much easier for staff to search for all risks in their area of work.

Medication storage systems were satisfactory. Staff recorded daily the temperature of the refrigerator used to store medicines. This meant that staff took appropriate action to check that refrigerator temperatures were appropriate and to ensure the effectiveness of medicines was not affected.

Patients were allocated to beds according to the level of observation they required. On the day of our inspection there were sufficient staff on duty to meet the needs of the patients.

Anticipation and planning

Staff were provided with essential training for their role. This included health and safety, moving and handling, fire safety and infection control. The majority of training was provided as e-learning and staff told us it could be difficult to find the time to complete this training. However, they told us there were systems in place to identify when training was due.

Staff carried out safe care assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and personal handling. Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care. Waterlow and Malnutrition Universal Screening Tool (MUST) assessments were carried out within six hours of admission and included a full skin assessment.

Are community inpatient services effective?

Community inpatient services

(for example, treatment is effective)

Evidence-based guidance

We observed that care provided was evidence based and followed recognised and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. For example, staff were used tools such as the Malnutrition Universal Screening Tool (MUST) to determine patients' nutritional needs. Policies were available electronically via the intranet and staff had access to these.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005. Training was being provided for all staff who worked on the wards. We noted in one patient's care records on Hopewell Ward that staff had recorded that the Occupational Therapist was to undertake a cognitive assessment and to consider the need for a mental capacity assessment. There was evidence in the records that these had been carried out.

Monitoring and improvement of outcomes

We saw care plans and risk assessments were reviewed and updated within the required timescales. Appropriate action was taken if patients were identified as at risk, for example, provision of pressure relieving equipment. Staff were completing venous thromboembolism (VTE) assessments and following the guidance regarding prophylactic measures.

We noted inconsistencies in care records in relation to monitoring and improving outcomes. We saw good examples, such as taking appropriate action for a patient who was losing weight. The nutritional assessment had been completed and reviewed, the patient was weighed regularly, advice had been sought from the dietician and a food chart was being maintained. However, we saw that for two patients on Hopewell ward the Waterlow score had been calculated incorrectly which may have provided an incorrect level of risk. Appropriate action was being taken to reduce the risks.

Medication administration records were available for the prescribing and recording of medicines. These records provided an account of medicines prescribed. However, the records were not always complete and so did not demonstrate that patients were given their medicines as prescribed.

Sufficient capacity

Medical staff cover was provided by local general practitioners (GPs), the only exception being out of hours cover, which was provided by an independent Out of Hours Service. Each ward also had an advanced nurse practitioner, who was actively involved in monitoring the care and treatment of patients.

Staff were positive regarding the recent changes to the induction process. The induction programme had been expanded to five days, and new staff commenced their employment at the same time during the month, and attended their induction during their first week before going on the wards. On the day of our inspection a senior member of staff was on duty but supernumerary so they could support a newly qualified member of staff on their induction period. Staff told us they thought the recruitment process was too lengthy. One recently recruited member of staff did comment that the recruitment process had taken three months from interview to start day, and they did not receive updates from the Human Resources department during this time.

Staff told us they were required to complete essential training, which was a mixture of e-learning (computer based) and face to face training. They told us this included moving and handling, fire safety, pressure area care, information governance, and health and safety. Staff were able to request additional training, such as leadership courses or university modules. Training was recorded electronically, and was flagged in red when due for update. Ward managers told us they received the prompts for their staff team and outstanding training was discussed at appraisals. This showed the provider ensured staff had the right skills, experience and support to deliver safe efficient care.

Staff told us they all had an annual appraisal. An appraisal gives staff an opportunity to discuss their work progress, objectives and aspirations with their manager. They told us they were able to access external training, if their essential training was up to date. They told us the provider was supportive of training, and usually provided the funding and study time to attend courses.

Agency staff were used to cover staffing shortfalls. We observed an agency qualified nurse being orientated to the ward at the start of the shift. We also noted that all staff received a handover at the beginning of the shift, where the needs of and plans for each patient were discussed.

Community inpatient services

Multidisciplinary working and support

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Are community inpatient services caring?

Compassion, dignity and empathy

We saw in care records that patients had been asked on admission what name they would like to be addressed by during their stay and we observed staff respecting this. We observed personal care being delivered in a discreet and timely manner. One patient we spoke with said, “The nurses are always popping in (side room), I feel safe and well looked after. They react well when extra pain relief was needed.” Another said, “I feel safe here, I press the buzzer and they are here straight away.” We overheard a health care assistant ordering an early lunch for a patient who was going off the ward at 2pm.

Compliance with same-sex accommodation guidelines was ensured through single rooms and single sex bays. Staff closed doors before delivering personal care or having discussions with patients about their care.

Involvement in care

Most of the patients we spoke with said they felt involved in the care they were receiving. Patients and their families were central to making decisions about their care and the support needed. We found by looking at care plans and talking with families and staff that care was planned in accordance with best practice and national guidelines.

We found that patients and /or the patient’s representative were involved in discussions around the discharge planning process. For example, relatives were informed of potential discharge dates and patients and relatives had discussions with members of the multidisciplinary team to ensure a smooth transition home. We saw that relatives were able to voice their concerns and these were listened to and respected.

We saw from the records that it was the responsibility of the doctor or advanced nurse practitioner to discuss with patients what their wishes were in terms of 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 from the care records that this information was not always

Community inpatient services

accurate, reviewed appropriately or had not been competed fully. We found on one occasion the patient was not involved in the decision made because it was felt, 'it would cause unnecessary distress'.

Trust and respect

Every patient we spoke with agreed that staff treated them with respect and we observed staff were caring in their approach. We saw staff encouraging patients to mobilise and maintain their independence in a positive manner.

Emotional support

A relative expressed their gratitude for the good quality nursing care their family had experienced at Ilkeston Hospital. They were also the full time carer for the patient when at home, and told us the Matron had been very helpful in allowing them to continue to be involved in the care and facilitating open visiting.

We observed patients making use of the day rooms and dining rooms. This provided patients with the opportunity to socialise with each other.

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

Meeting people's needs

Staff were meeting the needs of patients admitted for rehabilitation and palliative care. Patients' comments included: "They manage my pain" and "I am well looked after." There were good mechanisms for information sharing between in-patient and community teams and a willingness to engage with other service providers, such as social services, to ensure that all care needs were met.

Patients' medical needs were overseen by the advanced nurse practitioners (ANPs), with support from the local GPs. ANP's are nurses who have received additional training in prescribing medication and examining patients.

Patients were complimentary about the meals provided to them. Comments included "Food is lovely, my favourite today", "Food is good, there's always a choice and you can tell its fresh" and "Food is brilliant, good quality, well-cooked fresh food." We observed that patients seated by their beds had drinks to hand and could reach their call bell.

We saw a nurse being assisted by a student nurse administering medication. Both 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 incidents which can occur if the nurse is disturbed. We observed the nurse checked each patient's identity before giving the medication. One of the patients confirmed that this was the usual practice.

We saw that patients also attended the wards as outpatients to receive intravenous antibiotics. This meant that patients were able to remain in their own rooms whilst receiving treatment, rather than being admitted to an acute hospital.

Access to services

Both wards are located on the ground floor of the hospital and are easily accessible. Equipment was stored along the sides of corridors, although care was taken to ensure it did not obstruct access.

Patients accessed services either by referral from an acute hospital or admission via their GP for assessment for example following a fall.

Vulnerable patients and capacity

The Trust actively promoted dementia awareness within the staff group. The advanced nurse practitioners were arranging dementia training. The Mental Health Liaison Nurse also provided training on dementia and delivered training on the Mental Capacity Act if required. There were plans to have nominated staff on each ward as 'dementia champions' to promote good practice dementia care.

Staff told us if patients were vulnerable due to the risk of falls, they were cared for in areas of the ward where they could be observed easily.

Leaving hospital

The discharge and transfer of patients was well managed. Effective systems were in place to ensure that discharge arrangements met the needs of patients.

We saw that discharge checklists and pathways were recorded in patients' care records, and patients' progress was discussed weekly at the multidisciplinary team meetings. Discussions with families were also documented, including ongoing outpatient care. Ward staff provided

additional support at the time of discharge to ensure that the patient was safe on their return to the community. We observed a member of staff order and collect bread and milk for a patient to take with them on discharge.

Staff told us patients and families were involved in the discharge process. Most, but not all, patients were aware of their discharge plans. One patient told us "I won't need any external support when I get home as I have a good family." Another said "I'm not sure what is happening but I am getting on alright. I may go home in another week."

Learning from experiences, concerns and complaints

Patients told us they had no complaints about their care or treatment during their stay. Not all patients were aware of the complaints procedure or how to raise a complaint. However, everyone we spoke with said they would recommend the service to friends and family.

Are community inpatient services well-led?

Vision and strategy

Staff we spoke with were aware of the Trust's vision, the 'DCHS way', which has three elements: Quality Service, Quality People and Quality Business. Staff described this as putting patients first, providing safe care with privacy and dignity, and supporting staff. Information about the DCHS Way was on display around the hospital.

Staff told us the Board and particularly the Chief Executive maintained a visible presence and was approachable. They said members of the Board visited ward areas, often when carrying out quality audits. A newly recruited member of staff told us the Chief Executive had attended their induction programme to introduce herself to new staff. Information was cascaded to staff through a variety of channels including emails, the Trust newsletter 'The Voice', and face to face in team meetings.

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 confident that any incidents reported would be investigated.

Quality, performance and problems

There had been four local complaints over a three month period. Each complaint was investigated separately, staff spoken with and appropriate action taken.

At Trust level, a customer experience report was produced quarterly for the Board to provide an overview of patient experience across all locations. This report included an update on actions relating to issues raised from compliments, patient questionnaires, comment cards, websites, complaints and the Friends and Family Test. The report outlined trends and themes, and identified priorities for the Patient Experience Team. Information about the Friends and Family Test and the Patient Experience Team was displayed in the wards.

The quality and safety of inpatient 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 provided.

We received statistical information from the NHS Safety Thermometer prior to our inspection. The thermometer is used to monitor the four common harms to patients, development of pressure ulcers, falls with harm, urinary tract infections in people with catheters and venous thromboembolism. The data for the Trust showed decreased rates in all areas of harm.

Leadership and culture

Most staff we spoke with felt well supported at a local level within the ward environment and the hospital. Staff felt they could raise any concerns locally 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.

A ward at a neighbouring hospital closed recently, and patients and staff were transferred to Ilkeston Hospital. Some staff had found this unsettling.

Community inpatient services

Patient experiences and staff involvement and engagement

Communication about changes in the Trust were cascaded to staff through a variety of routes. The Trust issued a weekly bulletin, The Voice and the Chief Executive wrote a weekly update email to staff. Ward managers from the different community hospitals met on a regular basis and relevant information was discussed with staff at the ward team meeting. We were told that minutes of the ward meetings were emailed to each member of staff to ensure everyone received the same information.

Patients were positive about the care and treatment they received. One patient told us they had chosen Ilkeston Hospital for rehabilitation as they had heard good reports from other patients. Most patients were aware of how to make a complaint and were confident they would be listened to and their concerns acted upon.

Learning, improvement, innovation and sustainability

New staff were provided with an induction into the Trust. This had recently been improved so that all new staff attended induction at the beginning of their employment before they commenced on the wards. This meant that staff had completed some of their essential training and were aware of important policies and procedures prior to delivering patient care.

Staff told us they had good access to training. In addition to the essential training staff received they were able to access other training they identified to support their role. Essential training was provided either through e-learning or as face to face sessions. Staff told us it could be difficult to find the time to complete the e-learning. However, staff told us they were up to date with their essential training, and this was reviewed as part of their annual appraisal.

Elective care

Information about the service

Elective care

The diagnostic and treatment centre at Ilkeston Hospital offers a range of elective care interventions including orthopaedic, hand surgery, ear, nose and throat, ophthalmology, gynaecology, general surgery, urology, and endoscopy. All patients are admitted as day cases.

Summary of findings

Patients we spoke with and received feedback from were very happy with the care and treatment they received at the diagnostic and treatment centre.

Elective care services were safe, with effective incident reporting and learning from adverse events. Appropriate evidence-based guidance was followed. Staff were mindful that medical cover was not always available. They were aware of the safety limits, and told us patients had to meet defined criteria to be sutiable for day case surgery.

There was a good staff mix of skill and experience. Staff were up to date with training and had annual appraisals. This gave them an opportunity to discuss their personal and professional development with their manager. There was a clinical practice facilitator, who supported them with their learning and development plan, and provided monthly supervision.

Usually people did not have to wait too long for treatment and they could use the “choose and book” system once referred by their GP. We heard some concerns from a local organisation that the centre was under-used and not working to full capacity.

Staff felt well supported by managers, though some felt a little isolated due to the unique nature of the services provided. There was good communication within teams and staff felt able to raise concerns and that they were listened to.

Elective care

Are elective care services safe?

Learning and improvement

Staff were familiar with the reporting system for all incidents. Staff told us that all staff were responsible for reporting incidents and completing the electronic system. Staff were aware of the importance of reporting incidents and told us they were actively encouraged to do so. Staff told us that root cause analysis investigations were undertaken when incidents occurred and action plans developed and implemented as required. Staff told us they received feedback about incidents that had been reported both in relation to their area and from across the Trust.

Staff shared with us the learning that had taken place following an incident where a patient went to theatre without having given consent. They told us the incident was picked up at the stop moment in theatre (when the whole team pauses to confirm the correct site and procedure). As a consequence procedures had been revised. They also shared a more recent incident regarding take home medication, which was still being investigated. In the interim, they had reviewed the policy so that medication was checked by two qualified nurses, arranged additional training for one member of staff and were looking at changing the medication storage system.

Systems, processes and practices

Staff told us they followed the World Health Organisation (WHO) Safe Surgery checklist for all surgery. A pre-operative care plan was also used and staff told us this was a clear form, and relevant information such as allergies and anaesthetic risk could be added. A team brief also took place before every list, when all the patients were discussed and any changes communicated.

Monitoring safety and responding to risk

Staff told us they followed the World Health Organisation (WHO) Safe Surgery checklist for all surgery. A pre-operative care plan was also used and staff told us this was a clear form, and relevant information such as allergies and anaesthetic risk could be added. A team brief also took place before every list, when all the patients were discussed and any changes communicated.

Are elective care services effective?
(for example, treatment is effective)

Evidence-based guidance

Staff at the diagnostic and treatment centre followed national guidance in relation to screening for MRSA, and following the WHO Safe Surgery checklist.

Monitoring and improvement of outcomes

Staff told us there was an infection control link nurse at the centre. Surgical site infection rates were monitored but staff acknowledged that the current system was not ideal. Patients were given a letter to take to their GP, requesting information regarding any surgical site infections. This relied on the GP receiving the letter.

Sufficient capacity

Staff told us they were required to complete essential training, which was a mixture of e-learning (computer based) and face to face training. They told us they also received training from manufacturing companies, often in relation to the use of equipment. There was a good staff mix of skill and experience. Staff told us they were trained to the specific needs of the unit, but were multi-skilled, so there was flexibility to assist with unexpected staff shortages. There were vacancies on the unit, and they used two agency staff on a regular basis, which helped with continuity of care.

Staff told us they all had an annual appraisal, and the appraisals for all staff were up to date. An appraisal gives staff an opportunity to discuss their work progress, objectives and aspirations with their manager. They told us they had a clinical practice facilitator, who supported them with their learning and development plan, and provided monthly supervision. The Trust had a list of supervisors, and staff were able to choose who they wished to be supervised by. There were two trained supervisors on the diagnostic and treatment centre.

Are elective care services caring?

We spoke with one patient who had attended the diagnostic and treatment centre for their pre-operative assessment. They told us they felt fully informed by both the consultant and the pre-operative assessment nurse. They knew exactly what would happen on the day of the surgery. They had been given written information about the

Elective care

two types of anaesthetic that may be used, so they were fully prepared. They told us they hoped to see the physiotherapist before surgery but they had been given information about exercises to carry out post operatively.

Another patient told us they had previously been treated at the centre and had chosen to come back for this procedure. They said this was because it was friendly, nearer and more convenient for them. We received many positive feedback forms from patients about the care they had received.

Are elective care services responsive to people's needs?
(for example, to feedback?)

Meeting people's needs
Staff told us they worked to the national targets of 18 weeks from referral to treatment. The patient we spoke with had open follow up appointments following a previous procedure. They told us from seeing the consultant in outpatients to receiving treatment was nine weeks.

Access to services
People were referred to outpatients to see a consultant by their GP, often using the 'choose and book' method. Not everyone seen in outpatients would require surgery, and some patients may be referred back to the acute Trust as they did not meet the criteria for treatment at a community hospital.

We talked to a spokesperson from The League of Friends of Ilkeston Community Hospital. They support the diagnostic and treatment centre through the purchase of equipment and volunteers to sit with patients and make drinks, so nursing staff are free to get on with their roles. However, the spokesperson expressed concern that the centre was under-used and not working to full capacity. They had looked into the reasons why and said there was a misunderstanding about who could be referred, and reluctance on behalf of GPs to refer patients to the hospital.

Are elective care services well-led?

Vision and strategy
Staff told us the Board and particularly the Chief Executive maintained a visible presence and were approachable. They said the Chairperson had visited the hospital. They told us the Director of Nursing was supportive and open to staff contacting them with any concerns. Information was cascaded to staff through a variety of channels including emails, the trust newsletter 'The Voice', and face to face in team meetings.

Staff we spoke with were fully aware of the concerns with insulin administration and the training they needed to complete to ensure the same problem would not arise again.

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 confident that any incidents reported would be investigated.

Leadership and culture
Most staff we spoke with felt well supported at a local level. However, they did comment they sometimes they felt isolated at the centre, partly due to being managed by a professional from a different discipline, and the frustrations of explaining the specific needs of the centre.

Staff told us they attended regular 'Leads Meetings' with the senior staff from elective care services. These meetings were used to share patient stories, and discuss significant incidents across all areas. The matron cascaded relevant information to all areas, and this was an effective way of communicating information across the Trust. Staff told us there was good two-way communication and teams felt able to challenge, discuss and take issues to these meetings, and felt that they were being listened to.