Hertfordshire Community NHS Trust

RY4

# Community health inpatient services

## Quality Report

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Date of inspection visit: 17th - 20th February 2015
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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) |
|---|---|---|---|
| RY407 | Danesbury Home | | AL6 9PW |
| RY405 | Gossoms End Intermediate Care Unit | | HP4 1DL |
| RY409 | Hertfordshire & Essex Hospital | | CM23 5JH |
| RY411 | Langley House | | WD25 9NQ |
| RY402 | Potters Bar Community Hospital | | EN6 2RY |
| RY412 | Queen Victoria Memorial Hospital | | AL6 9PW |
| RY4X2 | Queensway Operating Suite, QEII | | AL7 4HQ |
| RY4X6 | St Albans City Hospital | | AL3 5PN |
| RY414 | St Peters Ward, Hemel Hempstead General Hospital | | HP2 4AD |

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

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

We rated this services overall as requires improvement

Standards in place across community inpatient services were variable and in some areas there was need for improvement.

Systems were in place to keep patients safe and staffs were aware of these however feedback about incidents to staff was inconsistent and dependent on the types of risk reported.

Staff had reported the continued practice of inappropriate referrals but there was little evidence that actions had been taken to minimise the risks these transfers posed for the patients.

Although staffing levels met the needs of the patients at the time of our inspection there was a significant number of vacancies in some areas. Information received from the trust demonstrated that vacancies within the inpatient nursing teams was just below 15% with temporary staff both bank and agency staff being used to address any staffing shortfalls. However such staff were not always available. Information provided by the trust showed only 64% of requested shifts were filled on occasions. There was also a significant level sickness, for the whole trust at 4.28%. This was almost equally divided equally between long term and short term sickness absence.

Nursing assessments and care plans were used but they were not always personalised or holistic to enable people to maximise their health and well-being. Access and response to translation service needs were limited and not always sufficient to meet patient's needs. Monitoring of fluid intake was not fully completed or evaluated which meant there was a risk of ineffective nutritional management and lack of fluid intake. The quality of patient's records varied between units.

Appropriate equipment checks of resuscitation equipment were not always carried out consistently across all inpatient areas.

Hand washing practices were inconsistently practiced when delivering care between patients. Staff uptake of some aspects of mandatory training was below the trust's target.

There was a strong focus on discharge planning which was commenced on admission to the community in-patient wards.

Overall inpatient services at the trust were caring. Patients mostly received compassionate care however patient's privacy and dignity were not always respected.

Patients were involved in the planning and delivery of their care and were provided with appropriate emotional support. Patients spoke well of the care they received and felt staff were mostly caring and kind.

There was an integrated approach to planning and delivering care in a way that supported people to receive and access care as close to their home as possible. Dementia champions had been introduced to help ensure best practice was used to meet the needs of these vulnerable people. Staff showed an awareness of the need to respect different cultures and religious needs.

Complaints were taken investigated and changes made where appropriate.

In most wards we found medicines were safely managed. Staff were aware of safeguarding procedures and knew how to report safeguarding concerns. Services were provided in clean and hygienic environments, which helped protect patients from the risk of infection.

There was evidence care and treatment was provided in line with national guidance. Multidisciplinary teams worked effectively together to provide care for patients. Food provision was positively rated by patients

The management of pain relief and use of recognised tools to assist assessment of pain levels varied between wards.

Generally, we found there were effective induction programmes provided including induction for students and agency staff. Staff received annual appraisals. There were opportunities for professional development of staff. Staff reported there was good local leadership and that most managers were thought to be approachable and supportive.

# Summary of findings

Governance processes were in place and there was evidence of effective use of patient feedback to improve services. Leadership training for staff was being provided and innovation amongst teams was encouraged to help develop and improve services.

# Summary of findings

## Background to the service

Hertfordshire Community Trust runs a number of in-patient units across the county of Hertfordshire. Most of them are small, less than 30 beds and specialise in rehabilitation of patients who have been discharged from an acute hospital and require a period of rehabilitation following a major fracture, falls, or stroke.

Danesbury is a neurological rehabilitation unit and offers specialist care and rehabilitation to patients who have had for a stroke or have other neurological conditions, for example multiple sclerosis or Parkinson's Disease.

The inpatient units had an occupancy rate as at January 2015 of 92.7%. The average length of stay (AVLOS) was 23 days (Stroke) and 27 days (Non-stroke). However, one unit, Danesbury had an AVLOS of 45 days, which reflected the complex needs of its patients.

As part of our inspection conducted over a four day period we visited the following hospitals or wards that were run by Hertfordshire Community Trust:

- Danesbury Neurological Unit
- Queen Victoria Memorial Hospital
- Potters Bar Community Hospital
- Langley House
- Oxford and Cambridge Wards
- Langton and Sopwell wards and the Holywell Neurological unit at St Albans City Hospital.
- The Minor Injuries Unit at the Hertfordshire and Essex Hospital was inspected as part of this core service

Our judgements were made across all of the hospitals visited, where differences have occurred at particular hospitals we have highlighted them in the report.

We spoke with 41 patients and their relatives, 75 staff including managers, ward sisters, nurses, therapists, doctors, receptionists and students. We looked at plans of care and associated records for 24 patients, including risk assessments and a variety of service based documents and plans. During an unannounced visit we revisited one location.

## Our inspection team

Our inspection team was led by:

**Chair:**Elaine Jeffers, Director of EJ Consulting Ltd, Bradford Hospitals NHS Foundation Trust.

**Team Leader:**Helen Richardson, Head of Hospital Inspections, Care Quality Commission.

The team of 29 included CQC inspectors and a variety of specialists: district nurses, a community matron, a GP, a community physiotherapist, a community children's nurse, palliative care nurses, a specialist safeguarding nurse, specialist sexual health nurse, a dental nurse, a governance lead, registered nurses, and an expert by experience who had used community services.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme. An early inspection was requested by the provider to support the trust's submission as an aspiring 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 between 16th February and 20th February 2015. We visited eight locations. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit to one of the inpatient units on 2nd March 2015.

## What people who use the provider say

We spoke with 41 patients and their families during our inspection. Most of the patients we spoke with were positive about the care and attention they received. They felt they were treated with dignity and respect and felt involved in decisions about their care. Patients commented how they were kept informed of progress and plans for their discharge and particularly praised the cleanliness of the wards.

## Good practice

- Wards were found to be clean and this was frequently commented on by patients at all locations.
- Patients praised the quality of the food provided.
- There were good innovative systems to minimise the risk of patient falls.
- The use of champions to lead and cascade good practice for certain aspects of care for example falls and dementia champions.
- Multi-disciplinary teams worked well and there was evidence of effective discharge planning.

## Areas for improvement

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

**Action the provider MUST take to improve**

- Action must be taken to ensure CDs, both liquids and tablets, which had been prescribed as take home medicines, are appropriately managed
- Action must be taken to ensure dressings are stored in an appropriate environment.
- Action must be taken to ensure resuscitation equipment is checked to ensure it is fit for purpose
- Action must be taken to ensure record keeping is improved and risk assessments are correctly used; there is evaluation of care and an easily accessible record of the whole patient episode of care.
- The trust must ensure there is effective fluid and nutritional management of patients provided and recorded.
- The trust must ensure attendance at mandatory training and staff receive appropriate supervision and annual appraisals.
- Action must be taken to ensure patients consent is obtained to take photographs of wounds for planning and evaluating effectiveness of wound care.

# Summary of findings

Action the provider **SHOULD** take to improve

- The trust could provide more guidance to staff regarding the Duty of Candour.
- The trust could review handover practices at the bedside and the time allocated for staff to effectively perform this.
- Action should be taken to review the accessibility to translation services
- Action should be taken to review inappropriate transfers of patients to community hospitals

Hertfordshire Community NHS Trust

# Community health inpatient services

**Detailed findings from this inspection**

Requires improvement

## Are services safe?

### By safe, we mean that people are protected from abuse

**Summary**

Patient information was not consistently recorded there was a variety of means being used to record care planning, patient's progress and essential communication about patients in the in-patient units

Important patient information was inconsistently recorded or omitted, such as a patients Do Not Attempt Resuscitation (DNAR) status. Records of patient care and treatment was fragmented with there being several different parts of the patient record being stored and used in different areas of the wards.

Documentation of some patient care was incomplete. Monitoring of fluid intake was not fully completed or evaluated which meant there was a risk of insufficient fluid intake not being identified.

We looked at the arrangements for the storage and security of medicines at in-patient units and in general we found these were safely managed. However some concerns were identified at Queen Victoria Memorial Hospital regarding management of controlled drugs and the temperature control of storage areas.

Appropriate equipment checks and maintenance were not always carried out. This meant that equipment such as resuscitation equipment was not effectively managed and fit for purpose.

Hand washing practices were inconsistently practiced when delivering care between patients which meant patients were exposed to the risk of infection. Staff uptake of mandatory training such as fire safety training was below the trust's target.

Staffing levels met the needs of the patients at the time of our inspection, but the dependency tool used was not linked to the dependence and acuity of the patient population and the staff rota.

Compliance with mandatory training was below the required level in some areas.

There was a high number of vacancies generally and a significant number in some individual areas. Gaps in staffing were addressed using bank, overtime and agency staff, but such staff were not always available.

Requires improvement

# Are services safe?

Staff were aware of safeguarding procedures and knew how to report safeguarding concerns. Patient safety information was displayed on wards in public areas and there was evidence this was discussed at team meetings. All wards used the NHS Safety Thermometer system to manage risks to patients, such as falls pressure ulcers catheter and urinary tract infections.

Staff received a variable level of feedback from reported incidents and near misses. There were arrangements to manage anticipated risks including use of risk assessment tools to identify patients who may fall or develop pressure ulcers.

Staff used an early warning system provided to help staff identify patients whose health was at risk of deteriorating.

Services were provided in clean and hygienic environments, which helped protect patients from the risk of infection, including hospital-acquired infections.

Staff training and appraisals were carried out to ensure that staff were competent and had knowledge of best practice to effectively care for and treat patients. A clinical governance framework was also in place, however, generally this was not embedded in the staff culture and staff were unaware of how clinical governance improved care.

**Detailed findings**

**Incident reporting, learning and improvement**

The trust reported a total of 35 serious incidents requiring investigation that related to community inpatient services during 2014. These incidents had been reviewed and many related to patient falls. We saw that a plan had been developed with actions being implemented to reduce the number of patient falls.

There had not been any 'never events' reported in the 12 months to October 2014. Senior managers we spoke with believed there was a good incident reporting culture and information was used to improve safety of patients. An example given was the service wide work undertaken to reduce the incidence of patient falls. This had involved a multidisciplinary team approach since mid-2013, whereby nurses and therapists worked together to devise an assessment and monitoring tool whereby patient who were at risk of falls were clearly identified on admission, their risk continually monitored and their care adjusted accordingly. Patients who were at risk had a shooting star symbol above their bed or on their room door to alert all staff of the risk. Falls were discussed weekly at all in patient units, reported through to the deputy director of nursing and the board. We saw evidence of this at both unit meeting minutes and board meeting minutes. This approach, highlighting falls and acting to decrease them, had reduced the number of falls within the trust, which was significant safety improvement.

In July 2013, 4% of patients were reported to have fallen. This was 2% above the NHS average. By February 2015, this had fallen to 2% of patients reported to have fallen and was slightly below the NHS average, the trajectory going downwards.

Patients and visitors were made aware of each wards' performance with regard to safety issues such as patient falls and hospital acquired pressure ulcers. These results were submitted to a national database and submitted to the NHS Safety Thermometer. A monthly chart was displayed which showed how many days had elapsed since the since a patient had experienced any falls, venous thrombosis, pressure ulcers or urinary tract infections. Their results were broadly in line with the national average, except for venous thrombosis of which there were negligible numbers, very much below the national average.

There was a trust wide electronic incident reporting system. The staff we spoke with confirmed that they had received training on how to use it. Access to this system was available on all wards visited and staff were able to demonstrate they understood how to use it correctly. We saw minutes of staff meetings which included review of safety issues such as pressure ulcers, falls and infections. These topics were standing agenda items for ward staff meetings at each unit. All locality managers met trust wide to review incidents.

An example of shared learning where an incidence of Methicillin Resistant Staphylococcus Aureus (MRSA) had been investigated and as a result changes to the trust's temporary staff induction programme had been introduced to minimise the risk of reoccurrence.

However, staff told us that although all types of incident were reported, they often did not get feedback. Staff felt if the incident was not related to a key national target such as pressure ulcer incidents then feedback was not provided. Examples given were the continued reported incidents of inappropriate patient transfers. These incidents related to

patients who were transferred to the wards in the middle of the night and early morning (11pm -6am). It was reported that patients transferred with poor quality photocopied patient records arrived on the ward without medicines charts or medicines that they required.

Information provided by the trust identified there had been 144 reported incidents of the type between September 2015 and February 2015 with 77 of those relating to inappropriate transfers with 15 identifying late transfers and 67 relating to issues relating to patients records.

Though there had been discussion at executive level with other organisations to address the issue staff within the inpatient units were unaware of the discussions and had not received feedback on the incidents they had reported.

This type of incident was not reflected on the trust risk register. Although there were local risk registers for each inpatient unit, these were incomplete and not updated regularly. For example, none had late or inappropriate transfers recorded as a risk. Therefore opportunities were lost to enable appropriate action to be taken and learn lessons so that similar incidents were not repeated. On Sopwell Ward we saw evidence that these incidents had been reported, but there was no action in place to reduce them. For example, we saw an incident report where a patient had been transferred, late in the evening. The photocopied notes said the patient had a painful hip after fall. No x-ray had been taken. An x-ray was carried out following their transfer to Sopwell Ward, which showed the patient had a fractured hip and subsequently needed to be sent back the referring hospital.

Safety alerts were displayed on the wards. These were discussed these with the teams and ensured action was taken as appropriate. The trust's escalation procedure was displayed in staff areas on the wards. This provided guidance and contact numbers for staff to use in the event a staff member became aware of an incident that had the potential to disrupt operational continuity. This would include existing or imminent major incidents, emergency or business continuity incidents that would have an immediate effect on service, or issues such as bed pressures capacity, staffing issues or a serious or notifiable infection control outbreak.

**Duty of Candour**

All NHS trusts are required to be open and transparent. This includes a Duty of Candour that requires the trust will ensure any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered. This is regardless of whether a complaint has been made or a question asked about it. We spoke with staff about Duty of Candour. There was limited understanding of this and that it now went beyond professional guidance about being open and honest and that it was now a regulatory requirement.

Some staff had received a hand-out with guidelines about the Duty of Candour and its meaning; this included a flowchart for the next steps to take if an incident occurred.

**Safeguarding**

Staff had been trained to recognise and respond to safeguarding concerns in order to protect a vulnerable patient. Records showed that 100% of staff had received training during their initial induction to the workplace. Staff also received safeguarding training as part of their annual mandatory training. Overall 87% of staff had been trained to level 1; this was below a trust target of 90%. Trust records showed that Potters Bar Hospital only 40% of staff were up to date with safeguarding training. There were safeguarding champions to help promote awareness and understanding of safeguarding issues.

We spoke with clinical staff at each location, regarding their role in ensuring patients were safeguarded from abuse. Staff were clear about their responsibilities to report abuse and staff we spoke with knew the trust had a safeguarding lead and could name them. Staff were able to discuss safeguarding in an informed manner. They understood and were able to describe different types of abuse and actions they should take if they suspected or witnessed abuse of a vulnerable adult. We saw information displayed including contact numbers and public notices for visitors to raise awareness of safeguarding. There were leaflets available on safeguarding, with details of the wards named safeguarding champion staff could contact.

Mental capacity assessments of patients were completed by social workers for all patients on admission. Deprivation of Liberty Safeguards (DoLS) were used and completed appropriately. Staff were knowledgeable about the process of DoLS, and were able to describe a recent application for DoLS. The application was made as the patient had

complex behavior and cognitive problems, and after an initial mental capacity assessment, the case was escalated to the clinical psychologist who applied for a DoLS to ensure the patient would be supported safely.

**Medicines management**

We looked at the arrangements for the storage and security of medicines at in-patient units. In general we found these were safely managed in that medicines were stored in secure cabinets and there were stock rotation systems in place. Quarterly Controlled Drugs (CDs) reconciliation checks of CDs stored with the drugs register had been completed by the pharmacist and found to be in order. Staff had access to guidance about medicines via the trusts' electronic medicines management policy although this had not been reviewed since November 2011. Policies should be reviewed every three years as a minimum. This meant staff may not have had access to guidance that was reflective of current best practice. Staff also had a supply of British National Formularies dated 2015. These were stored on medicines trolleys to enable staff to easily refer to during preparation and administration of medicines.

We observed medicines rounds being undertaken where staff wore tabards marked "Do Not Disturb" to minimise interruptions and risk of drug errors whilst administering medicines. Medicines were appropriately signed for and if discontinued, were signed and dated at the date of discontinuation and crossed through. We saw one chart where reasons for non-administration of medicines were clearly given.

Pharmacist support was available across all hospitals. Pharmacy reviews were undertaken by a pharmacist on each in-patient area once or twice a week. Staff reported there had been incidents when patients were transferred from another hospital with only a photocopy of the patient's medicines record. A photocopy of a prescription record is not a legal document from which medicines can be administered or used for recording of medicines provided to a patient. During out of hours this meant delays in provision of care to patients until an out of hour's doctor could attend to prescribe medicines. Staff reported occasions where they had to wait as long as six hours for a doctor to attend or staff had had to arrange for a taxi to collect the medicines and chart. We saw these incidents had been reported using the electronic reporting system but there was no evidence to show this matter had been addressed. Incidents of this nature had been reported to the senior managers who had advised staff to report such incidents on the trust's electronic recording system, but this had not been added to the risk register. There was also no evidence to show there had been any pharmacy involvement or guidance sought to help prevent this type of incident.

At Queen Victoria Memorial Hospital (QVMH) we found that some CDs, both liquids and tablets, which had been prescribed as take home medicines, were in the CD cupboard, which were unreconciled. That is, there was no record of the CD's being received from the pharmacy or being checked. One bottle and two boxes of tablets had been stored there since 26 January 2015. However, there had been a weekly audit check of the CDs by both the nursing staff and separately by the visiting pharmacist. Both had signed to indicate all the stock of CDs were correct. The Locality Manager agreed to contact the pharmacist straight away. In one drugs trolley at QVMH, we found a box of what the ward sister agreed looked like used needles and syringes. These had not been disposed of in the attached sharps bin which was not in accordance with the trust's policy.

We found boxes of prescription only dressings stored next to a computer server. Although we did not use a thermometer to check the room temperature, it was clear that it was in was far in excess of 25 degrees centigrade. The boxes that the dressings were stored in were warm to the touch. This meant that dressings were stored in an environment that would have decreased their potency. The ward sister agreed to review this immediately.

At Oxford and Cambridge wards, Hertfordshire and Essex Hospital, (H&EH) patient's medicines to take home on discharge were delivered to the ward in sealed pre-packed units and stored separately to the main stock in a secure room. Records showed consistent temperature checks for the drugs fridge and the room had been completed. Staff explained although the room temperature was monitored daily the temperature at times rose beyond the recommended range to 23-24 degrees centigrade. This matter had been reported and we were advised a ventilation system had been ordered although we did not see evidence of this during the inspection. At the time of the visit the temperature was found to be within the recommended range for the safe storage of medicines.

We observed staff check discharge medicines against the prescription to ensure all medicines prescribed were

present and correct prior to the patient leaving the ward. Staff noted a medicine had been dispensed which the patient no longer required. This was discussed with the doctor and the medicine was removed from the discharge pack with appropriate entries made to the patient records.

Medicine administration charts were completed correctly although it was noted on one record, a drug that was due, had not been signed for. This was reported to the ward sister who confirmed the medicine had been administered and the record was immediately corrected to prevent the patient potentially receiving more than the prescribed amount in a 24 hour period.

We spoke with a regular agency staff member who administered medicines. They confirmed they had not completed their competency assessment and considered they did not need to as they were a registered nurse this. In addition they were unaware of the wards fire procedure when asked what they would do if there was a fire on the ward they told us they would ask the nurse in charge. This demonstrated lack of induction for this member of agency staff, we brought this to the ward sisters attention at the time.

**Safety of equipment**

Equipment was found to be clean and safely stored. There were dated stickers to indicate it was clean and had labels to show it had been subject to a safety check. Maintenance was carried out by the trust's maintenance department. Staff told us they experienced some delays in getting equipment repaired, such as blood pressure machines, but we did not see or hear of any direct adverse impact on patient care. There was an awareness within the trust about maintenance of equipment and was this was an item on the high risk register.

Resuscitation equipment was checked daily to ensure it was complete and in date and records of checks made by staff were consistent over preceding months. Separate Anaphylaxis medicines kits were available to treat severe allergic reactions and oxygen cylinders were full and in working order.

At the Minor Injuries Unit, Hertfordshire and Essex Hospital (H&EH) the resuscitation pack was recorded as having been checked daily however on inspection equipment such as airways tubes, venflon needles and blood sample bottles were found to be out of date with some dating back to 2013 showing that these had not been checked robustly. The matter was raised with the nurse in charge and immediate action was taken to address this.

At Queen Victoria Memorial Hospital (QVMH) an Electrocardiograph (ECG) machine was found to have a faulty cable and was not fit for use. Staff were aware of this and a new main cable had been ordered in January 2015. However the machine had not been used but removed from the emergency equipment. We spoke with staff who agreed it should be removed from use and labelled not fit for purpose. An alternative ECG machine was made available.

**Records and management**

The patient notes and all associated clinical work, such as medicine administration, were all done on paper records. There was a plan to upgrade these to more secure, efficient electronic records. We were told that this was going to be implemented later in 2015. We saw examples of the electronic system in use at the Minor Injuries Unit which showed details including a patient medical history, treatments, tests ordered and results and referrals for treatment.

Medical records were stored securely and risk assessments and some care notes were stored at the patient's bedside. Entries to medical records were mostly legible, signed, timed and dated. During the inspection we looked at 24 sets of patient records.

At Sopwell Ward, St Albans City Hospital, the ward manager had introduced an index system to organise the paper records this was being used as an interim solution until the electronic patient record system was introduced.

Hertfordshire and Essex Hospital, Queen Victoria Memorial Hospital and Danesbury Neurological Unit had multiple systems for keeping records. When reviewing patient records there was little evidence of whom the patient was. There was no information about their personal history such as past jobs, life experiences or preferences. Where fluid balance charts were used we found inconsistency in the input and output being totalled to effectively evaluate the patient's status and whether further interventions such as encouragement for more fluids were required in at least six of the records we looked at.

Requires improvement

# Are services safe?

In Oxford and Cambridge wards, Hertfordshire and Essex Hospital (H&EH) during the inspection we identified and confirmed with staff that there were at least nine separate areas where patient information was recorded which were as follows:

- The patient folder at the patient's bedside containing risk assessments
- The handover sheets which were updated and disposed of daily
- A communication book containing such information as details of patient appointments
- A document referred to as a 'Kardex' which was completed intermittently including some evaluation notes
- A 'jobs for doctors' book containing requests/reminders for such things as blood tests
- The patient's medical record
- Notice boards including a patients estimated discharge date and such information resuscitation status
- An allocation book which included messages about patients' care arrangements
- Therapy notes

This meant there was the potential for key information to be missed or not communicated which could impact on the safety of the patient.

Staff used printed handover sheets which seemed a practice in place at most of the units. We were told these were updated daily by the nurse in charge of each shift. The handover sheet contained vital, confidential information about the patient's diagnosis, their progress and any plans. During the inspection one handover sheet had been left on a trolley in the ward corridor. This was brought to the ward sister's attention and it was removed. We observed there was a strong reliance on the handover sheets which were used for multi-disciplinary team meetings in addition to handovers between staff. We found the handover sheets on two occasions were not up to date. For example the Do Not Attempt Resuscitation (DNAR) status of three of the five patients were missing from the handover sheet that had been assessed as not being for resuscitation. This meant staff could potentially make an inappropriate response if a patient collapsed. The concern regarding patients DNAR status was reported to staff at the time of the inspection.

These handover sheets seemed to be the main nursing care record. Therefore vital information about the patient was not kept in their notes, but on pieces of paper that we were told were destroyed at the end of each shift. There were not always robust systems in place to ensure these were securely destroyed. The large bins used for the disposal of confidential paper waste were overflowing in both ward offices.

All the forms we saw being used to record patient information were of poor quality in that they appeared to have been repeatedly photocopied. Staff told us that they were waiting for an electronic system to be implemented, however there was no awareness when this would be.

**Cleanliness, infection control and hygiene**

All areas visited were visibly clean and tidy. Patients told us they thought the wards were very clean and had no concerns about the cleanliness of the facilities. Cleanliness was audited monthly by the senior staff and submitted to the trust's infection control team. However, the tool that was used was ambiguous and consisted of ticking boxes. For example, it asked that five equipment items were checked for cleanliness, but didn't specify what these were. Furthermore it asked that individual staff member's food safety training was audited, but no evidence was requested.

The patient led assessment of the care environment (PLACE) for January 2014 to June 2014 achieved a high score of over 95% for most areas. The assessment includes evaluation of aspects of the environment including cleanliness and condition, appearance and maintenance of facilities.

The general appearance and maintenance of wards was variable with some units having been recently refurbished such as Danesbury whilst others such as Sopwell and Langton wards at St Albans City Hospital were in need in refurbishment. The general appearance and maintenance score for the trust was well below the England average of 90% and had a score of 82%.

Staff had access to personal protective equipment (PPE) such as gloves and aprons. Sanitising hand gel was available throughout the areas inspected. Posters were displayed about effective hygiene encouraging staff and visitors to help maintain a safe environment for the patients. Monthly audits of hand washing were seen which recorded a high level of compliance. Equipment had 'I am clean' stickers on them showing the last date and time they had been cleaned. We observed most staff practicing good hand hygiene principles.

Requires improvement

# Are services safe?

Bedside curtains were labelled with the date they had been changed and when they were due to be replaced. All were noted to be clean and within date. We saw there were processes and systems in place to check that mattresses were clean and fit for purpose.

There was an awareness of the Trust policies in relation to infection control. Most staff were 'bare below the elbow,' although we did see some staff wearing inappropriate jewellery. This was removed as soon as we indicated that it conflicted with trust policy. All staff uniforms appeared clean and in good condition. Gloves, aprons, and masks were available and we saw these being used appropriately.

At Oxford and Cambridge Wards, Hertfordshire and Essex Hospital there were hand wash sinks in every bay. However, we observed there was a lack of hand washing by some staff when moving between patients they did not wash their hands or use hand sanitizer.

The PLACE scores for this ward for January 14 to June 14 showed all aspects of the assessment to have been scored below the England average and achieved the lowest score within the trust. We saw an action plan dated 2014, but the month of the plan was not specified. The action plan stated that many of the identified actions had been completed, for example basic cleaning of equipment. Some more complex items were scheduled to be done during 2015, for example replacement of worn flooring. There was also some evidence on the action plan that particular areas had been revisited and reviewed. This meant that there were efforts to ensure improvements were sustained.

A previous infection control audit reported eight commodes were found to be dirty. It had been noted there were eight staff on duty for 28 patients when this occurred. On the day of the inspection of Oxford and Cambridge wards all commodes were found to be very clean and labelled 'I am clean', timed and dated.

We observed a patient was being nursed with their catheter bag trailing on the floor which posed a risk of infection to the patient. This was pointed out to staff. Although there had been a decrease in the incidence of patients requiring a catheter during the previous year, according to data submitted to the NHS Safety Thermometer, it was noted that training for catheter care at this hospital had a level of only 44% compliance, which was below the trust target of 90%.

### Mandatory training

There was a mandatory training matrix with a trust target of 90% completion rate for all topics such as fire safety, catheter care and manual handling. The majority of the inpatient units had not achieved this target with the exception of some units such as the Minor Injuries Unit. Mandatory training was delivered either on line or through attendance to centralised dedicated sessions. Some staff reported they found travelling to attend sessions a challenge with some having to manage a four hour round trip for a couple of hours training which impacted their level of compliance.

At Oxford and Cambridge wards, Hertfordshire and Essex Hospital (H&EH) we did not see any evidence to show compliance with mandatory training was monitored. There were poor levels of compliance on these wards. For example training records showed fire training was out of date for ten staff members. Catheter care was out of date for 15 staff which equated to a 44% level of compliance, what was the compliance basic life support training for four staff out of date with one staff member not having received an update since 14th June 2013. There was no action plan in place to remedy this.

At Potters Bar Community Hospital fire safety training had been completed. Although no fire drills had been undertaken, a fire evacuation system flow chart was displayed showing steps to take in emergency and how to determine if an evacuation should be attempted. Patients' levels of mobility had been documented to aid staff should an incident occur that necessitated the need to evacuate the premises.

At St Peters Ward, Hemel Hempstead Hospital only six of the 29 staff had completed fire evacuation training although there was a separate set of fire training for the hospital which 23 staff had completed.

### Assessing and responding to patient risk

We reviewed 24 sets of nursing notes across all the units. Risk assessments and the care plans were completed. The care plans included the malnutrition universal screening tool (MUST) score, a pressure ulcer risk assessment tool, use of anti-embolism stockings, moving and handling risks, falls prevention and bedrail assessments. However we found these were not personalised to meet the individual patient's needs.

We saw good evidence in the inpatient wards of measures taken to reduce the incidence of falls with harm. Falls

management champions had been introduced to support ongoing learning for staff and introduce risk reducing measures such as the use of sensor mats used to alert staff when a person who needed assistance when trying to mobilise unsupervised. Colour coded wrist bands worn by patients had also been introduced to indicate level of assessed risk and the degree of assistance/supervision required. Units such as Danesbury which consists mostly of single rooms, ensured patients assessed as being at high risk of falls were located near to the duty station to enable closer observation. Some patients assessed as being at high risk received 1:1 nursing where indicated.

The safety thermometer results for new pressure ulcers have been relatively low for community inpatients throughout the past 12 months. The incidence of pressure ulcers had been slightly higher that the national average since March 2013 at 7% of patients. However, since the introduction of a pressure ulcer working group at the trust to monitor trends and identify and act on areas of risk, the incidence was in January 2015, was 4%, lower than the national average and showed a continued downward trajectory.

If a patient became unwell during their stay, the visiting GP or consultant reviewed them, this service was only available during the office hours in the week. During out of hours, the Hertfordshire on call GP service was contacted for further advice and treatment. However, if a patient became very unwell or collapsed, the 999 service was used and the patient transferred to the local Accident and Emergency department for further treatment. Vital signs were well documented at most sites. Because of the low acuity of the patients and most were medically stable, observations of vital signs were done only once per day. The trust had implemented the National Early Warning System (NEWS). This is a system that alerts nursing staff to escalate, according to a written protocol, any patient whose routing vital signs fall out of safe parameters. We saw that in two cases patient care had been escalated correctly.

At Oxford and Cambridge wards, Hertfordshire and Essex Hospital (H&EH) there was a key worker who worked closely with both the GP and the twice weekly visiting consultant physician. The clinical nurse specialist had advanced skills whereby they were able to clerk patients when they were admitted; prescribe certain medications, including antibiotics and intravenous fluids and discharge patients. They worked during the week and every other Sunday. This meant that patients did not have to be transferred to the local acute trust if they became unwell, unless they were critically ill, as they could be cared for locally.

At the Queen Victoria Memorial Hospital the routine observations at QVMH were not carried out until 10pm at night, this meant that if there was a problem identified that needed to be escalated, this had to be done via the on call doctor service, rather than the GP who visited the unit 3 times a week

**Staffing levels and caseload**

Staffing levels met the needs of the patients at the time of our inspection, but the dependency tool used was not linked to the dependence and acuity of the patient population and the staff rota.

There was a high number of vacancies generally, and a significant number in some individual areas. Gaps in staffing were addressed using bank, overtime and agency staff, but such staff were not always available. Trust data demonstrated that Hertfordshire and Essex Hospital reported an average fill rate for registered nurses below 80% for seven consecutive months to January 2015. In the service's Safe Staffing Update Report for January 2015, three of the 11 wards reported fill rates below the trust target of 90%. In December 2014, five out of 11 wards were below the trust target for staffing levels. This included registered nurses and care staff. This meant there was a risk of there being insufficient staff to care for patients. The trust had put in place an escalation process to raise staffing concerns, though staff told us that provided limited support. The trust had reported that Hertfordshire and Essex hospital had an average fill rate for Registered Nurse (RN) on day duty was at 73.6 %. The unit had 63 WTE staff; however, had a vacancy rate of 36%, which equated to 21 WTE vacancies.

Rolling 12 month sickness rates for the whole trust were just above 4% (although at around 3.5% for February and March 2015). Roughly half were long and half short term. We saw that there were no plans in place to replace staff who were on long term sick leave. At The Hertfordshire and Essex Hospital we saw that two members of staff had been on sick leave for a year, yet they had not been replaced.

Requires improvement

# Are services safe?

Most of the wards we visited had vacancies at all levels for nursing and allied health professionals such as physiotherapists and occupational therapists.

Patients reported to us that they felt safe, however, patients told us staffing levels on some wards were of concern on occasions and although they felt call bells were usually answered promptly there were delays when the ward was short staffed.

Staff had signed a waiver to work extra hours beyond the recommended hours specified within the European Working Time Directive. Ward managers were aware of who was working extra hours and monitored this closely to ensure staff were safe to practice. If staff had a recent episode of sickness absence, they were not permitted to work additional hours.

Agency staff were provided by an agency who were known to the trust and had given evidence and assurances that the staff they supplied were qualified and had current registration with the Nursing and Midwifery Council. In addition new agency staff were given a brief induction to the unit. This included emergency procedures and general policies, for example use of personal protective equipment. We saw copies of these at the Hertfordshire and Essex Hospital.

The Queen Victoria Memorial Hospital had recently recruited to all vacancies. They explained they experienced some recruitment challenges due to limited local transport services. Some staff we spoke with expressed concern about the lack of experienced staff on duty particularly at weekends and night time. We reviewed staffing for the previous month and were able to see there had been consistent numbers of staff used for each shift.

Danesbury Neurological Unit regularly used temporary staff to cover vacancies and long term sickness. There was evidence temporary staff received induction to ensure they were familiar with ward area, equipment and emergency arrangements. We observed patients were sitting in the day room with no one to supervise them, and no activities provided for them.

At Oxford and Cambridge wards, Hertfordshire and Essex Hospital there were 37 beds but only 28 patients at the time of the inspection due to a lack of substantive staff and increased use of temporary staff. A dependency score tool was used but there was no evidence of how this was applied to determine staffing levels. There was an agreed ratio of 1 registered nurse to 8 patients. In addition to this, Health Care Assistants provided extra support.

Duty rotas were checked for previous months and showed a pattern of consistent levels of staffing. Staff reported requests for additional staff to provide close nursing observation was always approved.

During the inspection we observed handover between staff. The handover took place in the ward corridor with no patient involvement.

**Managing anticipated risks**

There were security systems in place such as the use of keypad controlled access to certain ward and service areas. Signing in and out of visitors to units were used to ensure there was a record of how many people were in the building in the event of a serious incident, such as a fire.

The ward sisters were aware of trust wide emergency plans. Hospitals had contingency plans and equipment to help respond to emergency situations such as loss of essential services such as supply of water or electricity. The equipment and instructions were easy for staff to access and in good order. Fire escape routes were clearly signposted and unobstructed. The completion of fire training was between 73% and 96% which was below the trust target of 90%.

Safety alerts from National Patient Safety Alert System were received by the trust risk team and disseminated to the individual locality managers for action. At Queen Victoria Memorial Hospital we saw the important messages relevant to their unit were printed off and staff signed to say they had seen and read it. At the Hertfordshire and Essex Hospital we saw that any relevant alerts were discussed at staff meetings, displayed for staff to see and shared in staff meetings and at handover.

There were lone working arrangements used such as staff recording and notifying their team when conducting a home visit and some staff had personal alarms provided when working in the community.

Units had daily handover arrangements in place so that any new concerns or potential risks were discussed and actions taken to address them.

Requires improvement

# Are services safe?

We observed patients had their call bells placed within easy reach. Some patients were assessed as having a high risk of falls with bed rails in use however risk assessments had not been completed to ensure the bed rails were safe for use for the individual patient. Staff were able to describe actions taken for deteriorating patient such as calling the doctor or if urgent calling the emergency services.

There was a trust fire policy that was modified locally to reflect particular circumstances.

At Hertfordshire and Essex Hospital we saw that this local policy was laminated and displayed on the wall. However, when we asked for a fire risk assessment it took some time for this to be located. It was eventually found on an email from August 2014. This meant that the fire risk assessment for that unit was not well known by the senior staff. We also found a lack of knowledge with regards to leadership if there was a fire, for example who the fire marshals were. The manager and nurse in charge told us that there was a horizontal evacuation plan for that unit, which was situated on the 1st floor of the building. However, there were no mattress evacuation sheets in place and no means of getting immobile people down the stairs, for example fire evacuation chairs. We saw an email to evidence that actions had been taken to introduce slide sheets but the appointment had been cancelled. However this was dated February 2014 and there was no further evidence to show this had been progressed.

Requires improvement

# Are services effective?

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

**Summary**

The effectiveness of the services in some community wards and hospitals within Hertfordshire Community Trust require improvement.

Nursing assessments and care plans were used but they were not personalised or holistic to enable people to maximise their health and well-being.

The management of pain relief and use of recognised tools to assist assessment of pain levels was inconsistent between wards.

Although food provision was positively rated by patients monitoring of fluid intake was not fully completed or evaluated which meant there was a risk of ineffective nutritional management and lack of fluid intake.

Where patients had been identified as being at risk of malnutrition the care plans were not always followed. There were was little recorded evidence to show that care was evaluated and plans updated to reflect patient's current needs.

There was a strong focus on discharge planning which was commenced on admission to the community in-patient wards. Some referrals to wards were not always appropriate with some patients having to be referred back to the acute ward they had been discharged from.

There was evidence care and treatment was provided in line with national guidance. In most units we saw evidence that multidisciplinary teams worked effectively together to provide care for patients. The management of pain relief and use of recognised tools to assist assessment of pain levels varied between wards. Therapy notes were comprehensive to enable staff to share decisions about patient's mobility and ability and for plans for rehabilitation to be developed.

Staff received annual appraisals. Generally, we found there were effective induction programmes provided including induction for students and agency staff. There were opportunities for professional development of staff.

Information was available in a variety of formats and easily accessible to patients and their families. Patients told us staff sought their agreement to provide care before treating them. We saw evidence that consent for treatment was obtained in most cases and recorded in accordance with the trust's policy however patients' consent to have the photographs taken to assist wound care management had not been obtained.

**Detailed findings**

**Evidence based care and treatment**

Policies and procedures were developed in line with national guidance and were available for all staff on the trust's intranet site. At Hemel Hempstead Hospital staff had adopted a form for use produced by the Royal College of Nursing in conjunction with the Alzheimer's Society titled 'This is me.' This document was completed by staff with the patients and family members and gave staff relevant information about the patient, their needs, wishes and life history.

We saw that patients at risk of falling were identified and had risk assessments in place. At Danesbury, people identified as being at a high risk of falls were identified by a 'shooting star indicator – a picture of a shooting star on their room doors. This meant staff were alerted to a risk but this system ensured the person's dignity and respect were not compromised. There were also posters describing how visitors could help to reduce falls. At Danesbury Neurological Unit and Queen Victoria Memorial Hospital we saw evidence of trust wide initiatives regarding falls prevention in place and evidence both units having achieved a reduction in falls. In July 2013 4% of patients were reported to have fallen. This was 2% above the NHS average. By February 2015, this had fallen to 2% of patients reported to have fallen and was slightly below the NHS average, the trajectory going downwards at a greater rate than the national average.

There was access to specialist nurses such as infection control and tissue viability nurses however access to therapists such as physiotherapists were limited for some wards.

Requires improvement

# Are services effective?

Safety Thermometer results for new pressure ulcers had been low for community in patient areas throughout the last 12 months. However February 2014 recorded six new cases which is a higher rate than the national average of 2.73 incidents per 1,000 admissions. The national prevalence rate for new pressure ulcers on community wards fluctuated between 0.79% and 1.33% with the average also 1.1%. So although the rate was higher in February 2014 the average across the whole time period was not significantly different to the national average.

In Oxford and Cambridge Wards, Hertfordshire and Essex Hospital, nursing staff used nationally recognised tools to assess risk such as the Waterlow scoring tool to assess patient's risk of developing pressure ulcers. However we were not able to see a record of evaluation of the effectiveness of the care provided on a day to day basis. For example a skin assessment had been completed, but there was no evaluation recorded of progress of healing.

Where risk assessments had been completed and plans developed to minimise the identified risk, there was no evidence to show the plan was adhered to. Risk assessments stated four hourly turns were required. We saw two examples where turns were not recorded for up to eight hours. We saw one patient whose Waterlow assessment had been done on 31 January 2015 and correctly scored at 19, which means there is a high risk of skin damage. Patients, who are assessed as at high risk of developing skin damage, should be reassessed at least weekly. The Waterlow assessment was next calculated on 21 February 2015, some three weeks later and calculated at 21, very high risk. However, there was no evaluation of their skin condition in their care plan during those three weeks, or evidence of any measure to reduce the risk of damage to the patient's skin. There were no audits carried out of risk assessments to ensure they were completed appropriately, nor any action plans in place to ensure improvements.

**Pain relief**

Patients indicated they mostly received pain medication when they required it. Some wards used an assessment tool to determine if people were in pain. Others had nothing in place.

In Langton ward we saw evidence of good pain management. Patient's pain had been assessed including pain experienced when mobilising and a pain control chart had been introduced. Patient's comments regarding the effectiveness of their pain control had been recorded and goals regarding pain management had been set.

At Oxford and Cambridge Wards, Hertfordshire and Essex Hospital, feedback from patients was variable with some patients reporting they did not always receive pain relief in a timely manner. Care planning and evaluation of pain management was limited and outcomes recorded as to what actions had been taken and whether it had been effective not recorded in all cases. We did not see evidence of the use of a pain control evaluation chart in use at the bedside. When asked we were shown a copy of a pain chart in the patient file but this had not been completed and was difficult to read due to the size of the font of the text and poor quality of the photocopy.

**Nutrition and hydration**

Patients spoke positively about the food they received, they were given a range of choices and told us meals were served hot when they was supposed to be. Food was cooked off site, chilled and delivered to each unit, where it was reheated and served. The food was served individually, from large trays, so patients could have a portion according to their appetite and needs. Both patients and staff told us the food was good.

Meal times were protected (with no visitors allowed) and where wards had a dining room patients were encouraged to eat together as part of their rehabilitation. We saw that individual hand wipes were available on the tables in the dining areas. However, we noticed that these were not routinely offered to patients who required assistance or had their meal in their room or bay. We observed staff assisting with the serving of food but noted not all staff had recently attended food hygiene training this meant patients may be put at risk from inappropriate food handling.

Assessments were made of patient's risk of malnutrition using a nationally recognised tool. Where patients were identified as being at risk of malnutrition, plans were developed to address this. This included monitoring patient's food and fluid intake, provision of food supplements and referrals to dieticians. There were red tray and cup systems we used to alert care staff to people who had specific needs or required support with food and fluid intake.

Requires improvement

# Are services effective?

The patient led assessment of the care environment (PLACE) for January 2014 to June 2014 achieved a high score of over 95% for most areas. The assessment includes evaluation of aspects including ward food and organisation of food. The national average score for England for organisation of food was 91.35% and the overall trust scored 89.83%. However Queen Victoria Memorial Hospital and Hertfordshire and Essex Hospital reported lower scores of 72% and 68% respectively. We saw an improvement plan dated 2014, for Queen Victoria Memorial Hospital only, which included the quality of food. The month of the plan was not specified. The actions stated that there had been a further visit to test the food and although the auditors found some of the food acceptable, food was given poor for taste and texture. However, it was given an 'acceptable pass.' There were no actions stated to improve the food overall. This meant that there were minimal efforts to ensure improvement.

At Queen Victoria Memorial Hospital (QVMH) we observed lunch being served. Patients could change their minds and have something different if they didn't want what they had ordered the day before.

We observed that patients were not always appropriately supported at meal times. One patient being helped to eat their soup found it to be too hot. Although the care assistant immediately apologised, it transpired they had not checked the temperature of the soup before it was offered to the patient. We observed the same patient attempting to eat the soup by their self and because they were not supervised, they almost tipped it over onto their chest. We intervened to prevent this happening.

At Oxford and Cambridge wards, Hertfordshire and Essex Hospital, we observed that where patients had been identified as being at risk of malnutrition the care plans were not always followed. For example one person who had difficulty swallowing experienced problems getting an appropriate diet. They told us that as a result their family brought in suitable food for them to eat. We looked at the patient's record and saw an assessment had been completed by the speech and language therapist (SALT) on 16 February 2015 which advised the patient should have mashed soft food. There was nothing in the care plan to reflect this, or a record to show what the patient had eaten.

We saw four examples of daily fluid balance charts in use that were not completed. We looked at charts of the previous days and saw that intake and output totals had not been calculated and there was no evidence to show evaluation of this aspect of care in the numerous places where patient information was recorded. Where monitoring of fluid intake or urinary output was not fully completed or evaluated means there is a risk of insufficient fluid intake not being identified.

One fluid chart showed a person who was verbally reported at handover as being as dehydrated, had not had fluids for over six hours according to their fluid chart. We raised this matter with the nurse in charge during our inspection.

**Outcomes of care and treatment**

Quality and performance information was displayed on notice boards in public areas of the ward. This included data about the workforce, the numbers of complaints, and the numbers of reported patient incidents such as falls or pressure ulcers. We saw evidence this was regularly updated. Minutes of meetings provided evidence that this information was used and discussed to identify shortfalls and improve outcomes.

Patient outcomes were monitored through use of standardised goal attainment scores. Each patient had an expected date of discharge on admission. This was displayed clearly on all the wards. Rehabilitation goals were commenced as soon as the patient was admitted agreed between the therapy, nursing, medical and social workers and discussed with the patient. These were discussed at the weekly multi-disciplinary meeting and modified if needed, according to the patient's progress. However some staff we spoke with were unaware if the aggregated scores were utilised to plan further care.

Each ward had a dashboard showing the number of harm free days, which showed for example the number of urinary tract infections, falls and venous thrombosis. All were showing downward trends and although had not been below the national average in the past, were at the time of the inspection. For example, the rate of venous thrombosis was almost negligible in all units, despite some of the patients being assessed as high risk, for example following a stroke or lower limb fracture. Measures were put into place according to the risk assessments to ensure that risk factors were minimised.

The average length of stay was monitored and staff could quote the figures of the average length of stay for their respective units. Delayed transfers of care were comparatively high for the trust. We saw that there was a

variety of reasons for these; however, the trust broke them down by social and NHS delays. The rate of delays differed between each unit and the data we were shown, broken down as a percentage of delayed days against available bed days. The highest NHS delays were at Langley House at just over 7%, the lowest was Danesbury at 0%. There were similar percentage delays for social reasons, although this affected different units. Overall the lowest percentage of delays occurred at Sopwell (2%) and the highest at Langley House at 15%. To understand more fully the situation an exercise called a ''Perfect Week'' was undertaken. This helped identify the actions that needed to be taken to ensure patients were managed appropriately and discharged to a setting which reflected their care needs on a timely basis. There were contributory factors to take into account including those people that were non-weight bearing and those waiting for social care placements to be made available.

**Competent staff**

There was a comprehensive induction for new staff. This included both a trust wide induction and local induction. There was one designed for permanent staff and students and another for flexible workers, such as bank and agency staff. We spoke with two agency staff who told us they received a good induction and were shown around ward to help them orientate to their place of work.

Staff training and appraisals were carried out to ensure that staff were competent and had knowledge of best practice to effectively care for and treat patients. Therapy staff we spoke with reported they had regular appraisals where they could discuss their work. They confirmed that they could discuss performance and career aspirations with their line manager and they found the appraisal process useful. The appraisals were followed up during the year to ascertain progress against targets. Therapy staff reported they had monthly supervision and 1:1 interviews with their manager/ supervisor.

However, amongst the nursing and care staff this was not the case. Some reported having an appraisal in the last year, most said their appraisal was due. We spoke with several staff, some at a senior level who said they had not received an appraisal for over a year. One told us their last appraisal was in 2010. All confirmed that appraisals were not followed up. This meant that any there was not a monitoring process to ensure agreed objectives were met.

Nursing or care staff that we spoke with told us they had not received supervision or 1:1 interviews with their line manager to help them reflect on or identify improvements in their performance.

Staff were given the opportunity for specialist training. Many of the senior staff reported that the trust was responsive to requests for higher degrees or other courses to assist staff gain enhanced knowledge in the chosen speciality. Examples given were opportunities to attend leadership development courses, undertake specialist practice degrees and child assessment courses.

To ensure staff were competent to provide safe care and meet the needs of the patients and the service examples of specific training and assessment of competencies were evidenced, including phlebotomy skills training for health care assistants. Other competencies of staff assessed included safe use of syringe drivers, measuring blood glucose and monitoring intravenous infusions. Staff told us they were being supported to obtain skills in mentorship to support student nurses when they were allocated to the wards.

In the Minor Injuries Unit, Hertfordshire and Essex Hospital (H&EH) If they had to use temporary staff to cover unplanned absence such as sickness they had two temporary staff they used who were familiar with the department and had accident and emergency care experience

There were no paediatric trained nurses on the team, but arrangements were in place for staff to receive clinical supervision from a paediatric nurse practitioner. One staff member in the department had not received an appraisal for five years. As a consequence they had set their own objectives.

In Potters Bar Community Hospital staff reported they received training a variety of training including how to care for people with challenging behaviour. Training time was protected and external speakers sometimes attended to provide training updates for staff on topics such as safeguarding and use of the national early warning score system. We looked at records and saw within the past 12 months, 28 out of 34 staff had been appraised, although staff reported prior to this recent series of appraisals, they were inconsistently provided. The 2014 national staff survey results placed the trust as average compared to other community trusts for the percentage of staff receiving

a well-structured appraisal. Staff were aware a new on line system of appraisal was being introduced and staff were scheduled to receive training to use this hence there were some delays in completion of some appraisals.

There was evidence of professional development through the introduction of specialist link roles for example a specialist lead in diabetes. Competency assessments had been completed for a variety of tasks such as use of syringe drivers and blood glucose testing.

**Multi-disciplinary working and coordination of care pathways**

In most units we saw evidence that multidisciplinary teams worked effectively together to provide care for patients. For example in the Hertfordshire and Essex Hospital the therapists assisted the nurses get patients out of bed, get washed as dressed in the mornings as part of their therapy. However, at Queen Victoria Memorial Hospital, this was not the case. The therapists did not get to the ward until between 9am to 9.30am. Both nurses and therapists confirmed there was no formal daily discussion between them, to ascertain, for example if a patient had been unwell overnight and may not be well enough for therapy.

At the Hertfordshire and Essex Hospital, there was a morning "sweep meeting," where all the staff had a brief handover so that all were aware of any problems or information that may affect patient care.

All the units we visited had a weekly multidisciplinary team meeting (MDM). This was attended by the senior nurse, therapists, the doctor, either the visiting general practitioner (GP) or consultant and social workers. These meetings were held to discuss patient's progress against their goals and to plan discharge from the hospital effectively. We saw evidence of discussions from MDM's regarding patient discharge communicated to GP & community rehabilitation teams.

**Referral, transfer, discharge and transition**

Patients to all units were referred in the main, from the acute hospitals following for example, stroke, fracture or falls. The trust wide bed bureau was responsible for ascertaining where empty beds were and placing the patient in particular units. The nurse in charge carried out a paper or telephone assessment prior to the patient being accepted. Staff told us there had been occasions when patients transferred had been found too unwell to be cared for in the unit. The staff had been asked to record these on the trust incident reporting system, however, reporting of these incidents formally was fairly new and therefore meaningful data was not available. Anecdotally though, staff at each unit told us inappropriate transfers happened, on average, once or twice a month

Transfers from the acute hospitals were undertaken very quickly. After a bed had been requested, most were transferred within 48 hours. This meant that their rehabilitation programme or their particular needs could be met quickly in a suitable environment. Once a patient was admitted, their expected discharge date was planned according to their needs and social circumstances. This was written on a large whiteboard, which was present in all the units we saw. Other essential information was included, for example the patient's social worker and named therapist. Most patients had a named social worker who worked with the multi-disciplinary team and external social services.

Staff were knowledgeable about the purpose and aims of setting estimated discharge dates (EDD) and subsequent planned discharge dates (PDD).They explained the planning for discharge commenced when the patient was admitted to the ward hence the use of EDD's. During the patient's stay the multidisciplinary team developed a planned discharge date (PDD) which was recorded and given to the patient to discuss with their relatives. A discharge report was prepared approximately 48 hours before discharge. Ward managers explained PDD's and EDD's were being collated to examine trends and obstacles to not achieving the PDD but as yet no firm conclusions had been reached.

In Oxford and Cambridge wards, Hertfordshire and Essex Hospital (H&EH) discharge summary processes were good. We observed the process being completed by staff on two occasions where a copy of the patients discharge summary was provided to the patient to take home. In addition, a copy was faxed and also posted to the patient's general practitioner. A self-medication sheet was provided which was clearly written; explaining what each item of medicine dispensed to take home was for. This was given in advance to allow the patient to sufficient time for the patient to question anything they were unsure about.

The patient flow coordinator explained they felt their role made a difference to the average length of stay which had previously been 37 days was now 18.8 days. They acted as

a link and were a good point of contact between the patient, nursing medical and staff, therapists and relatives and community services. This meant there was continuity of communication and staff time was freed to manage direct patient care.

**Availability of information**

Details of the team caring for the individual patient were displayed above each bed in addition to patient's personal goals. Some units used a document called 'Going Home', this contained useful contact numbers of services the patient may require, for example, team members that would visit if required.

We saw a variety of patient information in all the units we visited. This included information on prevention of falls and moving in bed to prevent pressure ulcers. The therapists had a variety of patient information leaflets regarding correct limb positioning and exercises to aid recovery.

Some patient information had details about how to obtain copies in large print, braille, or audio tape, or if a person required the information interpreted in their own language. There was an interpreting service, with details of which languages were covered. There was a falls information board, written in an easy read format with illustrations, giving information on the frequency of falls in the unit, risks and how to avoid them. There was also information on local and national organisations, including Carers in Hertfordshire, The Alzheimer's Society and The Stroke Association. Information documents also included contact details of other organisations that could provide further information such as the National Institute for Clinical Excellence (NICE) or the Patient Advisory Liaison Service (PALS).

**Consent**

The trust had an up to date consent policy that reflected national and regulatory requirements.

We saw evidence that consents for treatment were obtained and recorded in accordance with the trust's policy. However it was noted that several patient records included photographs of their wounds to assist with the planning of their wound care. Of the records seen, written consent to have the photographs of their wounds taken had not been obtained from the patient.

Therapists recorded that they had gained the patient's consent prior to treatment and we saw documents used to record care included a prompt for the staff member to request consent from the patient prior to providing treatment. Patients told us that they were asked for consent before any treatment or procedure. One told us, "They always tell me what they're going to do and if it's ok." We observed therapists working with patients who explained what they wished to do and obtaining the patients agreement before commencing treatment.

Although trust records demonstrated that approximately 65% of staff across all units had received Mental Capacity Act training, against a trust target of 90%, all the staff we spoke with during the inspection were aware of their responsibilities with regards to people who did not have capacity to give consent. All the staff we spoke with were aware of the trust's procedure and knew who to contact if they had concerns.

Good

# Are services caring?

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

**Summary**

Overall inpatient services at the trust were caring. Patients mostly received compassionate care.

The degree of privacy and dignity afforded patients varied across hospitals and within the individual wards and this was reflected in the Patient Led Assessment of the Care Environment (PLACE) results which averaged 75%, below the England average of 85%.

Patients were involved in the planning and delivery of their care to ensure they were supported to manage their own health to achieve maximum independence prior to discharge into the community. Staff were responsive to the emotional needs of patients and ensured patients were given sufficient time and reassurance especially if the patient was disorientated or confused. Medical staff took time to provide clear explanations and that the patients understood their planned treatment.

There was information available to the patients and their families that included contact details if they required further information.The latest results of the friends and family test showed 79% of patients responded they were likely to recommend the service to friends and family.

The majority of staff were kind and had caring positive attitudes towards patients and their families. The friends and family test showed 99% of people using in patient services advised they were treated with dignity and respect.

**Detailed findings**

**Dignity, respect and compassionate care**

We spoke with 24 patients and relatives during our inspection. Most patients told us they were treated with kindness and respect. Staff usually responded compassionately to pain and discomfort in a timely manner and most call bells were answered promptly if there were sufficient staff on duty.

The majority of staff were kind and had caring positive attitudes towards patients and their families. The friends and family test showed 99% of people using in patient services advised they were treated with dignity and respect.

The Patient Led Assessment of the Care Environment (PLACE) survey results for 2014 regarding privacy, dignity and wellbeing showed the trust average score to be 75% which is below the England average of 85%. However, three of the eight locations we inspected had achieved very good scores:

- Potters Bar Community Hospital, 97%
- Gossoms End Rehabilitation Unit, 96%
- Danesbury Neurological Centre, 96%

There was promotion of dignity and respect awareness through training for staff ,notices and educational material displayed. Patient's told us staff were kind and took time to explain things. There had been 22 complaints regarding care for inpatient services between Oct 2013 and September 2014 of these 41% related to standards of care and 14% to staff attitude and behaviour.

In Langley House staff told us that they tried to fit each patient's care around the patient's needs. For example, one patient wanted to be able to eat and drink independently, and staff supported the patient through the process, by supervising and advising them. We noted that all care plans included a form titled "This is who I am and how I wish to be cared for". This detailed how the patient wished to be involved in their care, and gave examples of their likes, dislikes, how they wished to be addressed, their perception of their care and therapy needs, and their own goals. For example, one patient wanted to regain mobility following a fracture. The care plan detailed how this goal would be achieved, with the use of physiotherapy and nursing care. Review dates were included in this care plan. We found that nurses checked on patients regularly, and documented any issues in the two hourly rounds checklist. The checklist was used to check the patients status and comfort such as, if the patient was awake, asleep, comfortable, in pain or required assistance, for example with a drink or to go to the toilet.

In Queen Victoria Memorial Hospital (QVMH) feedback from patients and staff at QVMH was varied. On arrival we observed visitors being greeted in a warm and friendly manner. Relatives spoke positively about the care provided. One patient reported their dignity and privacy were not respected.They told us that when using a

commode staff would just come behind the screens to complete other tasks without apparent consideration for their dignity and staff did not always respond in a timely manner. The PLACE score in this unit for privacy, dignity and well-being was 68% which was the lowest score in the trust.

Another patient said, "Things could be better here and there. When I call somebody they don't come very quickly. I'm not sure why I am here. Some of the nurses are absolutely grand but others are not so caring. Night time care is not so good.''

In Oxford and Cambridge Wards, Hertfordshire and Essex Hospital staff were observed to speak with patients in a polite and discreet manner; they used screens to maintain dignity when providing personal care. We observed a patient declining medication; the nurse explained the importance of the medication but respected the patient's wishes. The doctor was advised and discussed matter with the patient to gain a better understanding of patient's concerns and achieve compliance with the prescribed medicine.

One patient said, ''The nurses are brilliant; they even brought me hot chocolate in the middle of the night. They listen and are caring, nice and friendly". Nursing staff were observed to have a gentle and respectful manner towards patients. Students working on the ward told us they had a positive experience in that they had time to give care and talk to the patients. The daughter of one patient said, ''They are very caring, they have gone out of their way to find out about my mother, I have no cause for concern.''

**Patient understanding and involvement**

Staff generally involved patients in planning their care and provided support where needed. Staff explained how they would provide support to patients who were confused or anxious through taking time to talk to a patient, tell them their name, smile, be relaxed and try and to help the patient relax. We saw this being practiced. Staff introduced themselves and explained the date and time of day to help orientate patients. Staff explained what they were going to do when delivering care, and why. They also explained, for example, when medicines were due, when staff changed at handover who would be looking after the patient, or what arrangements had been made for medical tests such as x-rays. Medical staff took time to explain to patient's changes to their planned treatment and involved family members where appropriate.

We observed how patients were involved in planning their daily care, for example a patient was asked

if they wanted a shower. The patient declined this but asked for assistance to have a wash at the bedside which was organised by the carer. We spoke with the patient later in the morning, they said, ''Staff were so kind and patient, they respect my decisions.

There was little evidence in patient's records that patient's preferences had been ascertained when planning care. Weekly timetables were developed for patients so that family visits and other appointments could be built into the patient's daily plan of care and therapy.

We noted from feedback forms that one patient on the ward at Oxford and Cambridge wards, Hertfordshire and Essex Hospital did not speak English. We enquired how staff communicated with the patient to ensure sure effective care. They explained there was a member of the housekeeping staff who spoke the patient's language and when on duty helped to interpret. The relatives of the patient also spoke English. Staff explained they had searched on the internet and printed some key words to use but the patient did not understand as they were spoken in the wrong accent. An interpreter service was available staff told us they had contacted them however there was no evidence of actions taken in any of the patient records except for a statement, "Does not speak English." We discussed this matter with the staff to ensure more effective measures were adopted to communicate with the patient.

**Emotional support**

Most patients we spoke with felt supported and were given encouragement where needed. There were policies for respecting patients' decisions about their care. Most staff we spoke with knew the resuscitation status of patients. Although patients were recovering from an illness or injury which meant a possible change in their circumstances or lifestyle there was minimal evidence of assessment of patient's emotional needs. Some wards had quiet areas

where discussions with patients or relatives could be held in private. Visiting times were flexible to allow good access to visitors. Ward notice boards included details about chaplaincy services.

At Oxford and Cambridge Wards, Hertfordshire and Essex Hospital a patient told us that staff phoned home for them so that they didn't have to worry about their next of kin and felt that communication on the ward was good. We spoke to one carer who was providing one to one care to a patient who was confused. They had a good understanding of the patient's rights and described techniques they used when looking after the patient. They knew their limitations and said they would notify the nurse in charge if they were concerned about the patient in anyway.

At Langford Ward, St Alban's City Hospital there was evidence a geriatric depression score tool was used to assess patient's mental well-being. At weekends a chaplain visited the ward to provide communion for those patients who requested it. There was a chapel available for patients and families to use. Contact details of the ministers were displayed advising a visit could be arranged if patients requested it.

**Promotion of self-care**

Patients were encouraged to do as much as they could for themselves prior to their discharge. For example room exercises were provided for patients to practice under supervision and to take home. Goal setting by therapists which were goals displayed at bedside for example to be able to safely transfer from the bed to a chair independently. Where appropriate patients were allowed to self-medicate once they had been assessed as safe to do so. This meant patients became familiar with the medicines they needed and had time to raise any concerns they had prior to their discharge home.

There were protected meal times for lunch (which meant visitors and interruptions by care staff were not allowed) but friends and family were encouraged to visit and be involved at all other times. On St Peters ward at Hemel Hempstead Hospital, patients were encouraged to use the day room where activities were organised for them such as bingo, quizzes and musical events.

There was promotion of self-caring to avoid patients becoming too dependent especially when in hospital for a long period and help prepare them for discharge home. The units had assessed and made arrangements to enable patients to go on overnight and weekend leave as a trial to assess how they coped in community and this allowed the family and patient more time together in a non-clinical environment.

Good

# Are services responsive to people's needs?

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

**Summary**

There was an integrated approach to planning and delivering care in a way that supported people to receive and access care as close to their home as possible.

Care was planned and delivered to meet the needs of people with complex needs such as those living with dementia.

Dementia champions had been introduced to help ensure best practice was used to meet the needs of vulnerable people.

Facilities and premises were appropriate for the services planned and delivered. Patients commented they appreciated the quieter atmosphere of the community inpatient wards.

Complaints were investigated in a timely manner and changes made where appropriate.

Staff showed an awareness of the need to respect different cultures and religious needs.

Awareness of access and response to translation service needs were limited and not always sufficient to meet patient's needs.

There was limited activity for patients in some in-patient areas.

**Detailed findings**

**Planning and delivering services which meet people's needs**

Patients were transferred from the acute hospitals for rehabilitation nearer their home and these transfers were coordinated through the central bed bureau. There was an emphasis on maximising patients' mobility and independence. One patient told us, "I've been here for two weeks and I'm going home next week, so they say. I would never have dreamt when I came in here how quickly I would walk and get going again. I'll be eternally grateful. It's brilliant."

Staff we spoke with at the various hospitals, including doctors and nurses, expressed concerns about the poor quality of patient information they received when patients were transferred to their respective units from other hospitals. Doctors expressed concern as they often did not immediately have a complete picture of the patient to effectively plan and evaluate patient's treatment. Staff told us that they brought this to the attention of their managers and had begun to complete incident forms on the trust's electronic reporting system. Formal reporting of these incidences was fairly new and therefore there was no meaningful data available. Staff though had not been informed of any actions taken to address this. We brought this to the trust attention during the inspection.

There was a community discharge manager whose key role was to ensure safe sustainable discharges, ensure effective coordination of the whole care team to meet the patients' needs there was an aim to achieve a 20% reduction in the average length of stay. Since December 2014, the average length of stay has been monitored to measure the effectiveness of the service but it was too early to draw any conclusions about how effective the service has been at this stage.

The Minor Injuries Unit,( MIU) Hertfordshire and Essex Hospital provided a service between the hours of 9am and 5pm Monday to Friday Patients seen in the MIU were offered a choice of which hospital they were referred to if they required further treatment based on where they lived. There was a lack of coordination between the MIU and the x-ray service which was provided to the MIU by the acute trust that ceased at 4.45pm meaning any patient attending after this time had to return the following day.

**Equality and diversity**

Staff were able to describe the areas of equality and diversity they had experience of supporting. They were knowledgeable about the strands of equality and diversity and what made each person an individual. Staff showed respect for different cultures and religious needs by, for example, providing only male or female staff if this was important to the patient. One nurse we spoke with told us, "If I am looking after a patient of the opposite sex, I would ask another nurse to help me wash the patient. I would leave the room if the patient was embarrassed about me

Good

# Are services responsive to people's needs?

being there." Staff we spoke with said all patients would be treated and cared for as individuals and adjustments would be made to ensure the outcomes for patients were as good as they could be.

There were no immediate on site translation services; if staff required an interpreter to translate they requested this via the hospital's switchboard according to trust guidance for access to translation services. If patients did not speak English, a family member or a member of staff would provide immediate assistance with translation if required whilst waiting for access to translation services.

Staff had access to a network of support for patients' differing spiritual needs, both within the hospital and from the local community. The chaplaincy based at the hospital visited the wards regularly and specific visits could be arranged. At the Hertfordshire and Essex Hospital, there was a Chapel, which was used for services and as a quiet place for contemplation and prayer.

### Meeting the needs of people in vulnerable circumstances

It was recognised that a number of patients admitted to the wards at any one time were living with dementia. Some staff had received training to understand and provide support people living with dementia. Dementia champions had also been introduced to ensure best practice was cascaded through the team. Care plans were person centred and met the needs of people living with dementia. Some of the units used the "This Is Me" document. This described the person, their life and likes, in an effort to help staff understand them as a person and their individual care needs and talk about things that may be familiar.

We saw there were appropriate access facilities for people with limited mobility such as step free access.

### Access to the right care at the right time

Patients were admitted to all units swiftly and there were minimal waits for beds. All admissions were managed centrally via a trust wide Bed Bureau. Medical out of hours care was provided by the local on call doctor service. Staff reported the service usually worked well and patients were seen within the hour except during peak demand such as during the winter months when demand was high. If a patient was in urgent need of medical attention staff called the emergency services.

Patients told us they had regular sessions of physiotherapy during the week and were provided with exercise plans to follow at the weekends when physiotherapy staff were not available. Staff told us access to wheelchairs was a problem and often patients ended up buying their own when being discharged. There was an awareness of this shortfall and it was recorded on trust's risk register and actions were being taken to improve access to them.

At Queen Victoria Memorial Hospital, apart from an average of two sessions of therapy a day, one of which may have been a group activity; there was no organised patient activity. We observed that patients spent most of their day in the dayroom unsupervised, we saw a patient get up from their chair, stumble and almost fall. We brought this to the attention of the nurse in charge at the time.

**In the Minor Injuries Unit, Hertfordshire and Essex Hospital**a board was displayed in the waiting area specifying the current waiting time e.g. five minutes and showed the names of the staff on duty. The target waiting time for patients to be seen was 15 minutes and there was evidence to show this was being met. All the MIU nurses were trained prescribers which meant patients could be treated promptly without waiting for a doctor to prescribe medicines.

### Complaints handling and learning from feedback

The trust had effective systems in place to gather information from service users, and had records about people's experience from patient surveys. We saw these displayed on the walls in the units. "What you said." "What we did." This was being used to improve care, for example, addressing delays in answering call bells. Positive comments such as thank you cards and letters from former patients and their families were also displayed on wards for staff and visitors to read.

Staff were able to discuss and understood the complaints process and how to report and escalate concerns in accordance with the trusts complaints policy. We saw complaints had been logged on the trust's electronic incident recording system and were discussed at ward meetings to learn from incidents.

There was evidence the trust had used the feedback to improve services. For example, complaints regarding poor communication with families with regards to patient discharge, led to a review of staff communication and use of the discharge check list. It had been identified through

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# Are services responsive to people's needs?

audits that the previous use of the checklist had been poor and that the correct use of the checklist had now risen to 80% compliance. Another example related to concerns about lateness of meals being served. This had led to food hygiene training being provided to allow more staff to serve meals at correct times and ensure food served was hot.

Patients knew how to raise concerns and were able to describe examples of where they had been unhappy about an aspect of their care and that this was quickly resolved, there were 22 complaints received between October 2013 to September 2014. Concerns and complaints were often dealt with and resolved at ward level by the ward sisters which avoided the need for a more formal approach and ensured people's concerns were addressed promptly.

There were two main themes quality of care and concerns related to admission and discharge procedures.

The trust had a strong focus on improving discharge processes. Patients now receive a letter explaining their expected date of discharge each week which they found helpful and were able to share the information with their families explaining why they were staying in hospital longer than anticipated.

Requires improvement

# Are services well-led?

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

**Summary**

The quality of local leadership was variable.

Staff were concerned regarding the quality of their appraisals in some areas. The 2014 national staff survey results placed the trust as average compared to other community trusts for the percentage of staff receiving a well-structured appraisal.

Although there were some appropriate arrangements for identifying and reporting risks staff did not always get feedback.

Risk registers were incomplete and were not regularly updated.

Staff told us that the recruitment was slow staff were not aware of a strategy to recruit and retain staff nor were they able to identify any succession planning for staff known to be leaving or retiring.

Staff were aware of the trust's values and able to describe them.

Governance processes were in place such as clinical and internal audit to monitor quality and safety of care and there was evidence of effective use of patient feedback to improve services through the use of patient survey and complaints information.

Leadership training for staff was being provided and innovation amongst teams was encouraged to help develop and improve services.

**Detailed findings**

**Service vision and strategy**

Not all staff were area of the trusts vison or what it meant for them and their service. The trust had implemented briefing notices to keep staff informed of planned developments with the trust.

When asked staff were able to describe the trust values. To promote awareness of the trust values, these were linked to appraisals and setting of objectives. Some staff told us they had not had regular appraisals though most had received one recently, staff told us they were concerned regarding the quality of their appraisals in some areas.

To further promote awareness of the trusts values these were displayed on all staff computers screen savers. Ward managers told us that locally they had adopted the six C's which are Compassion, Courage, Competency, Commitment Caring and Communication as their vision and strategy for nursing.

**Governance, risk management and quality measurement**

Although there were some appropriate arrangements for identifying and reporting risks staff did not always get feedback.

There were local risk registers for each in patient unit. However, all but one contained one risk, staffing. We saw that they were not updated regularly and staff we spoke with were unaware of their existence.

Staff received information from the National Institute of Clinical Excellence (NICE), safety alerts and hazard warning notices by email. This information was then discussed at staff meetings. There were not comprehensive local risk registers that were reviewed regularly and although the inpatient units fed information into the main governance structure, there was no local governance structure in place at each unit.

In some areas there were monthly ward meetings attended by all staff. We saw minutes from two separate meetings, and items discussed included quality assurance, falls, the use of new equipment such as sensor mats and voice alerts to reduce the risk of falls, and any training requirements, as well as organisational updates. However although staff had reported incidents of inappropriate transfers over the past months there was no evidence or feedback to staff about measures taken to minimise this risk.

**Leadership of this service**

Requires improvement

# Are services well-led?

Staff knew and had met the chief executive officer on several occasions. They told us they found them approachable and easy to talk to and that they appreciated the regular email newsletter from the CEO.

Managers used ward meetings to provide trust wide information such as organisational changes. They also communicated changes to staff via email using the trust intranet. Notice boards on each ward had a visual display of entire team and hierarchical structure to help inform visitors to the ward.

Senior staff told us that the recruitment for all types of staff was slow, even for direct replacements. None of the senior staff we spoke with were aware of a strategy to recruit and retain staff nor were they able to identify any succession planning for staff known to be leaving or retiring. There were some imprecise plans for overseas recruitment. However, the time from recruitment to staff taking up post was several months.

At Sopwell and Langton wards St Albans City Hospital staff spoke well of the leadership and support they received by their ward managers. The wards were well organised and the managers were actively involved in the supervision of clinical practice. The manager for Sopwell ward had only 50% of their allocated staffing establishment in post when they started but had taken measures to address this and now only had a few vacant positions to fill. They told us they would like to accept student nurse placements but were not prepared to do so until the workforce was sufficiently established in order to provide effective support and mentorship to students. Some staff were unable to work the new 12 hour shifts due to personal circumstances. The manager of Langton ward had introduced some flexibility to ensure staff were supported and retained.

Staff reported morale was low in one area, Hertfordshire and Essex Hospital, and that there was high sickness. Trust wide, sickness rates were a little above 4%. This was almost equally divided between those on short term and those on long term sick leave. There was a high number of hours worked as overtime and high use of agency staff. On one occasion during our inspection at The Hertfordshire and Essex Hospital, there were eight staff on duty; of these six were temporary staff members.

In one area the manager for the department had not received an appraisal in the past five years but had set their own objectives and developed a set of competencies for Band 6 & 7 staff.

**Culture within this service**

In general staff reported an open and learning culture. Staff were aware of who the senior management team were and found them approachable. The trust had a whistleblowing policy which was available to staff on the trust intranet. Staff consistently told us of their commitment to provide safe care regardless of the staffing difficulties they encountered at times. Most staff felt respected and valued for the contributions they made to ensure safe care and improve the quality of the service. Managers were able to describe actions they would take when performance of staff was not consistent with the trust's values which were in accordance with the trust's disciplinary policy.

In one area there was mixed feedback about the leadership of the ward team. Some staff expressed concern about the management style and attitude of the senior staff, but felt the majority of the team were supportive to each other. Some staff reported poor behaviour from trust senior staff and told us staff had reported concerns to the senior manager but that they were not aware of anything being done to address this. On discussion with the trust there was no record within the HR department of staff having raised this as an issue. However actions were being put in place to explore this and address any concerns.

Some staff told us they had experienced intimidating behaviours such from an external organisation. The trust have taken steps to address this.

**Public and staff engagement**

The trust had effective systems in place to gather information from service users, and had records about people's experience from patient surveys. We saw these displayed on the walls in the units. "What you said." "What we did."

The trust had a five year staff engagement plan (2012 -2017) which included annual staff and leadership events.

Staff spoke positively about the leadership training they were being offered. Staff were concerned regarding the

Requires improvement

# Are services well-led?

quality of their appraisals in some areas. The 2014 national staff survey results placed the trust as average compared to other community trusts for the percentage of staff receiving a well-structured appraisal.

**Innovation, improvement and sustainability**

Group meetings for ward sisters had recently been introduced to share learning and innovation. The nurses attending the meetings were very positive about how effective they were. We saw minutes of meetings which included discussion of serious incidents complaint and safety alerts to ensure a consistent response to events and share learning from incidents. For example the audit results of Do Not Attempt Resuscitation (DNAR) had identified gaps in information not completed.

A recent trust initiative was rapid improvement week, which was set up to address the issues of extended in-patient stays and turnover. The program led to changes such as on-site social workers at some bed bases to improve discharge planning. The trust had also introduced a method that simulated the television programme Dragons Den for staff to present innovations and requests for additional funding or support. For example one group had filmed some therapy activities with the patient's consent to present their case.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines<br>1. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.<br>**The regulation was not being met because:**<br>• CDs, both liquids and tablets, which had been prescribed as take home medicines, were in the CD cupboard unreconciled. That is, there was no record of the CD's being received from the pharmacy or being checked.<br>• Boxes of prescription only dressings were stored next to a computer server. The room temperature was in excess of 25 degrees centigrade. The boxes that the dressings were stored in were warm to the touch. This meant that dressings were stored in an environment that would have decreased their potency.<br>**Regulation 13** |

| Regulated activity | Regulation |
|---|---|
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment<br>1. The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is: |

This section is primarily information for the provider

# Requirement notices

1. properly maintained and suitable for its purpose

**The regulation was not being met because resuscitation equipment had not been checked to ensure it was fit for purpose.**

Regulation 16 (1) (a)

| Regulated activity | Regulation |
|---|---|
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br>1. The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from lack of proper information about them by means of maintenance of –<br>1. an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user<br>**The regulation was not being met because**<br>**patient's care and treatment were recorded in numerous areas therefore there was no easily accessible record of the whole episode of patient care. None of these included a written evaluation of care provided. The handover sheets seemed to be the main nursing care record. Therefore vital information about the patient was not kept in their notes, but on pieces of paper that we were told were destroyed at the end of each shift.**<br>Regulation 20 (1) (a) |

| Regulated activity | Regulation |
|---|---|
| Nursing care<br>Treatment of disease, disorder or injury | Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs |

This section is primarily information for the provider

# Requirement notices

Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration, by means of the provision of-

(c) support, where necessary for the purposes of enabling service users to eat and drink sufficient amounts for their needs

The regulation was not being met because where fluid balance charts were used, we found inconsistency in the input and output being totalled to effectively evaluate the patient's status and whether further interventions such as encouragement for more fluids were required. Patients were not provided with the soft diet recommended by the speech and language therapist

Regulation 14 (1) (c)