

# Northampton General Hospital NHS Trust

# Hazelwood Ward, Isebrook Hospital

## Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

### Ratings

Overall rating for this hospital

Requires improvement



Medical care

Requires improvement



# Summary of findings

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# Summary of findings

## Overall summary

Hazelwood Ward in Isebrook Hospital is one of three community hospital sites where Northampton General Hospital NHS Trust provides services on an inpatient basis. Hazelwood Ward is a 34-bedded ward providing 24-hour nursing and medical support for patients with subacute medical conditions or with rehabilitation needs.

Northampton General Hospital NHS Trust is an acute trust with 800 consultant-led beds, and provides general acute services for a population of 380,000. It also provides hyper-acute stroke, vascular and renal services to people living throughout the whole of Northamptonshire, which has a population of 691,952. The trust is an accredited cancer centre and provides cancer services to a wider population of 880,000 who live in Northamptonshire and parts of Buckinghamshire.

Northampton General Hospital NHS Trust also provides services at Danetre Hospital and Corby Community Hospital.

We found the medical service on Hazelwood Ward to be generally safe because there were assessment and reporting systems in place to identify risk, take action and learn lessons from incidents and complaints. Staff felt informed about incidents and able to report concerns. However, not all assessment tools were completed correctly and audit data demonstrated poor performance on some aspects. Staff felt that this was due in part to the new documentation that had been introduced, which was designed for an acute hospital setting rather than a community hospital.

Nurse staffing and patient dependency levels were assessed using a recognised tool. However, not all shifts were meeting the ratio of one registered nurse to eight beds and bank and agency staff bridge the gap. There remained vacancies, particularly for healthcare assistants and this was having an impact on some shifts and the ability to provide one-to-one supervision of patients. The trust was in the process of recruiting more staff.

There were arrangements in place for the safe administration and handling, storage and recording of medication. However, there had not been an allocated

pharmacist to the ward since May 2011 to oversee and review medicine and prescribing arrangements. This meant that patients were at risk of not receiving appropriate treatment, possible medication errors occurring and necessary reviews of medication not taking place. The trust had employed a locum pharmacist who was due to start by the end of January 2014.

Analysis of infection rates in the trust showed them to be within expected limits. The ward was clean and there were arrangements in place for ward cleaning and decontamination of equipment. We found gels, aprons and gloves were in good supply and waste appropriately dealt with. There were assurance mechanisms in place to identify when standards for cleanliness and infection prevention needed improving.

We sought the views of the public at a listening event prior to the inspection and also checked on a range of patient feedback and survey information. We spoke with patients during the inspections who reported that they were happy with the care and treatment on the ward and staff were kind. There was an effective multidisciplinary team supporting patients with their rehabilitation needs and patients reported that they were highly satisfied with their care and treatment.

There were clear clinical, organisational, governance and risk management structures in operation. Staff had confidence in the ward managers and felt well supported. However, not all staff had completed their mandatory training or had an appraisal. This meant that the trust could not be assured that staff were up to date with their skills and knowledge to appropriately meet patients' needs. Issues over the lack of a pharmacist for the ward and non-completion of training and appraisals had been known to the trust for a significant time, with insufficient action taken to address the issues.

We found that the trust had breached Regulation 9 (care and welfare), Regulation 13 (medication) and Regulation 23 (staff support and training) for the regulated activity treatment of disease, disorder or injury.

# Summary of findings

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### Are services safe?

We found the medical service was generally safe because there were systems in place to identify risk, take appropriate action and learn lessons from any areas of poor performance or incidents. Staff were confident about how to report incidents and felt well informed. Nurse staffing levels and patient dependency levels were assessed using a recognised nurse staffing tool. Some shifts were not always meeting the one registered nurse to eight beds ratio. Agency nurses were used to bridge the gap. We found the medication arrangements had not had pharmacist oversight since May 2012. This was because there had been no allocated pharmacist for the ward during this time. A locum pharmacist was expected to commence by the end of January 2014.

Requires improvement



### Are services effective?

Not all assessment tools were completed correctly. The trust had recently introduced new documentation that was designed for acute services. Not all of this had been adapted to a community ward setting and staff were experiencing difficulties in interpreting what was needed. Audit data demonstrated poor performance on some aspects, which staff felt was in part due to the use of the new documentation. We found there was good multidisciplinary team working throughout the ward and with trust specialist teams. Outcomes for patients were good.

Requires improvement



### Are services caring?

Patients were positive about their experience and found staff kind and caring. We saw several examples of compassionate care. Patients reported they liked the food and we saw positive interactions between patients and staff. The local ward results from the Friends and Family Test were 83 in October 2013 and 50 in November 2013.

Good



### Are services responsive to people's needs?

The services on the ward responded to the needs of the local population by providing a 'step-up' facility with enhanced care to patients from the community, with the aim of preventing the need for admission to the acute hospital. Similarly, a 'step-down' facility provided rehabilitation services for patients needing nursing and medical support after discharge from Northampton and Kettering General Hospitals. In addition, the ward provided care for patients with subacute medical conditions. We found that there were no formal arrangements in place for spiritual or multifaith provision. Local ministers supported the ward but staff had to ask individual patients and their families where to obtain support for them if the support available was not appropriate.

Good



# Summary of findings

## Are services well-led?

There were clear clinical, organisational, governance and risk management structures in operation. There was an open culture of reporting incidents and learning from incident investigation and complaints. Staff had confidence in the ward managers and felt well supported. The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and a failure to complete appraisals had been known to the trust a significant time but insufficient action had been taken to address these issues.

**Requires improvement**



# Summary of findings

## What we found about each of the main services in the hospital

### Medical care (including older people's care)

We found the medical service was generally safe because there were systems in place to identify risk, take appropriate action and learn lessons from any areas of poor performance or incidents. Staff were confident about how to report incidents and felt well informed. Nurse staffing levels and patient dependency levels were assessed using a recognised nurse staffing tool. Some shifts were not always meeting the ratio of one registered nurse to eight beds. Agency nurses were used to bridge the gap. We found the medication arrangements had not had pharmacist oversight since May 2012. This was because there had been no allocated pharmacist for the ward during this time. A locum pharmacist was expected to commence by the end of January 2014.

We found that not all assessment tools were completed correctly. The trust had recently introduced new documentation that was designed for acute services. Not all of this was adapted to a community ward setting and staff were experiencing difficulties in interpreting what was needed. Audit data demonstrated poor performance on some aspects, which staff felt was in part due to the use of the new documentation. We found there was good multidisciplinary team working throughout the ward and with trust specialist teams. Outcomes for patients were good.

We found the ward clean. Arrangements were in place for cleaning the ward and individual items of equipment. Staff knew how to decontaminate medical equipment. Hand gels, aprons and gloves were in good supply. There were effective systems in place for the classification, segregation, storage and handling of waste. Assurance systems ensured ward cleanliness and equipment met appropriate guidelines and standards.

Patients were positive about their experience and found staff kind and caring. We saw good examples of compassionate care. Patients reported they liked the food and we saw positive interactions between patients and staff. The local ward results from the Friends and Family Test were 83 in October 2013 and 50 in November 2013.

The services on the ward responded to the needs of the local population by providing a 'step-up' facility with enhanced care to patients from the community, with the aim of preventing the need for admission to the acute hospital. In addition, a 'step-down' facility provided rehabilitation services for patients needing nursing and medical support after discharge from Northampton General Hospital and Kettering General Hospital. We found that there were no formal arrangements in place for spiritual or multifaith provision. Local ministers supported the ward but their support was not always appropriate and staff had to ask individual patients and their families where to obtain help for their particular faith.

Requires improvement



# Summary of findings

There were clear clinical, organisational, governance and risk management structures in operation. There was an open culture of reporting incidents and learning from incident investigation and complaints. Staff had confidence in the ward managers and felt well supported. The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and completion of appraisals had been known to the trust a significant time but insufficient action had been taken to address these issues

# Summary of findings

## What people who use the hospital say

Northampton General Hospital NHS Trust performed 'about the same' as other trusts for all ten questions in the Care Quality Commission's Adult Inpatient Survey 2012. The survey covered the whole of the trust, with no specific information on individual community hospital locations.

For the Friends and Family Test, the overall performance for the trust was in line with the England score. Hazelwood Ward scores for the Friends and Family Test were 83 in October 2013 and 50 in November 2013.

The trust was given a score of 3.5 stars out of 5 stars from contributors to NHS Choices, with the main positives as excellent care, professional staff and being treated with respect and dignity. The issues raised were about waiting times, communication and misdiagnosis. There was no specific information available on individual community hospital locations, including Hazelwood Ward.

## Areas for improvement

### Action the hospital **MUST** take to improve

- Address the lack of pharmacist allocated to the ward to review and advise on the medication arrangements.
- Ensure staff are up to date with mandatory training.
- Review the staff appraisal process so that the ward achieves target.
- Ensure risk assessment records are consistently completed.

### Action the hospital **SHOULD** take to improve

- Care record templates and audits were based on an acute hospital setting and not necessarily appropriate for a community hospital service.

### Action the hospital **COULD** take to improve

- There were no formal arrangements in place to provide multifaith spiritual support.

## Good practice

Our inspection team highlighted the following areas of good practice:

- The multidisciplinary team worked successfully in partnership to improve outcomes for patients.



# Hazelwood Ward, Isebrook Hospital

## Detailed findings

### Services we looked at:

Medical care (including older people's care)

## Our inspection team

### Our inspection team was led by:

**Chair:** Mr/Dr Edward Palfrey, , Medical Director, Frimley park, Consultant Urologist

**Head of Hospital Inspections:** Siobhan Jordan, Head of Hospital Inspection, Care Quality Commission

The team of 35 included Care Quality Commission inspectors and analysts, doctors, nurses, patients and public representatives, Experts by Experience and senior NHS managers.

Julie Walton, Head of Hospital Inspection, led the roaming team that visited the three off-site services with an experienced clinician.

and medical care. In addition, the ward provided nursing and medical care for patients with subacute medical conditions. There were six beds dedicated to stroke rehabilitation.

The ward provided continuing support and care closer to home, offering help with rehabilitation and recovery from stroke. The aim was to provide care closer to home for patients fit for discharge from the acute hospital, with a clinical need for medical rehabilitation, offering a 'step-down' facility or had subacute medical needs. The ward also offered care to patients referred directly from the community with the aim of providing care and treatment, in order to prevent the need for admission to the acute hospital, so providing a 'step-up' facility.

The ward was supported by a multidisciplinary team including nursing, medical and therapy staff.

## Background to Hazelwood Ward, Isebrook Hospital

The services on Hazelwood Ward in Isebrook Hospital were provided by Northampton General Hospital NHS Trust (NGH). The inpatient ward had 34 beds and provided a programme of rehabilitation from a specialist therapy team for people with clinical needs requiring 24-hour nursing

## Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose Northampton General Hospital NHS Trust because it represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient

# Detailed findings

and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Northampton General Hospital NHS Trust was considered to be a high-risk level trust.

## 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 inspected the following core services at this site:

- Medical care (including older people's care)






Before our inspection, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 16 January 2014.

We spoke with eight members of staff including the matron, ward sister, trained nurses, support workers, physiotherapists and the doctor for the ward. We also spoke with three patients and observed the care of patients throughout the ward. We checked all aspects of three personal care and treatment records and a further nine patients' risk assessment records.

We held a listening event where patients and members of the public shared their views and experiences of the hospital trust services.

The team would like to thank all those who attended the listening event and were open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

# Medical care (including older people's care)

Safe	Requires improvement 
Effective	Requires improvement 
Caring	Good 
Responsive	Good 
Well-led	Requires improvement 

## Information about the service

The services on Hazelwood Ward were provided by Northampton General Hospital NHS Trust (NGH). The ward had 34 beds and provided a programme of rehabilitation, nursing and medical care from a multidisciplinary specialist therapy team.

The ward was located on the ground floor. It had eight single rooms, one side room with two beds and four bays with six beds each. Six beds were dedicated for patients who had suffered a stroke.

## Summary of findings

We found the medical service was generally safe because there were systems in place to identify risk, take appropriate action and learn lessons from any areas of poor performance or incidents. Staff were confident about how to report incidents and felt well informed. Nurse staffing levels and patient dependency levels were assessed using a recognised nurse staffing tool. Some shifts were not always meeting the ratio of one registered nurse to eight beds. Agency nurses were used to bridge the gap. We found the medication arrangements had not had pharmacist oversight since May 2012. This was because there had been no allocated pharmacist for the ward during this time. A locum pharmacist was expected to commence by the end of January 2014.

We found that not all assessment tools were completed correctly. The trust had recently introduced new documentation that was designed for acute services. Not all of this was adapted to a community ward setting and staff were experiencing difficulties in interpreting what was needed. Audit data demonstrated poor performance on some aspects, which staff felt was in part due to the use of the new documentation. We found there was good multidisciplinary team working throughout the ward and with trust specialist teams. Outcomes for patients were good.

We found the ward clean. Arrangements were in place for cleaning the ward and individual items of equipment. Staff knew how to decontaminate medical equipment. Hand gels, aprons and gloves were in good

# Medical care (including older people's care)

supply. There were effective systems in place for the classification, segregation, storage and handling of waste. Assurance systems ensured ward cleanliness and equipment met appropriate guidelines and standards

Patients were positive about their experience and found staff kind and caring. We saw good examples of compassionate care. Patients reported they liked the food and we saw positive interactions between patients and staff. The local ward results from the Friends and Family Test were 83 in October 2013 and 50 in November 2013.

The services on the ward responded to the needs of the local population by providing a 'step-up' facility with enhanced care to patients from the community, with the aim of preventing the need for admission to the acute hospital. In addition, a 'step-down' facility provided rehabilitation services for patients needing nursing and medical support after discharge from Northampton General Hospital and Kettering General Hospital. We found that there were no formal arrangements in place for spiritual or multifaith provision. Local ministers supported the ward but their support was not always appropriate and staff had to ask individual patients and their families where to obtain help for their particular faith.

There were clear clinical, organisational, governance and risk management structures in operation. There was an open culture of reporting incidents and learning from incident investigation and complaints. Staff had confidence in the ward managers and felt well supported. The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and completion of appraisals had been known to the trust a significant time but insufficient action had been taken to address these issues.

## Are medical care services safe?

Requires improvement 

### Safety and performance

An analysis of trust reporting indicated that it was reporting the expected number of incidents compared with similar trusts. This meant that staff were identifying and reporting patient safety incidents appropriately. Staff were confident about how to use the procedures for reporting.

### Performance

An analysis of incidents on Hazelwood Ward showed that from April 2013 to December 2013 there were nine grade 2 and one grade 3 new pressure ulcers. Actions had been taken to address this, such as more detailed risk assessment (NGH Community Hospital Incident Data, 16 January 2013).

### Ward cleanliness

We found the ward clean. Arrangements were in place for cleaning the ward and individual items of equipment. Staff knew how to decontaminate medical equipment. Hand gels, aprons and gloves were in good supply. There were effective systems in place for the classification, segregation, storage and handling of waste. Assurance systems ensured ward cleanliness and equipment met appropriate guidelines and standards. Results of monthly monitoring of environmental cleanliness were generally good; for example, December's environment audit scored 90.2% when measured against the national cleaning standards. Monthly board ward visits took place and reported the ward clean (Monthly board report entitled Beat the Bug, Stop the Clot, Save the Skin, dated 27 November 2013). Action plans were put in place when improvements were identified, for instance with hand hygiene and labelling equipment (QuEST audit November 2013 and Are your wards safe? NGH review dated 06 December 2013). This meant staff could be confident that the environment and an item of equipment were appropriately cleaned and safe before any patient contact.

### Learning and improvement

Staff were aware of how the ward was performing and the number of incidents taking place and were keen to continually improve care to patients. All serious incidents were investigated and reports shared with staff so that lessons could be learned. Staff were kept informed through

# Medical care (including older people's care)

ward performance data on the notice board, staff meetings and through news bulletins, as well as learning from incidents within the trust as a whole. We saw one set of staff meeting minutes, which contained performance analysis and learning outcomes (Ward meeting minutes, dated 26 November 2013).

## Systems, processes and practices

There was a system in place to reduce or eliminate risk that commenced with the assessment of the patient on admission when plans were put in place then developed with the support of specialist teams across the trust, such as the falls team. We examined three sets of patients' records and found risk assessments were completed and up to date in all three cases.

## Infection prevention and control

Analysis of infection rates in the trust showed the trust to be within expected limits. The trust's total percentage of patients with a catheter contracting urinary tract infections had been consistently above the England average. On Hazelwood Ward there had been 15 cases of urinary tract infections; three involved patients with a urinary catheter in the past year. The ward sister explained they had experienced difficulties with patients drinking enough. To address this, patients had been risk assessed and put on fluid and nutrition balance charts; some had one-to-one supervision to ensure they drank fluids regularly. However, analysis of the sample of patients' records audited for November 2013 showed variable performance when recording food and fluid intake. Only 65.67% of patients identified as moderate to high risk had food intake recorded, and only 50% identified as high risk had fluid intake recorded (Ward Safety Thermometer dashboard data, dated November 2013). Improvements required for reassessment of nutrition and fluid balance charts for those at risk were highlighted in the ward's QuEST review results report (Quality, Effectiveness, Safety Team Review Results, dated November 2013). This meant that, although actions had been taken to improve fluid intake and nutrition, there was a lack of assurance that these were consistently being applied to improve patient hydration and nutrition.

## Medicine management

Arrangements were in place for the safe administration, handling, storage and recording of medication. We examined medicine storage areas and records, including medication under strict controls due to their effect and potential for abuse. These were well organised and records

were well maintained (Quarterly check of controlled drugs, dated 02 October 2013). There had been no allocated pharmacist since May 2012 to review prescribing practices (NGH Patients with omitted medicines data spreadsheet, dated 22 August 2013). We found medication reviews were not always taking place as part of falls risk assessment (Serious incident investigation report, fractured neck of femur, December 2013). This meant patients were at risk of not receiving appropriate treatment, possible medication errors occurring and necessary reviews of prescribing not taking place.

## Monitoring safety and responding to risk

Performance was audited and monitored monthly and the results advertised on the ward notice board. Staff were made aware of any risks to patients as part of the handover process and there was a range of mechanisms in place for sharing lessons and actions to be taken following poor ward performance and incidents. Staff were aware of the risk assessment procedure for general risks on the ward and actions resulting from them.

## Staffing levels

Nurse staffing and patient dependency levels were assessed using a recognised nurse staffing tool (the Hurst Nursing Workforce Planning Tool). Some shifts were not always meeting the ratio of one registered nurse to eight beds and agency nurses were used to bridge the gap (Medical director's quality report, 31 October 2013). There remained vacancies for healthcare assistants (HCAs) bands 2 and 3, and this was having an impact on the late shift in particular and the ability to supervise patients who required one-to-one supervision. A serious incident investigation report regarding a fall listed an organisational factor involved as 'HCA vacancies' (Serious incident investigation report, fractured neck of femur, December 2013).

## Anticipation and planning

We found mechanisms in place to identify and act on risks found at ward level. However, when risks to patient safety had been identified and action was required at divisional or trust level, this had not consistently been taken. The lack of an allocated pharmacist for the ward had been recorded on the Medicine division's risk register since June 2011 with no action taken to address the issue (Medicine division risk register 2012). This put patients at risk because there was

# Medical care (including older people's care)

no pharmacist oversight to reduce the risk to patients of receiving inappropriate treatment or possible medication errors, nor to review antibiotic prescribing and medication as part of falls risk assessments.

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

Requires improvement 

### Using evidence-based guidance

#### Clinical audits

We found there was little information about outcomes to clinical audits for the ward. We were informed by the matron that information was collected from the ward to be included in the audit of stroke patients but they had not yet heard the results.

Where applicable, we found care practice was being carried out in line with national guidance, for instance with the care for patients who had a stroke (care pathway) and dementia care.

#### Performance, monitoring and improvement of outcomes

Monthly audits were taking place using the Safety Thermometer assessment tool and a recently introduced tool known as QuEST. These are NHS tools designed for frontline healthcare professionals to measure a snapshot of potential harms to patients such as falls, pressure ulcers and infections.

#### Care and treatment records

Record keeping was audited monthly and we were informed audit sample size was five care records. An analysis of data showed that of records audited there was inconsistent recording with falls risk assessments achieving only 40% in October 2013. The ward sister explained that this was mainly due to how the documentation was being completed and risk assessments were being carried out. We checked nine falls risk assessment records completed for November and December 2013 and found improvements had been made.

We had concerns about Early Warning Score (EWS) documentation used for identifying the deteriorating patient. Poor performance was identified including miscalculation. Analysis of audited records showed only

4% of November observations were done on time with a slight increase in December to 7%. The data also showed only 75% of the scores were calculated correctly for November, and this decreased to 67% in December. The ward sister explained that this was due to the new documentation, which was designed for an acute setting rather than a community service, and staff training. The director of nursing confirmed that the documentation was designed for acutely ill patients who needed more frequent observations. However, the staff were expected to follow trust policy and complete the records with the required frequency (QuEST, November and December 2013). This meant that patients were at risk due to confusion over the use of the scoring tool, and the poor calculation of results. Staff might not identify that a patient's condition was deteriorating in order to ensure medical attention was given appropriately.

### Staff, equipment and facilities

#### Mandatory training

Hazelwood Ward was not meeting the trust target of 80% for mandatory training, scoring 74%, with varying degrees of attendance at different courses. The target was achieved for safeguarding children and young people level 1, equality and diversity levels 1 and 2, manual handling and safeguarding vulnerable adults level 1. The target was not met for refresher fire training (44%), infection prevention and control (44%), information governance (39%) and health and safety including risk management (78%) (NGH screenshot data, 17 January 2013). This meant that patients were put at risk because staff might not have all the necessary skills and knowledge to ensure care met appropriate standards of quality and safety.

#### Equipment

We examined the emergency medical equipment for the ward and found it appropriately maintained with records showing it was checked daily. Staff knew of the location of the emergency equipment, how to use it and their responsibility in checking and maintaining it. This meant that staff would be able to appropriately support patients until medical assistance or an ambulance arrived to transfer them to either Northampton General Hospital or Kettering General Hospital, should this be required.

#### IT and facilities

The community hospital IT systems were not totally compatible with the main trust system. This meant at times access to the trust's website and databases was slow or



# Medical care (including older people's care)

difficult. Staff reported how frustrating this was and could cause distractions and delays when caring for patients. Actions required to address the lack of an integrated IT system had been rated as red (the highest risk). Project work was in progress to resolve the problem, but no dates were specified for completion of the action plan (Integrated Healthcare Governance Committee meeting minutes, 19 December 2013).

## Multidisciplinary working and support

Multidisciplinary team work was integral to the operation of the ward. Each of the specialist teams worked positively together. There were weekly meetings and we found evidence of outcomes to these in three patient care records. Staff spoke with enthusiasm about team working and outcomes for patients were good.

### Are medical care services caring?

Good 

## Compassion, dignity and empathy

### Patient feedback

Analysis of data from the Care Quality Commission's Adult Inpatient Survey 2012, showed that the trust scored about the same as other trusts in all 10 areas of questioning. There was no site-specific information for Hazelwood Ward.

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment. The trust scored 68 overall in the inpatients' Friends and Family Tests for July 2013 to October 2013, which was overall in line with the England average. Hazelwood Ward scores for the Family and Friends Test were 83 in October and 50 in November 2013.

The trust was given a score of 3.5 out of 5 stars from contributors to NHS Choices, with the main positives as excellent care, professional staff and being treated with respect and dignity. The issues raised were about waiting times, communication and misdiagnosis. There was no specific information available on individual community hospital locations, including Hazelwood Ward.

## Involvement in care and decision making

Patients told us they were enthusiastic about the care they received and found staff kind. They said food was good. They confirmed they were informed of their treatment, consulted over decisions and given sufficient information.

## Trust and communication

Patients reported that staff were always willing to spend time explaining procedures with them and that they felt comfortable asking questions. Staff took feedback from patients seriously and we saw how the patients' experience was part of the ward audits, including board ward visits. Action plans following feedback from patients demonstrated a willingness to improve patient experiences: for example, to address call bell response times and noise at night (Are your wards safe? NGH review, 06 December 2013).

## Emotional support

We saw staff of different disciplines talk with patients in an encouraging, kind and compassionate manner. We observed that privacy and dignity were maintained during intimate procedures. Staff supported both the patients and their families. Patients reported they felt well looked after by the multidisciplinary team. One patient said they could not praise staff enough, "They have been absolutely fantastic."

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

Good 

## Meeting people's needs

Hazelwood Ward provided services mainly for people from Northampton, Wellingborough, Rushden and the surrounding towns and villages. Most patients were admitted from Northampton General Hospital and Kettering General Hospital but there could be referrals from out of county. Hazelwood Ward provided care closer to home for patients fit for discharge from the acute hospital but with a clinical need for medical rehabilitation, thereby offering a 'step-down' facility or help for patients who had

# Medical care (including older people's care)

subacute medical needs. The unit also admitted patients from the community for care and treatment, in order to reduce the need for admission to the acute hospital, so providing a 'step-up' facility.

Services were provided by a multidisciplinary team consisting of qualified specialist nursing, therapy and medical staff. There was an admission criterion, which was used to identify patients who could benefit from being admitted to the ward, needed 24-hour nursing and medical support, and had a potential for rehabilitation.

## Medical support

The ward was supported by a doctor on a daily basis Monday to Friday, as part of a rota of five staff grade doctors. The five doctors were on call out of hours and at weekends. The consultant for the ward was based at Northampton General Hospital and attended weekly for ward rounds and multidisciplinary meetings. The specialist consultant for stroke also visited the ward weekly. In an emergency situation with a deteriorating patient, the staff would call the ambulance using the 999 service. Staff reported that there were few delays with ambulance arrivals and they had no concerns for patients using either the 'Out of Hours' service or 999.

## Spiritual support

There was no formal chaplaincy arrangement with the trust for the patients on the ward. The staff reported that local ministers would visit the hospital and offer spiritual support, but there was no access to support for different faiths. Ward staff would ask the patient and their families whom to contact and individual arrangements would be made on a case-by-case basis. Staff reported that there were very few patients who could not be supported by local ministers. However, there could sometimes be a delay in obtaining spiritual, cultural and emotional support, while arrangements were put in place to support patients and their families.

## Vulnerable patients and capacity

### Safeguarding

Staff were aware of how to identify safeguarding concerns and confident using trust safeguarding policies and procedures, including the whistle-blowing policy. Staff felt comfortable about raising concerns and felt their views were listened to on the ward. Staff were up to date with

safeguarding training (NGH screenshot data, 17 January 2013). This meant that staff understood how to recognise potential or actual abuse and act appropriately to safeguard patients and others visiting the ward.

### Mental capacity

Staff were aware of the Mental Capacity Act 2005, and the need for best interest assessments. They were able to describe the process for capacity assessment and confirmed that these were carried out on the ward. There were no patients at the time of the inspection subject to a mental capacity assessment or who had any Deprivation of Liberty Safeguards in place.

### Dementia

The trust was introducing a dementia strategy, which included staff taking on the role of dementia champions. The role started in December 2013 and was supported by the Dementia Care Action Committee. Training was scheduled for February 2014. A Dementia Care Focus Group had been established. The draft dementia pathway had been completed and sent out for consultation (Integrated Healthcare Governance Committee meeting minutes, dated December 2013).

The ward was applying the 15 Steps Challenge (a toolkit with a series of questions and prompts to guide staff through the first impressions of a ward to understand and identify high-quality care that is important to patients and carers) and had identified that improvements were required because there was inconsistent practice on completion of documentation (Hazelwood Ward meeting, dated 26 November 2013). Each patient diagnosed had a patient profile developed based on their known likes, dislikes and activity patterns. Patients diagnosed with dementia were identified by a butterfly symbol placed on the ward board and at their bed head. This practice was audited monthly, with scores of 100% in October and November 2013. This meant that staff were alerted to the vulnerability of patients with dementia and need for enhanced support.

### Leaving hospital

Patients tended to stay longer on the ward than they did at the acute hospital. The average for elective patients was 13.7 days and non-elective 46.5 days (NGH Average length of stay by speciality group and ward 01 April 2013 to 31 December 2013, data spreadsheet 18 January 2014).



# Medical care (including older people's care)

Staff reported delays were generally due to accessing appropriate care packages in the community and organising assessment for nursing home care. The problems with delayed discharges had been known to the trust since September 2011 (General medicine risk register, 08 March 2012). In addition, there had been some issues over the quality and coding of community hospital discharges, and these were being monitored (Medical director's quality report, 31 October 2013).

Staff said that they planned for discharge at admission, or within a short space of time once diagnosis had been confirmed. The multidisciplinary team work between hospital staff and the local authority was reported as good. The delays in discharge meant that patients were staying longer in hospital than they needed to be, which could have an impact on their morale and independence.

## Learning from experiences, concerns and complaints

There was one complaint recorded against Hazelwood Ward in the past 12 months. Staff reported that, if a patient or their family were unhappy with any aspect of their care, they would try and resolve this at the time, and use the feedback to improve services (Hazelwood Ward meeting minutes, 26 November 2013).

## Are medical care services well-led?

Requires improvement 

## Vision, strategy and risks

There had been a change in leadership at the trust, with half the executive directors, chair and chief executive appointed in the past few months. Many posts were interim and there were two new chief operating officers. The leadership team was establishing new ways of working, and introducing new strategies and initiatives. Quality and safety had become a priority for the trust and new monitoring processes had been introduced. Staff were aware of the new priorities and challenges.

The trust was to stop providing services in the community hospitals by April 2014. The staff and inpatient provision would transfer to another provider. Staff generally accepted

the changes, including their transfer to a new employer, although none of the staff knew any details of what the new service configuration would look like and mean to them. This caused some anxiety and frustration.

## Governance arrangements

There was a clear organisation structure in place, with services in the community hospitals aligned to the medicine division. There was a corporate risk register, with divisional risk registers held locally. Risks that scored a higher rating were considered by the trust board. We found some high-rated risks could be identified but stay on the risk register a significant time without action taken. This was the case for pharmacy support on Hazelwood Ward, which had been identified and recorded on the risk register on 02 September 2009. In addition, the trust's own monitoring systems had also identified that medication was not being administered without an explanation recorded as to why, against trust policy (Medicine risk register 08 March 2012). However, no action had been taken to address this. This lack of response put patients at risk of inappropriate treatment and exposed them to medication errors. It did not offer appropriate support to the management and staff locally on the ward.

## Appraisals

The ward was not meeting the trust target for appraisals, which was 80%. Performance data was based on the numbers of personal development plans received within the learning and development department; this stood at 12.20% (NGH screenshot data, 17 January 2014). Staff and management agreed that the numbers actually completed were higher, but the plans were not yet logged on the system. The poor performance on completing appraisals was on the medicine division risk register, and had been since 08 May 2011. Without an effective appraisal process, the trust could be assured that its staff were competent to carry out their duties and receive necessary support and development opportunities: both factors that could have an impact on staff retention (Medicine risk register 08 March 2012).

## Mandatory training

Hazelwood Ward was not meeting the trust target of 80% for mandatory training, scoring 74%, with varying degrees of attendance at different courses. A new process had been introduced whereby appraisals would no longer need to be submitted in paper form, which was expected to improve performance figures. Appraisals were also being linked to

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increments with salaries. The aim was to time the attainment of increments to completion of mandatory training, with an appraisal to be arranged three months prior to the increment date. This was expected to increase attendance at mandatory training, but it did not address the backlog of appraisals.

## Leadership and culture

There were only two key findings in the 2012 NHS Staff Survey where the trust performed within expectation or better:

- The percentage of staff that received equality and diversity training in the last 12 months.
- The percentage of staff that said hand washing materials were always available.

The trust performed within the bottom 20% of trusts for 24 of the 28 key findings. There were no site-specific information in the survey for Hazelwood Ward, although staff confirmed that they had been encouraged to take part by the ward management.

## Patient experiences, staff involvement and engagement

Local feedback on patient experience was generally good. Patients were happy with their care.

Staff felt supported by management at ward and matron level and were encouraged to develop their skills and experience. They felt well informed about ward performance and new developments, and were able to contribute to improving the service. However, concerns were raised over the impact of the low staffing levels on patient care.

## Learning, improvement, innovation and sustainability

All serious incidents were investigated and reports shared with staff so that lessons could be learned. Staff were kept informed through ward performance data on the notice board, staff meetings and news bulletins, as well as learning from incidents within the trust as a whole. We saw one set of staff meeting minutes that contained performance analysis and learning outcomes. This meant that there was an open and honest reporting culture and keenness to learn lessons to improve care and reduce harm to patients (Ward staff meeting minutes, 26 November 2013).

The nursing documentation was provided by the acute trust, including early warning scores for the deteriorating patient. Staff were monitored for the completion of these documents against trust policy and guidance. However, they reported that some of the guidelines and protocols were not appropriate in the community hospital setting. Poor completion of the early warning scores put patients at risk of not having their deteriorating condition identified promptly, although staff felt this was unlikely given the health status of their patients who were there for rehabilitation purposes only. This meant that the trust senior management were not always given robust and accurate information to base decisions on, and that ward staff were not following trust policy (QuEST, November 2013).

The lack of dedicated pharmacy support, poor levels of attendance at mandatory training and completion of appraisals had been known to the trust a significant time and insufficient action had been taken to address these issues.

This section is primarily information for the provider

## Compliance actions

### Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities)  
Regulations 2010: Requirements relating to workers.  
  
People who use services were at risk of not receiving care and treatment by appropriately trained staff. Regulation 23 (1) (a).

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities)  
Regulations 2010: Requirements related to the management of medicines.  
  
People who use services were at risk of receiving inappropriate treatment because there was no dedicated pharmacist review and oversight of the management of medicines.

#### Regulated activity

#### Regulation

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities)  
Regulations 2010: Requirements relating to workers.  
  
People who use services were at risk of not receiving care and treatment because the provider had not made suitable arrangements for the appraisal of nursing and care staff. Regulation 23 (1) (a).

#### Regulated activity

#### Regulation

This section is primarily information for the provider

## Compliance actions

Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities)  
Regulations 2010: Requirements relating to workers.

People who use services were not protected from the risks of receiving care or treatment that is inappropriate or unsafe because risk assessments were not consistently carried out to ensure care was delivered to meet service users' individual needs and ensure their safety and welfare. Regulation 9 (1) (a) (b) (i) & (ii)