St. Peter's Community Hospital Ward

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

St Peter's Community Hospital ward has 26 beds split between stroke rehabilitation (10 bedded) and rehabilitation and end of life care for adults (14 bedded). It also offers day case admission for patients.

We chose to inspect St Peter's Community Hospital Ward as part of the first pilot phase of the new inspection process we are introducing for community health services. St Peter's Community Hospital Ward was last inspected in February 2013 when we found it to be compliant in the five standards we reviewed.

In general, we found that St Peter's Community Hospital ward provided safe care. People were protected from abuse and avoidable harm. Systems for identifying, investigating and learning from patient safety incidents were in place.

Inpatient services were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices and sufficient staff available to meet the needs of people accommodated within this facility.

The majority of people said that they had positive experiences of care. We saw good examples of care being provided with compassion and of effective interactions between staff and patients. We found staff to be hard working, caring and committed. We noted many staff spoke with passion about their work and were proud of what they did.

St Peter's Community Hospital ward responded to people's needs. We found the organisation actively sought the views of patients and families. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time and without delay.

The ward was well-led. Organisational, governance and risk management structures were in place. The senior management team were visible and the culture was seen as open and transparent. Staff were aware of the vision and way forward for the organisation and said that they generally felt well supported and that they could raise any concerns. Many staff told us that it was a good place to work.

Although mechanisms were in place for staff to receive individual clinical supervision, there were inconsistencies in practice. Monitoring systems were not in place that would ensure staff received the four individual supervision sessions per year as per policy, or that ensured sufficient time for reflection between sessions.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm.

Are services effective?

Inpatient services were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices and sufficient staff available to meet the needs of people accommodated within this facility.

Although mechanisms were in place for staff to receive individual clinical supervision, there were inconsistencies in practice. Monitoring systems were not in place that would ensure staff received the four individual supervision sessions per year as per policy, or that ensured sufficient time for reflection between sessions.

Are services caring?

The majority of people said that they had positive experiences of care. We saw good examples of care being provided with compassion and of effective interactions between staff and patients. We found staff to be hard working, caring and committed. We noted many staff spoke with passion about their work and were proud of what they did.

Are services responsive to people's needs?

St Peter's Community Hospital ward was responsive to people's needs actively seeking the views of patients and families. People from all communities could access services and effective multidisciplinary team working, including inpatient and community teams, ensured people were provided with care that met their needs, at the right time and without delay.

Are services well-led?

The ward was well-led with organisational, governance and risk management structures in place. The senior management team were visible and the culture was seen as open and transparent. Staff were aware of the way forward and vision for the organisation and said that they generally felt well supported and that they could raise any concerns. Many staff told us that it was a good place to work.

Summary of findings

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

Community inpatient services

Services were safe because there were systems for identifying, investigating and learning from patient safety incidents and an emphasis in the organisation to reduce harm. Risk assessments were in place with input from healthcare professionals.

Inpatient services were effective and focussed on the needs of patients. We saw examples of effective collaborative working practices and there were sufficient staff available to meet the needs of people staying on the ward. However, although mechanisms were in place for staff to receive individual clinical supervision, there were inconsistencies in practice. Monitoring systems were not in place that would ensure staff received the four individual supervision sessions per year as per policy, or that ensured sufficient time for reflection between sessions.

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Summary of findings

What people who use the community health services say

The Friends and Family Test (which asks a single, standard question: "How likely are you to recommend our ward to friends and family) was conducted at St Peter's Hospital between April 2013 to September 2013. The results were mainly positive with the majority of people confirming that they would recommend the ward to friends and family.

An internal customer survey was conducted at St Peter's Community Hospital between May 2012 and July 2012. A sample of 66 patient views were collected upon their discharge, and the results were generally favourable. The provider identified the following actions from the negative feedback:

Communication with patients about medication and treatment could be improved

To ensure staff assessed patient's medication routines at admission

Fifteen comment cards were completed for St Peters inpatient ward during the inspection. The feedback from patients and relatives about this ward was overwhelmingly positive with nothing but praise and gratitude expressed for both the clinical and support staff who worked on the ward. A number of responses referred to the cleanliness of the ward and the care and dignity with which loved ones had been treated. The only negative feedback that was recorded were two comments that at times the ward seemed understaffed and a report that the call system in the day room needed to be fixed.

Areas for improvement

Action the community health service SHOULD take to improve

- Ensure effective systems are in place to record, monitor and inform staff training needs.

Action the community health service COULD take to improve

- Enhance staff understanding of clinical supervision and ensure processes are in place to monitor clinical supervision received per individual member of staff.

Good practice

Our inspection team highlighted the following areas of good practice:

- The multidisciplinary approach to completion of patient risk assessments
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work, felt proud and understood the values of the organisation.
- The positive feedback received from patients regarding the quality of care received
- The care provided was person centred and based on evidence based guidelines

St. Peter's Community Hospital Ward

Detailed findings

Services we looked at: Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Tracy Taylor, Chief Executive, Birmingham Community Healthcare NHS Trust

Head of Inspection: Amanda Musgrave, Care Quality Commission

The team included CQC inspectors, an analyst and a variety of specialists: Physiotherapist (adults and children), Pharmacist and patient 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to St. Peter's Community Hospital Ward

St Peter's Community Hospital is the head office and home to a number of the provider's services.

The community ward is managed by Central Essex Community Services C.I.C. on behalf of the NHS. Central Essex Community Services C.I.C. run a number of clinics from this hospital, including:

- Assessment and Rehabilitation Unit
- Breastfeeding Support
- Community Hospital Wards
- Community Hospitals & Clinical Services
- Diabetes - Adult Community Service
- Falls Prevention
- Integrated Orthopaedic Service
- Lymphoedema - Jennifer Neale Unit
- Outpatient Physiotherapy and Occupational Therapy
- Parkinson's Disease
- Podiatry
- Sexual Health
- Speech & Language Therapy - Children and adults

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Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

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

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

The inspection team looked at the following service:

- Services for adults requiring community inpatient services

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

We carried out an announced visit on 22 January 2014. During our visit we held focus groups with a range of staff, we observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the service.

The team would like to thank all those who attended the focus groups and listening event and were open and balanced in the sharing of their experience and their perceptions of the quality of care and treatment at Central Essex Community Services C.I.C.

Community inpatient services

Information about the service

St Peter's Community Hospital is the headquarters for Central Essex Community Services C.I.C. St Peter's community hospital ward has 26 inpatient beds split between stroke rehabilitation (10 bedded) and rehabilitation and end of life care for adults (14 bedded). It also offers day case admission for patients. A total of 290 patients used the inpatient facility at St Peter's hospital between November 2012 and October 2013. During our inspection, we spoke to approximately six patients and six staff and reviewed information from comment cards that were completed by people using the inpatient service.

Fifteen comment cards were completed for St Peters inpatient ward during the inspection. The feedback from patients and relatives about this ward was overwhelmingly positive with nothing but praise and gratitude expressed for both the clinical and support staff who worked on the ward. A number of responses referred to the cleanliness of the ward and the care and dignity with which loved ones had been treated.

Summary of findings

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Community inpatient services

Are community inpatient services safe?

Safety in the past

We found that community inpatients were protected from abuse and avoidable harm as staff were confident about reporting serious incidents and providing information to the ward matron or senior manager if they suspected poor practice which could harm a person. Staff told us that falls, pressure ulcers, medicines management issues and fractures were reported to the quality and safety department and that this department collated this information.

All staff we spoke with were aware of the safeguarding policy and had received training at the appropriate level with regards to safeguarding vulnerable adults. The 2014 mandatory training records reported 100% attendance at Safeguarding Adult and Children levels 1-3 at St Peter's Hospital Ward.

Information highlighted by the NHS Safety Thermometer assessment tool (used by frontline staff to measure a snapshot of these harms once a month) identified an increase in pressure ulcers between April 2013 and June 2013 for the over 70's group. However, this snapshot figure is of all patients identified with a pressure ulcer and includes patients that may have been admitted with existing pressure damage as well as those patients that have developed a pressure ulcer whilst in hospital. The provider has reported two grade 3 or 4 pressure ulcers at St Peter's Hospital between April and November 2013; one was avoidable and had resulted from a delay in the assessment of the patient.

Patient Led Assessments of the Care Environment (PLACE) had been conducted and scores were displayed in the ward area. The results for this ward were all above the National Average.

Infection Prevention Committee Minutes of September 2013, also noted that no healthcare associated infections for Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium Difficile (C.diff) had been attributed to St Peter's Hospital for the first two quarters of 2013.

We found that medicines in the ward storage areas were stored safely for the protection of patients. A comprehensive recording chart was available for the prescribing and recording of medicines. These charts were well completed, provided an account of medicines prescribed and demonstrated that patients were given their medicines as prescribed. Daily recording of the refrigerators used to store medicines were conducted and monitored. This meant that staff took appropriate action to check that refrigerator temperatures were appropriate and to ensure the efficacy of medicines was not affected. We found medicines for emergency use were available and in date.

Learning and improvement

We found that mechanisms were in place to monitor and report safety incidents, including "never events". Staff were familiar with the reporting system and could provide examples of reporting serious incidences and the lessons learnt. For example, Fifty-one falls were entered into Datix between April 2013 and December 2013 for the community ward of which only one was rated as an orange risk. A root cause analysis (RCA) investigation was conducted for each of these incidents, and we saw an RCA which had been completed in full following a fall two days before our inspection. The provider identified that there was an increasing trend in the number of falls that had been reported during the six months to December 2013. As a result, a review was undertaken in order to monitor the incidence of patient falls in relation to the numbers of staff on duty, the ratio of agency staff and the location of staff on duty when falls had occurred. The outcome of this review has yet to be reported.

A customer experience report was produced on a monthly basis for the Board and provided an overview of customer experience across all locations. This report included an update on actions to date relating to issues raised from internal audits, patient surveys and complaints. Complaints were categorised as only concerns, moderate or severe. There were no severe complaints to date in November 2013 and 55 complaints attributed to the inpatient wards at all three sites. The report outlined individual complaints and how they were dealt with and the key learnings to be shared. We found that where complaints had been made in regards to care received on the ward that action had been taken to prevent recurrence.

Systems, processes and practices

The majority of staff reported that their managers were supportive. They told us they were able to raise issues without fear of negative consequences.

Community inpatient services

The provider had policies and processes in place regarding incident reporting which were available for staff to refer to. On the ward staff were routinely monitoring quality indicators such as falls and pressure ulcers through the NHS safety thermometer. However the Board didn't receive regular reports about safety thermometer information collected at ward level. Incidents of concern were reported by staff on the Datix incident reporting system.

The 2013/14 Pressure Ulcer strategy acknowledged there was still some confusion amongst staff around what should be reported and a delay in reporting pressure ulcers. At a minimum, the Board expected that all grade two and above pressure ulcers should be recorded using the Datix incident reporting system. Once reported on Datix, incidents were reviewed and a judgement was made about whether the pressure ulcer was acquired at the providers site (Central Essex Community Services acquired). The number of grade 3 and 4 pressure ulcers (Central Essex Community Services acquired) were reported as serious incidents and the number of grade 1 and 2 pressure ulcers categorised as incidents and reported internally. Pressure Ulcer incidents graded 3 and 4 were reviewed at the Stop the Pressure group.

Although Grade 3 and 4 pressure ulcers were defined as serious incidents they were reported separately from the organisation wide serious incidents.

We looked at recently completed root cause analysis (RCA) investigation report for serious untoward incidents and saw that all members of the multidisciplinary team were involved in these investigations. We also found that action plans had been developed and implemented. We saw one investigation outcome for a patient who had been referred from a nursing home who had a number of grade 3 and 4 pressure ulcers. Staff took appropriate action such as completing the appropriate risk assessments and photographing all the wounds. The staff asked the nursing home to report the wounds to the Care Quality Commission and provided the appropriate care.

Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:

- Hand washing facilities and alcohol hand gel available throughout the ward area
- Staff following hand hygiene and 'bare below the elbow' guidance
- Staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care
- Suitable arrangements for the handling, storage and disposal of clinical waste, including sharps
- Cleaning schedules in place and displayed throughout the ward area
- Clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.

Patient records were kept securely in key coded trolleys and we were able to follow and track the patient care and treatment easily as the records we reviewed were mostly well kept, up to date, and accurately completed. In addition staff were able to easily locate and obtain any additional notes we required when conducting our patient record review

An audit of resuscitation equipment had been conducted in September 2013, and received 79% compliance with the expected standard overall. Issues found included:

- Having no standard Resuscitation council notices indicating where the defibrillator is located on the ward
- The suction machine was not located next to the trolley
- The service date of the pulse oximeter was not current

An individual action plan with timescales was developed. The November 2013 update indicated that all the identified issues had been resolved. We saw daily and weekly checks were in place and staff were following a standardised checklist. All equipment was within the service dates and all single use items were in date.

Monitoring safety and responding to risk

We found that staffing levels and skills mix, supported safe practice. We noted that the November 2013 quality and safety committee board report identified a staffing shortfall of two full time equivalent qualified staff and one healthcare assistant. However, staff told us that plans were already in progress to recruit these additional staff and whilst bed occupancy from April 2013 to October 2013 was reported as 96%, no staff shortages had been reported.

Information relating to patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents. The notice board

reported that there had been no healthcare associated infections attributed to the ward in the previous six months, and a high compliance of over 90% on the cleanliness and hygiene audits.

A range of risk assessments were undertaken to ensure staff and patient safety, of which all the staff we spoke with were aware. These included: ward environment; lone working; manual handling; Control of Substances Hazardous to Health (COSHH); and ward security. We saw an example of a risk assessment that had been carried out for moving and handling in bathrooms after an issue was noted in the risk reporting system. Therapists were involved in the process to ensure patient safety was maintained.

Anticipation and planning

There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and bed capacity issues. The majority of staff we spoke with reported that they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The 2014 central log for mandatory training confirmed that nearly all staff on the St Peter's Hospital ward had attended required mandatory training.

Patient dependency assessments were used to determine the numbers of staff required but only when patient acuity levels were judged by staff to be high and the skill needs analysis, used to determine the appropriate ratios of qualified and unqualified staff within the ward compliment, had been conducted using a model developed for the acute hospital sector. However, staff told us that where additional staffing numbers were required that these requests were met through ward staff working additional hours or agency staff.

Where staff identified potential concerns relating to patient safety, these were assessed and placed on risk registers, so the risks could be assessed and minimised through action plans. The November 2013 quality and safety committee board report identified risks raised by staff and outlined the number of falls in the ward.

All patients admitted to the community hospital ward underwent screening for Methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-sensitive Staphylococcus aureus (MSSA). This screening was used to identify those patients who were at 'high risk' of acquiring MRSA so these risks could be minimised. Results were recorded in patient notes and also documented in discharge planning records. Staff told us that by recording this information on discharge planning records other professionals, such as the patients GP, were also able to plan appropriate aftercare if required.

Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, nutritional needs, and falls and infection control risks. Care pathways and care plans were observed as being in place for those patients identified to be at high risk, to ensure they received the right level of care.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

We observed that care provided was evidence based and followed recognisable and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. For example, staff were using tools such as the Mini Mental Test to determine capacity and the Malnutrition Universal Screening Tool (MUST) to determine patient's nutritional needs.

Policies were available electronically via the intranet and some in paper format so all staff had access to these. They reflected national guidance with appropriate evidence and references. For example, all inpatients were screened for Methicillin-resistant Staphylococcus aureus (MRSA) following national guidance from the Department of Health (DH). The policy noted the evidence base and references included the DH Saving Lives guidance for: reducing infection, delivering clean and safe care and The Health Act 2006, Code of Practice for the Prevention and Control of Healthcare Associated Infections. Staff we spoke with could direct us to these policies. The ward matron described the guidance and showed us the procedures for admitting and discharging patients to the ward.

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. For example, we reviewed the records for one patient who had been assessed as lacking capacity to make decisions and for

whom a decision had been made not to attempt cardio pulmonary resuscitation (DNACPR). We saw that the appropriate people, including relatives had been involved in the decision making process and that the decision had been clearly documented in the patient's notes and this had been subsequently reviewed and updated.

We also observed the charge nurse speaking to two patients who wanted to go home (husband and wife) despite problems and against advice. The charge nurse told us "they have capacity and have to be allowed to take risks." The charge nurse considered and discussed the potential risks and documented these in the plan as guided by the patient's preferences, which were different to the families.

Monitoring and improvement of outcomes

We saw that the performance and delivery of this service was included within the quality and safety board report for senior leaders. Performance data included outcomes of clinical audit activity such as the High Impact Intervention (HII) audits that relate to key clinical procedures that can reduce the risk of infection if performed appropriately and the NHS Safety Thermometer Programme. Staff we spoke with were aware of the current outcomes and this information was clearly displayed on ward notice boards.

Staffing arrangements

There were systems and processes in place to identify and plan for patient safety issues in advance and included any potential staffing and bed capacity issues. When patient acuity levels were judged by staff to be high, patient dependency assessments were used to determine the numbers of staff required.

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff worked in a supernumerary capacity until completion of their induction. We found that professional body registration checks took place at the time of initial recruitment and annually.

Staff told us there was good access to mandatory training study days. Weekly group supervision meetings had been held since September 2013 when the safeguarding lead had noted concerns in the way staff were dealing with patient choices, dignity, respect and consent. Topics discussed at these sessions included safeguarding issues, infection prevention and control, moving and handling, medicines management and health and safety. Staff told us the content was appropriate. We looked at the mandatory training attendances as recorded by the provider in January 2014 and we found that overall an average of 97% of staff had met their training requirements on the St Peter's Hospital Ward. This showed the provider ensured staff have the right skills, experience and support to deliver safe efficient care.

Although mechanisms were in place for staff to receive individual clinical supervision, there were inconsistencies in practice. Monitoring systems were not in place that would ensure staff received the four individual supervision sessions per year as per policy, or that ensured sufficient time for reflection between sessions. One member of staff told us that they had received four clinical supervision sessions within one month. However it is noted that the provider has already taken action to improve their performance through the review and introduction of a revised clinical supervision policy. Further work is needed by the provider to ensure effective implementation and monitoring of compliance with the standards set within this policy.

A practice development facilitator has recently been appointed. The provider told us that this individual was tasked to undertake a workforce modelling project, looking at national and international models of staffing. The future staffing capacity needs of the organisation is to be determined as a result of this workforce modelling exercise.

Multidisciplinary working and support

We observed and staff we spoke with told us, that there was effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Weekly MDT meetings, involving the general practitioner, nursing staff, therapists as well as social workers and safeguarding leads, where required, ensured the patient's needs were fully explored.

Issues discussed at the weekly MDT meetings included identification of the patients existing care needs, relevant social / family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support. We saw evidence of the outcomes of these meetings in patient's files. We observed staff working well together, healthcare professionals valuing and respecting each other's contribution into the planning and delivery of patient care.

Community inpatient services

Communication between staff was effective, with staff handover meetings taking place during daily shift changes. We heard staff handover discussions that included information regarding care, support needed from other providers on discharge, as well as risks and concerns of each patient, discharge date and plans as well as any issues that required follow-up.

Electronic patient records that detailed current care needs were available for all patients ensuring staff were fully informed of the patient's diagnosis and current physical and emotional needs.

Are community inpatient services caring?

Compassion, dignity and empathy

We observed all staff treating people with dignity and respect and taking extra time with patients who didn't have full capacity to fully understand the advice being given.

Compliance with same-sex accommodation guidelines was ensured through the designation of single sex bay areas and ample provision of toilet and bathing facilities. We observed curtains being drawn around each bed prior to delivery of care and discussions with patients in regards to their care. We also observed staff respecting patient dignity whilst assisting with their toileting needs.

The majority of patients and their relatives were positive about the care and treatment they had received. Patients told us "the staff have been wonderful" and "the staff are caring".

We observed staff treating people with compassion and empathy. One example being where staff were comforting a patient who was due to be discharged the previous day. The notes stated the home assessment was unsuccessful so they needed more time in the ward area. The patient seemed very stressed and anxious; however, staff managed to calm the patient and explained further options.

Involvement in care

Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. We found by looking at care plans, reviewing clinical guidelines and talking to families and staff that planned care was consistent with best practice as set down by national guidelines.

We saw good evidence through observation of practice and review of patient records that staff were assessing the patient's capacity to be able to give valid consent using a Mini Mental Test (designed to give the examiner an indication of the mental state of the patient), for most patients upon admission. We found that relatives and/or the patient's representative were involved in discussions around the discharge planning process. For example, relatives being informed of potential discharge dates and patients and relatives having discussions with members of the multidisciplinary team to ensure a smooth transition home upon their discharge from hospital.

Staff had a good understanding of consent and applied this knowledge when delivering care to patients. Staff we spoke with had received training around consent and had the appropriate skills and knowledge to seek consent from patients or their representatives. On the majority of instances we observed positive interactions between staff, patients and/or their relatives when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered.

A range of literature was available for patients, relatives and/or their representatives and provided information in regards to their involvement in care delivery from the time of admission through to discharge. This included: complaints processes, key contacts information and follow-up advice for when the patient left hospital.

On the majority of occasions we observed positive interactions between staff and patients, this was particularly the case at meal teams. However, we did observe a lack of involvement between staff and patients sitting in the day room. We saw the TV was left on with patients left on their own in this area when not receiving specific care. We also observed an instance where a staff member was assisting a patient in a wheelchair and stopped in the corridor to have a conversation for several minutes. They didn't involve the patient who was left with their back to the staff and even glanced around a few times

Trust and respect

We observed staff treating patients with dignity and respect when attending to care needs. Where patients had to be isolated, for example if they had an infection, we saw the staff respected their dignity and placed a sign on the door stating "Please speak to the nurse in charge" rather than noting their condition.

Community inpatient services

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care. We observed patients being encouraged to use the communal dining area at meal times with minimal assistance provided by staff. Those patients who were not able were offered food at their bedside.

The mandatory training log January 2014 noted that 100% of staff on St Peter's Hospital Ward had received equality and diversity training. Staff we spoke with confirmed that they had received this training and could demonstrate through the care planning process that they were taking into account each person's culture, beliefs and values. Staff described that there were no large ethnic minorities within their catchment areas. However, they were all aware where support could be obtained if it was required, for example, a translator if English was not the person's first language.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. We observed positive interactions between staff and patients, where staff knew the patients very well and had built up a good rapport. We saw staff providing reassurance and comfort to people. One example being the calm and positive manner a member of staff displayed when explaining to an elderly couple who wanted to go home.

A further example was the emotional support we observed being given to a patient who was receiving palliative care (comfort care given to a patient who has a serious or life-threatening disease) in a side room. We observed staff interactions with this patient that demonstrated a knowledge and understanding of the patient's emotional needs.

An advocacy service, provided by Age Concern Essex, is available at St Peter's Hospital, providing additional assistance to patients in making any crucial decisions about their future.

One patient described themselves as being "overwhelmed at the thought of going home and not managing". We observed that staff provided reassurance to the patient and agreeing with them the support they and their partner would need to have in place before they would be discharged.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

There was evidence from staff we spoke with that staff were meeting the needs of patients admitted for stroke, rehabilitation and palliative care. For example, there were good mechanisms for information sharing between in-patient and community teams and a willingness to engage with other service providers, such as the mental health teams and acute trusts, to ensure that all care needs were met.

Staff were knowledgeable regarding the community in which they provided services and the written information provided to patients upon admission to and upon discharge from hospital, were reflective of this. Whilst there were no large ethnic minorities within the catchment areas, written information in different languages or other formats, such as braille were not readily available. However, staff knew how to obtain support when required. For example, a translation service was available if the patient's first language wasn't English.

Patients were complimentary about the meals provided to them and specific patient's dietary requirements were displayed in the kitchen area. Staff were knowledgeable about meeting the religious and cultural nutritional needs of their patients. We also observed staff asking patients what they would like for lunch. Ensuring that people were provided with suitable and nutritious food and drink based on what they would like currently like to eat. In addition, we also observed refreshments being offered by a member of staff who was in constant contact with nursing staff, so that refreshments were not offered to those patients whose food and fluids were restricted.

Access to services

Accessibility to the ward was good as services were provided on the first floor level with lifts and stairs. Free car parking was available on site, however, places were limited and it was a busy site.

Patients could access the ward by referral from three main routes which were either from the rapid assessment unit (RAU) at Braintree Community Hospital, from the rehabilitation wards at the acute hospitals or from the

palliative care team (comfort **care** given to a patient who has a serious or life-threatening disease). The system in place meant that patients with specific needs could be admitted in a timely manner to receive appropriate care.

Vulnerable patients and capacity

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). In addition to the mandatory training, staff working within this inpatient facility had received training for caring for patients with dementia and those who displayed challenging behaviour. Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.

Where patients lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. For example, we reviewed the records for one patient who had been assessed as lacking capacity to make decisions and for whom a decision had been made not to attempt cardio pulmonary resuscitation (DNACPR). We saw that the appropriate people, including relatives, had been involved in the decision making process and that the decision had been clearly documented in the patient's notes and this had been subsequently reviewed and updated. In another patient's records we found that consent had been gained for assisting them with their personal care.

Arrangements were in place with another provider for those patients admitted with mental health needs. Staff knew how to access these services, including referral back to local mental health teams upon discharge if a patient was admitted from out of area. Staff spoke positively about the effectiveness of relationships with the mental health team.

Leaving hospital

The discharge and transfer of patients was well managed. Effective systems are in place to ensure that discharge arrangements meet the needs of patients including a policy. For example, a specific patient discharge list, which included details such as a drugs chart, mental capacity assessment and infections data. These details are completed and copies sent with the patient on discharge or to their GP.

Discharge planning commenced at the point of admission for all patients when a provisional discharge date of 12 or 28 days was assigned. This date was flexible and increased or decreased according to the patient's progress. Information relating to the average length of stay and time to discharge was displayed on notice boards in the ward area and the provisional date was also displayed on a board behind each bed so patients, their representatives and healthcare staff were aware of the expected discharge date and could prepare accordingly.

Multidisciplinary team meetings (MDT) were held every Wednesday which included the GP, nursing staff, social workers, physiotherapists and occupational therapists as well as a member of the safeguarding team. Patient discharges were discussed at the MDT and all the staff worked towards the provisional agreed discharge date. Staff told us that there was no pressure to discharge patients earlier, nor were discharges delayed as a result of awaiting decisions about funding. Patients could be fast tracked without the full MDT panel if they were deemed to be medically fit. We saw evidence of discussions around discharge during our review of patient files.

Where patient discharge was delayed, the staff had recorded the reasons for this in the notes. For example, a patient discharge was delayed because the patient was unwell. We saw everything fully documented in their notes with discussions around the delays. Most patients were discharged on their planned discharge date. Delays were mostly caused by:

- Patients being medically unfit
- Waits for equipment
- Physiotherapy assessment or delay in assessments due to staff sickness
- Placement of patients in care homes

Discharges to nursing home placements were delayed due to receiving decisions or funding from the panel. The assistant director had dialogue with commissioners about the slow process for arranging nursing home funding and the bottleneck it caused. It should have been a 28 day process and was overrunning. The delayed discharges were monitored daily by the ward matron and assistant director

via a spreadsheet. The ward matron told us they reported any delays to the clinical commissioning group who funded the patients and also used the data to inform any potential admissions who may be delayed as a result.

We saw that medicines prescribed on a "when required" basis, for example for pain relief, were offered and given to patients when they needed them. We also found that people were encouraged to look after and take their medicines themselves in preparation for discharge. Patients we spoke with told us they had been given enough information to be able to understand and take their medicines safely.

Learning from experiences, concerns and complaints

Staff told us that the provider was open and transparent about complaints and concerns and that they were encouraged to improve or develop services where issues had been raised by patients and their families. The provider's Board meetings include a customer experience report which looked at trends in complaints, compliments, feedback from visits by the Executive Team and other patient feedback.

Staff were knowledgeable in regards to the processes available to advise patients and relatives about how to make a complaint and aware that a log of all complaints was held on a centralised system.

Patient Advice and Liaison Service (PALS) leaflets were available and clearly visible. Patients were aware of how to raise a complaint and that they would do this by speaking with the ward staff or to the PALS team.

Complaints were reported monthly and we were told that the ward matron cascaded this information to ward staff. Staff told us that discussions were held with staff involved in the complainants care and that any issues that were raised by patients outside of the complaints process would be addressed immediately. The organisation also collected feedback from families who used the service and acted upon the results. For example, a customer survey had been conducted at St Peter's Hospital Ward in August 2012 and whilst the overall results were very positive, action had been taken to improve the provision of information to patients, an area of poor performance identified within the survey.

Staff told us that local resolution of complaints was preferred and staff were involved in the investigations. In cases where the complaint was escalated, an investigator from outside the speciality was appointed. Then a formal process, monitored by the customer service team, was followed. A process including defined timescales for investigation and draft response and development of action plans addressing areas of concern identified within the complaint.

Are community inpatient services well-led?

Vision, strategy and risks

Staff were clear about the organisation's vision and noted that the corporate induction for all new staff included the provider's core values and objectives for the organisation. Information relating to core objectives and performance targets were visibly displayed in the ward area. Staff told us that the board and senior managers were visible and approachable.

As a not-for profit social enterprise organisation, every employee, from frontline medical staff to admin support staff, were given the opportunity to become an owner of the company for just £1. As an owner, they have a say in the future direction of the company and could make suggestions for improvements. The majority of staff we spoke with had taken this opportunity and received regular updates regarding their suggestions for improvements.

Staff knew about the provider's priorities, as outlined in the Quality Account of June 2013, for 2013/2014 focused mainly around patient safety. Priorities that were applicable to the inpatient ward were: working with other relevant organisations to develop a holistic and integrated frailty pathway; maintaining MRSA and Clostridium Difficile performance; and building on the pilot approach to Customer Engagement.

We looked at performance and quality data at ward level. This showed that information relating to patient safety and risks and concerns were accurately documented, reviewed and updated at least monthly. The risk register included key risks such as fractures, aggression and complaints.

Quality, performance and problems

We saw that the Board received quality and safety reports every other month that included information such as staffing vacancies, numbers of falls and pressure ulcers,

medications incidents, serious incidents and HCAI indicators by service level. We noted that discussion about quality indicators had become more detailed and focused in the last six months.

We observed some positive examples of learning and changes to practice following reporting and escalation of serious incidents. One example being the decision taken by the Board to implement monitoring system to ensure a falls risk assessment was conducted on all patients within six hours of admission, following the report of a serious incident concerning a patient fall.

The ward matron told us that medication charts were not routinely checked for accuracy but would expect that any errors or omissions would be picked up the next time they were used. We found that there was no formal process to audit these records and so pick up any trends in the analysis of errors.

Leadership and culture

The majority of staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with senior managers would be acted on.

Staff told us that their managers were visible, accessible and approachable and that opportunities were available to speciality link nurses to develop skills, knowledge and experience in their specialist areas, for example, infection control.

Whilst care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. The staff roles and responsibilities were clearly defined with a sufficient skill mix of staff across all staff grades and all staff spoke of their commitment to ensuring patients were looked after in a caring manner.

Patient experiences and staff involvement and engagement

Staff told us they were communicated with in a variety of ways, for example newsletters, emails and briefing documents. We saw evidence of this. Staff told us they were made aware when new policies were issued and that they felt included in the organisation's vision.

The Friends and Family Test (asks a single, standard question: "How likely are you to recommend our ward to friends and family) was conducted at St Peter's Hospital between April 2013 to September 2013. The results were mainly positive with the majority of people confirming that they would recommend the ward to friends and family. The majority of patients we spoke with were also complimentary about the care they were receiving and the staff delivering care.

Learning, improvement, innovation and sustainability

Staff new to the organisation received a two day induction, which included e-learning, and were supernumerary to the identified staffing requirements for a period of one month following completion of their two day induction.

Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. Training data demonstrated a 98% mandatory training completion rate for staff working at St Peter's Community Hospital ward. The remaining staff who had to complete their training were either ill, working on nights or were absent when courses were held. Staff told us that night shift allocations were flexed to ensure mandatory training attendance.

We noted that the majority of the training was done through e-learning; this is a computer generated way of learning. Staff watch a video or briefing and have to answer questions on a specific subject. The e-learning training included modules around dementia and safeguarding vulnerable adults, which also included managing patients with challenging behaviour. The ward matron had taken the initiative to improve the effectiveness of e-learning, by arranging for staff to complete the training in groups, enabling a more interactive training experience. Other training such as manual handling was classroom based as staff needed to carry out practical tests to confirm competence. In addition to the mandatory training requirements, staff were encouraged and supported to access other training.

There was an open culture that supported learning whereby staff were trained in performing root cause analysis (RCA) and were encouraged to report incidents and errors. However, risk assessment training was not noted on any training sheet as being mandatory or essential.

Training records were inconsistent and didn't reflect the current status or levels of training staff had attained. One

example being the conflicting staff training information concerning the 'safe use of insulin'. This training had been introduced as a result of a number of reported serious incidents concerning insulin administration within the organisation. This training was mandatory for some staff groups but our review of records found that some staff had not received any training, whilst others were judged to be competent and the training was not required. Those judged competent without training were those that had completed e-learning training, e-learning training that was not considered by the organisation to be mandatory.