Cornwall Partnership NHS Foundation Trust

RJ8

Community health inpatient services

Quality Report

Date of inspection visit: 25, 26, 27, 28 & 29 September 2017

Date of publication: 02/02/2018

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ8A3	Bodmin Community Hospital		
RJ817	Camborne and Redruth Community Hospital		
RJ842	Falmouth Community Hospital		
RJ805	Helston Community Hospital		
RJ8A3	Liskeard Community Hospital		
RJ807	Newquay Community Hospital		
RJ8Y2	St. Austell Community Hospital		
RJ8Y7	Stratton Community Hospital		
RJ803	Edward Hain Community Hospital		
RJ8A5	Fowey Community Hospital		
RJ870	Launceston Community Hospital		
RJ8A4	St. Barnabas Community Hospital		
RJ8Y4	St. Mary's Community Hospital		

This report describes our judgement of the quality of care provided within this core service by Cornwall Partnership NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Cornwall Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cornwall Partnership NHS Foundation Trust.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall we rated community inpatient service as requires improvement because:

- Staffing levels across the service were inconsistent. There were high levels of vacancies, which, despite a high agency and bank staff use, resulted in unfilled shifts.
- Feedback from incidents was not provided promptly.
- Storage of medicines was not always safe.
- Cover provided by pharmacists and pharmacy technicians across the service was inconsistent.
- The recording of equipment across the service was not always effective which presented safety issues.
- There were delays in repairing and replacing equipment.
- Processes for checking resuscitation trollies were not always followed across the service.
- Safety issues occurred in relation to infection, prevention and control measures as process were not always adhered to.
- Staff did not always follow policy, guidance and legislation regarding the Mental Capacity Act as documentation was not always completed.
- Clinical supervision was not formalised or embedded across the service.
- Managerial supervision was inconsistent.
- Patients using the community hospital alcohol detoxification service were receiving treatment from staff who had not received the appropriate training.
- The training offered by the service was not easily accessible to all staff.
- Confidential patient matters were not always kept private as telephone conversations could be heard when taking place at nurses' stations.
- Some patients were left without assistance during mealtimes.
- The senior management team did not always communicate important information, regarding changes to services at community hospitals, to ward staff.
- There was limited engagement with ward staff regarding significant decisions regarding the hospitals they worked in.
- The processes for identifying, managing and mitigating risk were not effective.
- The vision, strategy and specific values of the community inpatient service were not known by all staff.

However,

- Incident reporting was encouraged and staff were supported to do so by their supervisors and service leads.
- The duty of candour was understood by all and applied in all appropriate circumstances.
- An organisational safeguarding action plan had been implemented and was being followed in response to an increase in alerts regarding staff conduct.
- Record keeping within the service was of a high standard.
- Thorough risk assessments were carried out and mitigated at all appropriate times.
- Assessments were carried out to assess patient's pain and regularly reviewed to ensure treatment was given to increase comfort.
- Patient nutritional and hydration needs were regularly assessed and reviewed. Appropriate referrals were made to specialists when required.
- Communication and cooperation of staff was good which enhanced the multidisciplinary team working within the service.
- Discharge planning was commenced upon admission and all staff were dedicated to ensuring patients achieved good outcomes.
- Staff were compassionate, kind and sensitive to patient, relative and visitor's needs.
- Staff communicated with patients clearly and kept them updated on their condition, progress and treatment.
- The service planned and delivered services which met patient needs.
- Staff showed commitment to ensuring patients accessed the right care and treatment at the right time.
- There were low levels of complaints within the service but they were investigated thoroughly.
- There was good local leadership within the community hospitals as leaders were approachable, supportive and visible.

Summary of findings

- Safe care and treatment was central to the culture within the service.
- Most staff were happy in their roles which contributed to positive morale on most wards.
- Managers and supervisors addressed any concerns raised by staff.

Summary of findings

Background to the service

The provider runs 13 community hospitals which provide community inpatient services across Cornwall and the Isles of Scilly. At the time of our inspection, four community hospitals were temporarily closed to inpatients due to low staffing levels at St. Barnabas Community Hospital and Fowey Community Hospital, fire safety concerns at Edward Hain Community Hospital and refurbishments at Launceston Community Hospital. Each of the 13 community hospitals vary in size, ranging from ten beds at St. Mary's Hospital to 44 beds at Bodmin Hospital. The hospitals provide general inpatient services such as rehabilitation, inpatient nursing and medical care for people with long term, progressive and life-limiting conditions.

Cornwall Partnership NHS Foundation Trust provides NHS healthcare services to a population of just over 545,000 in Cornwall and the Isles of Scilly. The demographics of Cornwall and the Isles of Scilly are such that one in four of the population are aged 65 or over and 98.2% of the population are white with 1.8% being from a non-white background. Deprivation in Cornwall and the Isles of Scilly is lower than the England average, although 15.9% of children live in low income families.

We visited nine of the community hospitals during our inspection. At the time of the inspection Launceston Community Hospital, Edward Hain Community Hospital, Fowey Community Hospital, and St. Barnabas Community Hospital were closed to inpatients so were not visited.

Cornwall Partnership NHS Foundation Trust employs staff across all 13 community hospitals and are supported by local GPs and consultants who carry out ward rounds during the week. Medical cover at the hospital was generally Monday to Friday, 9am to 5pm, with cover outside of these hours being provided by the out of hours GP service or in the event of an emergency, calling emergency services.

During our inspection, we spoke with 40 staff. These included two locality managers, four doctors, eight matrons, nine ward managers, ten registered nurses, seven healthcare assistants, four occupational therapists, five physiotherapists, four administration staff and three housekeeping staff. We also spoke with 21 patients, four relatives, friends or neighbours and reviewed 31 patient care records.

Most patients admitted to the community inpatient service are stepped down into the community wards from local acute hospitals to continue their rehabilitation or care plan. However, some patients are referred to the community hospitals by their GPs. There are two-day case beds, at two of the community hospitals, which are utilised for patients who do not need to be admitted but whose care can be provided in a hospital setting. There is also one detoxification bed at both Bodmin Community Hospital and Helston Community Hospital, which make up part of the Community Hospital Alcohol Detoxification pathway.

Our inspection team

The inspection of Cornwall Partnership NHS Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection, supported by Michelle McLeavy, inspection manager, mental health and Mandy Williams inspection manager, community health.

The team who inspected this core service included three Care Quality Commission (CQC) inspectors, a CQC pharmacy inspector, three specialist nurse advisors. They were supported by one expert by experience. An expert by experience is someone with lived experience of using such services.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive inspection programme.

The trust merged with Peninsula Community Healthcare NHS Trust in April 2016 and as such we always undertake a comprehensive inspection at an appropriate time following a merger.

How we carried out this inspection

During our inspection we reviewed community inpatient services provided by Cornwall Partnership NHS Foundation Trust across Cornwall and the Isles and Scilly. We visited nine of the 13 community hospitals.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out announced visits on 25 to 29 September 2017 and 3 to 5 October 2017. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We spoke with people who used the community inpatient services. We observed how people were being cared for and talked with carers and family members and reviewed care records of people who use services.

What people who use the provider say

Patients we spoke with during the inspection were highly complementary of the care and treatment they received at the community inpatient hospitals. Quotes from patients we spoke with included;

"All staff were lovely, cheerful and encouraging"

"The ward seemed short staffed as staff were always really busy"

"Absolutely wonderful staff who are kind and helpful."

"Staff are brilliant and look after my father really well"

"You can ask questions and staff will do their best to answer them"

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

The provider must ensure:

- Staffing levels across all community hospitals are safe and account for the acuity of patients on the wards.
- All relevant staff receive consistent and structured clinical and managerial supervision.
- All relevant staff must be appropriately trained to care for patients using the community health alcohol detoxification service.
- All risks to the service are identified and recorded on the divisional risk register, with mitigating actions detailed and implemented.
- All appropriate staff are updated and consulted before decisions are made to withdraw or modify services which will adversely affect their roles and responsibilities.

Summary of findings

Action the service SHOULD take to improve

The provider should ensure:

- All appropriate staff have completed relevant safeguarding training.
- All medicine fridges are locked and are not used to store blood specimens.
- The temperatures of store rooms, containing medicines, do not exceed 25 degrees.
- All infection prevention and control practices are adhered to at all times.
- All asset registers at each community hospital are up to date and contain all relevant information.
- All staff treating patients using the detoxification service have completed the necessary training to do so.
- All appropriate staff are aware of when records audits should be carried.
- All staff are afforded opportunities to develop.
- All documentation related to a patient's mental capacity and consent is complete and accurately and appropriately recorded on all occasions where applicable.
- Telephone conversations regarding patient care are kept confidential.
- All patients requiring assistance, when eating, are provided with the support they need.
- Information on how to make a complaint is easily accessible and visible to patients and relatives across all community hospitals.
- Dementia awareness training is delivered to all relevant staff and measures introduced to aid dementia patients are implemented across all community hospitals where appropriate.
- Staff have the required training and skills to care for patients living with learning disabilities.
- All risks identified at all community hospitals are appropriately risk assessed and recorded on the risk register as appropriate.

Cornwall Partnership NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Safe staffing levels across the community inpatient service hospitals were inconsistent, with high levels of agency and bank staff use and unfilled shifts.
- Two community hospitals shared registered nursing staff between wards and minor injury units at night, which left wards with unsafe staffing levels when those staff were called to attend the minor injuries unit.
- Feedback from incidents was not provided promptly and staff could wait months to receive information regarding a reported incident.
- There were safety issues regarding the storage of medicines at two community hospitals.
- Pharmacy cover across all community hospitals was inconsistent.
- The processes for recording equipment on an asset register were ineffective.
- Repairs and replacement of equipment was not dealt with promptly.
- The processes for checking resuscitation trollies were not being followed properly.
- Infection, prevention and control measures were not always adhered to.
- It was not clear how or when audits of paper based patient health records were audited.

However;

- Staff were encouraged and supported to report incidents.
- All staff understood the duty of candour and could provide examples of when it had been applied.
- Safeguarding processes within the community inpatient services had improved, and an organisational safeguarding action plan was being implementing and followed.
- The quality of record keeping was of a high standard.
- Risks to patients were appropriately assessed and mitigated where possible.

Detailed findings

Safety performance

- The community inpatient service monitored the safety performance of the wards. Each ward within the

community hospitals was monitoring safety performance, specifically avoidable patient harm. The prevalence of pressure ulcers, venous thromboembolism, falls and urinary tract infections were monitored. Each ward displayed their monthly performance for staff, patients and visitors to see. Venous thromboembolism (VTE) is a condition in which blood clots form (most often) in the deep veins of the leg (known as deep vein thrombosis, DVT) and can travel in the circulation and lodge in the lungs (known as pulmonary embolism, PE).

- It was the responsibility of the matrons to submit their hospital's safety data to their locality director, so it could be incorporated into a monthly quality and performance report. The locality director reviewed the monthly performance data and results were disseminated at monthly senior management team meetings, matron's meetings and then shared with staff at various ward meetings. The reports were also presented to the board by the locality directors to highlight any trends or themes. We saw minutes from these meeting and could see performance was discussed in detail and actions were taken to address issues.
- If safety performance did not meet expectations, actions were implemented to improve practice. For example, between 1 June 2016 and 31 May 2017 there were a total of 27 serious incidents reported within community inpatient services. Serious incidents are incidents where one or more patients or staff members experience serious injury or harm, alleged abuse, or the service provision is threatened. Of the 27 serious incidents, 17 were related to slips, trips and falls. The trust recognised this as an issue and introduced measures to reduce the risk of patients suffering falls. As a result, falls links nurses were appointed at each community hospital to raise awareness, and deliver training to reduce the frequency of falls. Intentional rounding was also promoted more widely, which meant, at risk patients were observed more regularly and in theory less likely to suffer a fall. Intentional rounding is a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs. However, despite these initiatives, we did not see any data demonstrating a reduction in falls.

Incident reporting, learning and improvement

- Staff understood their responsibilities to raise concerns, report safety incidents, concerns and near misses, and to report them internally and externally. However, feedback following incidents was not always timely. There was an electronic incident reporting system in use across the trust, which all staff had access to. Staff were aware of when an incident should be reported and knew how to use the trust's electronic incident reporting system to do so. However, they told us it could take weeks or months to receive any feedback on incidents they reported.
- Staff could recall incidents which had been reported locally. We were provided with multiple examples of recently reported incidents. One concerned sharps bins which were being over filled and the lids not being attached securely. The incident was reported online through the trust's electronic incident reporting system and forwarded to relevant senior staff. Following an investigation, appropriate actions were taken and staff received feedback verbally. Once the incident was signed off by the matron it was fed into the locality quality and performance report.
- When things went wrong, thorough reviews and/or investigations were carried out. All staff involved in the investigation of serious incidents had received appropriate training. We saw evidence of investigations being carried out and saw detailed reports which included input from all relevant staff and people involved. For example, there had been an incident resulting in the death of a patient following a cardiac arrest. During the incident, emergency services had been called and paramedics arrived at the scene. The hospital staff, patient's family and the paramedics were involved in the investigation. The investigation was carried out by someone working within another area of the trust. Ultimately, the investigation determined the death was unavoidable, but had identified learning points, which resulted in a review of the resuscitation process in use at the hospital, and further resuscitation training to be delivered to staff to ensure improved practice.
- When an investigation was complete, learning was disseminated to staff by the investigator at relevant

meetings, including matron and ward meetings. However, in some community hospitals, staff told us they could not recall receiving any shared learning from other hospitals within the service.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Patients and their families were told when they were affected by something that went wrong. We received data from the trust which demonstrated the community inpatients service had applied the duty of candour 64 times between 1 June 2016 to 31 May 2017.
- We saw evidence of the duty of candour being applied when patients and/or their relatives made complaints, but also when incidents occurred. Documentation sent to patients and/or relatives included what went wrong, why and what was being done to reduce the risk of it occurring again. An apology and the opportunity to discuss the issue with the matron or senior nurses was offered to the patient and relatives. Staff were open and honest with patients, relatives and carers.
- A report was produced each time the duty of candour was applied and tracked what had been done and when letters had been sent to patients and/or their relatives/ carers. The duty of candour reports were discussed by the matrons and locality leads at quality meetings each month to review what had been done and whether any actions were required.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse which reflected relevant legislation and local requirements. Data provided by the trust showed there had been 61 safeguarding referrals between 1 May 2017 and 30 April 2017. Staff understood their responsibilities and adhered to safeguarding policies and procedures. All staff we spoke with were aware of when a safeguarding referral should be made and what process to follow. Each ward had access to information on safeguarding processes and relevant contacts.
- Safeguarding adult and children training was available to all relevant staff, but data provided demonstrated that not all relevant staff had completed it. The data showed there were many safeguarding training courses available to staff, but none of them had achieved the trust's target of 85% compliance. For example:
- Only 47% of relevant staff had completed safeguarding children level two training.
- Only 35% of relevant staff had completed 'prevent' training. 'Prevent' training is part of the Government's counter-terrorism strategy and aims to stop people becoming terrorists or supporting terrorism.
- Only 31% of relevant staff had completed safeguarding adults level two training (human rights).
- However, the majority of inpatient leaders undertook adult safeguarding level 3 training in September 2017.
- There had been an increase in safeguarding alerts raised about the conduct of staff within community hospitals over the last 12 months. During our inspection, an organisational safeguarding action plan had been created and the actions were being implemented. The plan was devised in response to the increase in safeguarding alerts regarding the practice and conduct of staff at some community hospitals, but was being implemented across the whole service. This was identified as a serious issue and actions had been taken to address the culture, systems and processes and care provided at all community hospitals. None of the actions had been fully achieved as the plan was still in the early stages of implementation. Examples of measures to be implemented included:
- Contact rounds to be run daily on each ward to check whether patients had additional care needs, including assistance with toileting or safety needs.
- Safety briefings which were used to discuss all issues related to the ward on each shift.
- A nurse in charge was identified on each shift.
- 'See, say, do' which was an initiative used to publicise actions to take if there are concerns over standards of care.
- Dementia awareness training for all staff across all community hospital wards.
- At some community hospitals, matrons held feedback meetings with staff following safeguarding alerts and investigations. These were also attended by a member of the trust's safeguarding team to ensure the issues and actions were understood.

Requires improvement

Are services safe?

Medicines

- Not all arrangements for managing medicines at the community hospitals ensured the safety of patients.
- Medication rounds took place in all community hospitals we visited. During the rounds, nurses carried out appropriate checks to confirm patient identity. Patients were given explanations as to what medications were and why they needed to be taken. We observed a registered nurse administering medicines to patients at Falmouth Hospital which demonstrated safe practice. The medicines trollies were locked and secured when not in use.
- The ordering, storage, administration and disposal of controlled drugs were safe. The trust had an up to date standard operating procedure for controlled drugs which was produced in line with relevant legislation and guidance, for example NICE guideline NG46: Controlled drugs: safe use and management. We saw staff adhering to the policy at all community hospitals. We reviewed the controlled drugs register and storage in the community hospitals we visited and found no discrepancies in stock, administration or disposal. We observed controlled drugs being stored appropriately and administered to patients safely.
- The arrangements for storing medicines in refrigerators at most community hospitals were safe. Refrigerators were locked and temperature checks and audits were carried out to ensure drugs were kept at safe temperatures. However, the drug fridge at Newquay Community Hospital was unlocked, and staff on the ward allowed district nurses in the community team to store blood specimens in the fridge. This allowed for the opportunity for drug theft and tampering. At Helston Community Hospital we found the refrigerator temperatures had not been checked on six occasions in July, three occasions in August and five occasions in September 2017. There was no record of when the fridge was last cleaned, defrosted or stock date checked. This showed there was a lack of assurance the medicine in the refrigerator was safe for use.
- Storage of medicines within store rooms was secure, as the doors were kept locked and only authorised staff held the keys. The temperatures of storage rooms were monitored and recorded, but there were occasions over the summer where the temperature of storage rooms, specifically at Stratton Community Hospital and Newquay Community Hospital, had exceeded 25 degrees Celsius. The majority of medicines stored in the storage rooms should have been kept at 25 degrees Celsius or below. Both community hospitals sought pharmacist advice and in order to ensure the safety of patients, affected medicines had their use by dates reduced by 12 months and were destroyed upon reaching the modified date. However, staff were unable to tell us what was being done to address the temperature issues and were unaware of any formal action plan.
- Pharmacy cover across the community inpatient service was inconsistent. Across most community hospitals, pharmacy cover was provided by either a pharmacist or pharmacy technician once a week. Where pharmacy cover was provided, either a pharmacist or pharmacy technician attended the ward each week to review the ward stock. The pharmacist who attended Falmouth Community Hospital was also a prescriber so could assist with medicine prescriptions and medicines for patients to take home. There was no pharmacy cover in place at Bodmin Community Hospital. We were told cover had previously been provided by a pharmacy technician up until recently but was withdrawn but staff had not been told why. We were told both wards at the hospital could access the pharmacy teams for advice and guidance. All clinical checking of medication, on the wards was carried out at the local acute NHS trust when medication was ordered.
- We were told a plan had been developed to implement a ward based medicines management technician. A pilot was soon to be implemented at two sites, Camborne and Redruth Community Hospital and St Austell Community Hospital and the learning will influence the trust's development of pharmacy support.
- Tablets for the patient to take home were generally prescribed by the ward doctor and ordered from the local acute trust pharmacy.
- Prescription charts were complete, contained all relevant information and writing was legible. We reviewed over 30 prescription charts and found patient allergies were recorded, all medicines omitted had a reason documented and antibiotics were prescribed in line with guidance. If patients required venous thromboembolism prophylaxis, it was prescribed and recorded.
- At Falmouth Hospital we saw creams and lotions which were unnamed and opened. Two creams were on a patient's bedside locker and did not have the patients

name or the date of opening on them. This ran the risk of the cream being used for the wrong person and cross infection taking place. There was also a cream in the medicine storage cupboard that had been opened but did not have the date of opening recorded on it. Creams and lotions should generally be used within six months of opening.

Environment and equipment

- The design, maintenance and use of facilities and premises generally kept people safe. However, we had concerns about the maintenance of equipment and how equipment was stored in some hospitals we visited. Most community hospital environments were safe but when visiting Liskeard Community Hospital and Bodmin Community Hospital, corridors were cluttered with equipment and trollies. Staff had said storage at the hospitals was limited and therefore equipment needed to be stored on the ward. On one occasion, a two-door emergency exit was blocked with cleaning equipment. Given the large proportion of admitted patients with mobility issues, this was of concern, as it would have been difficult for patients to exit the premises in the event of an emergency without having their path partially or fully blocked.
- The maintenance and use of equipment kept people safe, but the processes for recording equipment on an asset register was ineffective. At each community hospital we visited, we checked equipment to ensure it had been serviced and had been safety tested. We found most relevant testing and servicing had been carried out on the items of equipment we checked. However, at Falmouth Community Hospital we saw two pieces of equipment that was overdue for a safety test. One of which was an intravenous infusion pump which had been due to be tested in December 2015.
- Following a review of the asset register for medical equipment at Helston Community Hospital we saw the last and next service date for a large amount of equipment was unknown. The asset register was also missing relevant data including when the equipment had last been safety tested, and both the equipment asset and serial numbers had not been recorded. All equipment on the list had been marked as being in use but it was not clear from the record whether it was in fact safe to do so.
- Repairs and replacement of equipment was not always carried out promptly. Repairs were referred to the trust maintenance and equipment department. There was no shared electronic record which staff could access to refer items for repair/replacement or track progress. Staff at most community hospitals told us when equipment was no longer fit for purpose, it often took weeks or even months for the item to be repaired or replaced. Staff felt this had a direct impact on patient outcomes as vital pieces of equipment were unavailable. For example, the ice machine at Liskeard Hospital had been broken for over a week and staff had not been updated. Therefore, patients could not receive ice pack therapy at the hospital.
- The availability of equipment at community hospitals fluctuated. Staff gave mixed responses on whether they thought they had enough equipment to provide safe care and treatment to patients. The majority told us they thought there was enough equipment. However, the number of available pieces of equipment fluctuated between wards within the same community hospital. For example, at Bodmin Community Hospital, staff on Harbour ward had to regularly borrow equipment from Anchor ward. Staff felt this inconsistency led to time being wasted and delayed patient treatment. Staff were not sure why equipment levels differed on some wards within the same hospital. The matter had been escalated to ward managers but staff had not received any answers.
- The arrangements for managing waste and clinical specimens kept people safe. Waste was segregated appropriately with separate waste bins for both general and clinical waste. We saw sharps bins being used appropriately and none were overfilled.
- Resuscitation equipment was available, fit for purpose and in easy access locations at all community hospitals. However, we saw daily checks of the resuscitation trollies were not always carried out at some community hospitals. We reviewed the resuscitation trolley daily check record books at each community hospital we visited. Those at Liskeard Community Hospital, Camborne and Redruth Community Hospital and Bodmin Community Hospitals showed in some cases, the resuscitation trolley had not been checked on up to eight days in a month. We also saw weekly full checks were being recorded, but it was not clear whether those checks were being carried out correctly. For example, at Liskeard Hospital, a full check had been carried out in

January 2017 but failed to identify that the suction machine required servicing that month and had not been serviced until March 2017 when it was eventually highlighted.

- Pressure relieving mattresses and cushions were readily available in the hospitals. There were stores at each community hospital but if additional specialised equipment was needed, it could be ordered from the central loans store. Staff felt equipment was delivered promptly.
- The fire extinguishers in all community hospitals were checked and maintained by an external company. We saw annual checks had recently been carried out on all extinguishers.

Quality of records

- Patients individual care records were mostly written and managed in a way that kept patients safe. Records were accurate, complete, legible, up to date and stored securely. We reviewed 34 patient records and the name and grade of the doctor or nurse reviewing the patient was clearly documented in most notes. However, there were some entries where not all staff printed their name next to their signature and did not consistently record their role. This meant there was a risk the staff member would not be identifiable.
- All patients within the community inpatient service had a care plan. Of the 34 patient records we reviewed, each patient had a care plan which was specific to them. It was reviewed regularly and changes were made as the patient's condition improved or deteriorated.
- All patient risk assessments were contained in their care records. We did not see any missing patient risk assessments and all had been completed thoroughly. When applicable, we saw records of assessments being carried out and reviewed where appropriate.
- Records included entries from all those involved in a patient's care. We saw evidence of input from the multidisciplinary team in all records where other health professionals had been involved. Within the 34 patient care records we reviewed, where applicable, all had comprehensive input from nurses, doctors, physiotherapists, occupational therapists, dieticians and speech and language therapists.
- Records were stored in cabinets on wards and could only be accessed by combination lock. All cabinets were locked when left unattended and were in locations close to nurses' stations, which allowed staff to have clear line of sight.
- It was not clear when or how often audits of patient health records, within the community inpatient service, were carried out. We reviewed multiple trust policies relating to patient health record audits and found references to when audits should be carried out. One policy said audits should be carried out on a regular basis to check for completeness, consistency and accuracy, but this related to the trust's electronic health record systems. Another policy relating to management of information said monthly reports were generated and reviewed by team leaders each month. However, the vast majority of records within the community inpatient service were paper based and the trust's policies were not clear on when audits of paper records took place. Staff told us audits took place but could not confirm when, how often or how many patient records were checked. We did, however, see a monthly ward assurance tool which was used by matrons, to check the performance of the wards within the community hospitals they managed. Part of the tool required five patient records to be reviewed each month. The reviews included checks on assessments and falls, nutrition and hydration, tissue viability and observations. Not all matrons were aware five patient records were to be reviewed each month as when asked, some said they were not sure when patient health records audits were carried out. It was unclear whether these reviews fed into a service wide audit as we did not receive any recent audit results for the community inpatient service.

Cleanliness, infection control and hygiene

- Standards of infection, prevention and control were not adhered to in some of the community hospitals we visited.
- Hand hygiene compliance within the community hospitals was not in line with trust targets. According to data provided by the trust, hand hygiene audit results across the trust were 95% throughout the period from 1 April 2016 to 31 March 2017. This result was based on audits returned by each specific clinical area. However, validated data from the trust wide infection prevention and control team indicated compliance during the same period as 77%. We were not provided with specific data

for each community hospital, however, while on inspection, we saw recent hand hygiene audits results were displayed on the wards. At Falmouth, a hand hygiene audit carried out in September 2017 identified low compliance amongst staff, with 50% of observations being inadequate and 30% of staff being non-compliant with the hand hygiene procedures. The issues raised included no hand hygiene after glove removal and an inadequate length of time washing hands. During the hand hygiene observations, additional issues were identified including the wearing of jewellery by staff on the ward, a patient's isolation room had the door left open and staff not consistently wearing personal protection equipment (PPE) when entering isolation rooms. The ward manager acted by providing written feedback to all staff together with a reminder of the hand hygiene policy. Staff were required to sign this to show they had read this memo.

- We saw hand hygiene audits results for August 2017, on Harbour Ward, at Bodmin Community Hospital and results showed performance had become worse over time. The ward had scored 85% compliance in June 2017 but was at 65% by August 2017. Issues included poor handwashing technique, hands not always cleaned after patient contact and not always cleaning hands at the point of contact.
- It was not always clear whether equipment was clean and ready for use. Stickers were attached to some equipment to show it was clean and ready for use. However, we observed not all wheelchairs had stickers on, which indicated they may have been used by patients. We also saw stools and chairs in bathrooms which did not clearly state they were clean.
- Equipment was not always stored appropriately. For example, at Falmouth Hospital we saw air mattresses stored partly on the floor and not on shelves. Also, reusable hoist slings were unlabelled and did not indicate if they were clean and ready to use. There were dates attached to the slings but we were told this was when they were required to be assessed to ensure they were still safe to use. Staff told us the slings were all clean and ready to use. They were washed and returned to the ward in plastic bags which the staff then removed and hung up the slings.
- All crockery and cutlery used at St. Mary's Community Hospital and in the community for meals on wheels was currently being washed by hand as the dishwasher was broken. This provided a risk of cross infection and did not promote the control of infection.
- We saw all staff washing their hands before and after each patient direct contact or episode of care, in accordance with NICE QS61 (Infection prevention and control). There were infection prevention and control link nurses in each community hospital who were responsible for undertaking audits on cleanliness and hand hygiene. They were also responsible for delivering any additional training introduced by the trust.
- Reliable systems were in place to prevent and protect people from a healthcare associated infection. However, they were not always followed. Any patient identified as having an infection was cared for in an isolation room. We saw the rooms being used at all community hospitals. Signage was used to advise staff and visitors on the ward and highlight the precautions which needed to be taken. For example, there were signs on the isolation room doors stating they needed to remain closed. However, we observed doors to the isolation rooms being left open frequently across all community hospitals we visited. This meant the risk of the spread of infection was increased.
- At each community hospital there was signage requesting medical, nursing, healthcare and housekeeping staff keep bare below the elbow in clinical areas. We saw almost all staff adhering to this but saw, on one occasion, a member of staff wearing a cardigan while on a ward.
- There was good availability of PPE at the community hospitals, with gloves and aprons positioned outside bays and isolations rooms. We saw staff using PPE consistently at each community hospital we visited. However, on one occasion we saw a member of staff, at Bodmin Community Hospital, not using PPE when caring for a patient in an isolation room.
- Each community hospital we visited was visibly clean. Of the eight hospitals we visited, each one was clean and we saw housekeeping staff cleaning all areas thoroughly. Recent audits undertaken indicated wards within community hospitals were clean. Patient led assessments of the clinical environment (PLACE) had been undertaken at ten of the community hospitals. Four of the ten sites had scored above (better than) the England average (97.8%) for cleanliness. The remaining

hospitals scored between 91.7% and 97.3%. PLACE assessments are self-assessments undertaken by teams of NHS and private / independent health care providers, and include at least 50% members of the public (known as patient assessors). They focus of different aspects of the environment in which care is provided, as well as supporting non-clinical services.

Mandatory training

- Mandatory training in safety systems, processes and practices were available to staff but data showed compliance levels, with a high number of courses, were low across all community hospitals. We were not provided with mandatory training compliance data for staff at specific community hospitals. Data provided showed the position across all community hospitals at 31 May 2017, and demonstrated staff had achieved an overall mandatory training compliance rate of 28%, against a trust target of 85% or 95% depending on the course. Only two of the 51 mandatory courses had achieved compliance above trust target. However, matrons at all the community hospitals we visited told us their mandatory training compliance was higher and the system used for monitoring it was incorrect.
- As part of the mandatory training programme nursing and healthcare assistants were required to complete training on fire safety awareness, health and safety awareness, moving and handling theory, equality and diversity awareness, harassment and bullying, infection prevention & control, information governance, Mental Capacity Act, adult safeguarding level one, children's safeguarding level one, slips, trips & falls and waste management. These training programmes were included in their essential learning packages, compliance for which was 91% and 92%, against a trust target of 95%.
- All staff told us mandatory training was to be completed in the third quarter of the year, between October and December 2017. Staff told us they were due to complete their training and were booked on courses.
- The process for monitoring training compliance was managed centrally. Matrons and ward managers responsible for the supervision of staff did not monitor compliance, as this was done by a central team. Staff were sent emails when training was due for completion. Staff said it was easy to miss emails as they received so many.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who use services and risk management plans were developed in line with national guidance. Where appropriate, we saw evidence that patients had been risk assessed for pressure ulcers, falls, venous thromboembolism (VTE), malnutrition and the requirement of bedside rails. In all circumstances, where required risks had been managed appropriately. For example care bundles had been implemented when patients' skin integrity was at risk and VTE prophylaxis prescribed where applicable. VTE prophylaxis consists of pharmalogical and non-pharmalogical measures to diminish the risk of a deep vein thrombosis.
- The community inpatient service had implemented measures to ensure staff identified and took action when patients were suspected of having sepsis. However, there were issues in how those measures were implemented. Sepsis is a serious condition which involves a systemic response to severe infection in the body. Information for staff relating to the signs, symptoms and action to take for a patient presenting with sepsis was clearly displayed on staff noticeboards across all community hospitals. The trust also had a policy for sepsis screening in community hospitals. However, the policy appeared incomplete as it did not outline all the incorporated related legislation and national guidance. Therefore, it was unclear whether the policy was based on the most recent National Institute for Health and Care Excellence guidelines for sepsis (NG51). It was also unclear whether training on sepsis identification and escalation was mandatory for all staff. Most staff told us they had completed training but did know if it was to be completed yearly, although, the policy stated sepsis training was mandatory.
- Staff identified and responded appropriately to changing risks to patients. The trust had a policy for the care of deteriorating patients and assessed patients using the national early warning score (NEWS). NEWS is a combination of observations detailed within limits that indicate whether a patient is deteriorating and what associated actions should be taken. Staff were aware of how to apply NEWS and we saw examples in records where a patient's score had been calculated

using NEWS observational charts. The policy was clear on what steps should be taken, depending on a patient's score, and staff were also aware of what processes needed to be followed.

- Arrangements for staff handovers and shift changes kept patients safe. All staff starting a new shift attended handover meetings, either in the morning, afternoon or evening. Handover meetings took place at each of the community hospitals and involved all relevant staff caring for patients. At handover, the attendees briefly discussed each admitted patient, whether any discharges were expected along with any new admissions. Any safety issues and measures taken to reduce risk were shared.
- Staff introduced measures to reduce the risk of patients suffering a fall. Staff told us falls prevention measures were in place within community hospitals. For example, pressure alarms and individual specialised physiotherapy programmes were used for patients at a higher risk of falls.
- There were occasions when assessments and records were not complete. At Falmouth Community Hospital, we observed that fluid charts were not consistently totalled for each 24-hour period. This meant that it was not clear if the patient's fluid intake and output balanced.

Staffing levels and caseload

- Staffing levels and skill mix did not always ensure patients at every community hospital received safe care and treatment. A safe staffing tool, based on the Shelford safe nursing care tool, was used by the director of nursing, with input from the community hospital matrons, to determine safe staffing levels across the community hospitals. However, ward managers told us they had limited input into how the staffing on the wards at the community hospitals was determined.
- Matrons and ward managers at most community hospitals felt there was no formal tool used to assess and address differing levels of acuity. The process involved identifying any issues at local level and then escalating to the locality directors. The locality directors then escalated to the senior management team to authorise additional staff to be rostered into shift(s).
- Rostering was managed centrally using an electronic system. The rota was sent out to wards every six weeks and then reviewed and any required changes were made by the health roster department. Staff at the community hospitals could not make changes independently. Staff commented that each month there were errors in the roster which required amendment. Each one needed to be commented on and sent back to the e-roster team to make the required changes. For example, not all staff worked 12-hour shifts but were often included on the rota on such a shift. Staff commented the review of the rota was time consuming and could take three hours to complete.
- The safe staffing tool determined how many registered nurses and healthcare assistants were required for each early, late and night shift. We saw the proposed safe staffing tool used and proposed numbers for each hospital. However, at the time of our inspection, the number of inpatient beds had been reduced at some community hospitals due to low staffing levels. For example, Lamorna ward at Camborne and Redruth Community Hospital had reduced inpatient beds from 21 to 12 and Falmouth Community Hospital had reduced inpatient beds from 24 to 16. Staff at Falmouth Community Hospital and on Lamorna ward reported staffing levels had been sufficient to meet the needs of the patients on the ward, since the reduction in bed numbers.
- The safe staffing tool stipulated each ward should have a ward manager; however, this was not the case on Lamorna ward. Also, there were no band 6 registered nurses in post at the time of our inspection. Management of the ward fell to the matron who was also responsible for services at Helston Community Hospital and Edward Hain Community Hospital, which included a minor injury unit and two outpatient departments. Staff felt the absence of band 6 nurses and ward manager had caused a lack of stability. There had been an absence of band 6 nurses and a ward manager for over six months. There were plans to recruit two band six nurses and ward manager but it was not clear when those appointments would be made.
- At Stratton Community Hospital and Helston Community Hospital ward staff supported the minor injury unit (MIU) at night. Helston MIU does not provide an over-night service as it closed at 8pm. However, the staff on the inpatient ward provided cover until that time. This meant if a patient arrived at the MIU at night, a registered nurse on duty on the ward was required to leave to provide care and treatment. This would lead to a lack of nursing cover for patients who were on the ward. At Helston Community Hospital this would leave

one registered nurse to 24 patients, whist the other registered nurse was called away and at Stratton Community Hospital it would leave one registered nurse to 12 patients.

- The safe staffing tool stipulated the safe staffing numbers for the night shift at St. Austell Community Hospital on both wards was two registered nurses and two healthcare assistants. The staff on the shifts covered 22 patients on each ward. However, staff on Harold White ward told us there was a lack of registered nurses which would often leave one registered nurse looking after 22 patients at night, on the ward. They felt this was unsafe.
- We reviewed data relating to the registered nurse staffing levels on Harold White ward at night, over a period from January 2017 to September 2017. The data showed registered nursing staffing levels at night were regularly unfilled on Harold White ward. Filled shifts ranged from 52.5% to 81.7% per month. For example the lowest figures included:
- 63.5% of shifts filled at night in March 2017;
- 56.4% of shifts filled at night in May 2017; and
- 52.5% of shifts filled at night in June 2017.
- Most community hospitals had vacancies for both registered nurses and healthcare assistants. A high proportion of registered nursing shifts were filled by bank and agency staff or left unfilled. Between the period of 1 June 2016 and 31 May 2017, 4.3% of registered nursing shifts were left unfilled across all community hospitals. Over the same period, 4.8% of shifts were filled using bank staff and 10.4% using agency staff. This meant that 19.5% of all registered nursing shifts, across all community hospitals, being left unfilled or filled by bank and agency staff. The community hospital with the most unfilled registered nursing shifts was Stratton Community Hospital with 8.7%. The community hospital with the most registered nursing shifts filled with bank staff was Newquay Community Hospital with 9.9%. The community hospital with the most registered nursing shifts filled with agency staff was St Mary's Community Hospital with 43.1%. Staff said filling shifts with bank or agency staff worked but often created issues when they failed to turn up.
- A high number of healthcare assistant shifts were filled by bank and agency staff or left unfilled. During the same period, 3.5% of shifts across all community hospitals were left unfilled. The greatest proportion of shifts being left unfilled occurred at Liskeard Community Hospital with 12.5%. During the same period, 12.2% were filled using bank staff and 4.2% with agency staff. In total 19.9% of all shifts were filled using bank and agency or left unfilled. The community hospital with the most healthcare assistant shifts filled using bank and agency staff was Liskeard Community Hospital with 38.3%.
- Staff of all levels said the staffing issues were influencing the amount of time they could spend caring for patients. This was due to time being spent inducting or training bank and agency staff on the ward. Tasks also took longer to perform with reduced staff, such as medicine rounds and serving meals. Staff felt the high use of bank and agency staff resulted in a lack of continuity for patients.
- There were vacancies at each community hospital we visited. The vacancy rate within the community inpatient service was high. Between 1 June 2016 to 31 May 2017, the average monthly vacancy rate across all the community hospitals was 6.9%, against the trust average of 5.1%. Although, not much higher than the trust average, there were roles which had significantly higher vacancy rates than the trust average, for example, registered nurses had an average monthly vacancy rate of 16.7%. All levels of staff at each hospital felt staffing was a problem and a risk to patient safety, although we did not see any examples of incidents caused by low staffing levels.
- The community inpatient service had high turnover rates. The service had an average annual turnover rate of 15.5%, against the trust average of 12.5%. Leaders within the community inpatient service said it was difficult retaining staff due to the trust's location and lack of financial incentives.
- There was recognition by the trust that there was a lack of band 6 nurses across all community hospitals. As a result, funding had been put in place to recruit additional band six nurses. Recruitment had been successful at all hospitals except on Lamorna ward, although, at the time of our inspection, it was hoped the post would be filled by an internal candidate.
- The staffing at St. Mary's Community Hospital was not ideal. At St. Mary's Community Hospital, on the Isles of Scilly, staff confirmed the staffing establishment had been worked out by the locality director using the safe staffing tool. This was repeated each January and June, during which staff collected information regarding the

numbers and dependency of patients, including those attending the minor injuries unit. There were normally two staff on duty, a registered nurse and healthcare assistant. The matron and ward manager were available to provide support at times. The ward registered nurse also covered the minor injuries unit. We saw they had left the ward on four occasions to provide care and treatment in the minor injuries unit which left patient's on the ward without registered nurse cover and so was potentially unsafe. Despite the average low bed occupancy and low numbers of patients attending the MIU, staff reported that during the summer months the occupancy on the ward rose and attendances at the MIU increased. The staffing levels were not increased during these busier periods.

- There were three whole time equivalent registered nurse vacancies, two of which had been unfilled for 2 years. Recruitment at St. Mary's Community Hospital was ongoing but was difficult due to location. Incentives were recently added to job adverts but the detail of the incentives were unavailable to ward staff. The job vacancies advertised offered an island allowance, rent allowance and accommodation support plan. However, staff did not know what this meant and had not been provided with any additional information. Enquiries were made to the human resources department and their locality manager but staff had not received any further information. Some enquiries had been made to the ward sister, who was unable to provide interested applicants with this information, potentially losing out on candidates to fill vacancies.
- The recruitment of band 6 nurses was part of the organisational safeguarding action plan, described above in the safeguarding section of the report. Recruitment of band six nurses was initiated to increase the depth of clinical and senior leadership within the nursing team.
- In addition to recruiting additional band 6 nurses, the community inpatient service safe staffing tool established that all wards with 19 or more beds were required to have two whole time equivalent band six nurse cover. This was not being achieved across all relevant wards at the time of our inspection.
- Across some of the localities, recruitment days were being held to attract and find the best candidates for positions. Part of the recruitment days involved practical based tasks which highlighted which candidates were most suited for the position.
- The service was aware of the risk their staffing levels posed. To address unfilled shifts, daily teleconferences were held across each locality team, where staffing issues were discussed and arrangements made to promote safe staffing levels. This included requesting additional bank or agency staff and moving staff between wards, departments and hospitals.
- A team of peripatetic staff were employed by the trust to work within the community hospitals. Staff confirmed that this system worked well, as staff were aware of the trusts policies, procedures and systems. The peripatetic staff team had reduced the need for bank and agency staff on wards. Peripatetic staff worked in multiple locations across the community inpatient service and were accessed centrally. They could be deployed by the trust in any hospital where additional staffing was required. The trust tried to place peripatetic staff in a location for a number of shifts to promote continuity of care for patients.

Medical Cover

- Medical cover was delivered differently, but on the whole safely between community inpatient services, however, formal arrangements to cover for staff sickness or annual leave were not always in place. At some community hospitals, medical cover was provided by local GP practices and at others, cover was provided by consultants or junior doctors supplied by local acute trusts. All community hospitals had some type of cover between Monday and Friday, 9am to 5pm and relied on the out of hours GP service at weekends and outside of normal hours. The emergency NHS ambulance trust was used if emergency care and treatment was required. Staff at some hospitals felt medical cover was unsatisfactory and put patients at risk. This was because there was a lack of formal arrangements in place for when doctors were sick or on annual leave. It was felt there was a lack of contingency planning as some wards could be left with little to no medical cover.
- For example, at Liskeard Community Hospital and Camborne and Redruth Community Hospitals, if one ward did not have medical cover across the week, the doctors from another ward had to cover it. This meant neither ward received a full service and patients with the most urgent needs were prioritised.
- At Falmouth Hospital, there was no medical cover at the beginning of the week, Monday, as the doctor was off

sick. Staff said they were going to try to get cover from a locum doctor but in the event of an emergency, staff would call the 111 service and discuss with the covering GP.

- We were told the trust had contractual arrangements with a local acute trust for geriatrician support, which covered Bodmin Community Hospital, Falmouth Community Hospital, Camborne and Redruth Community Hospital and St. Austell Community Hospital. The arrangements covered geriatrician in-reach services. However, there were no formal processes for doctors to obtain peer support or additional advice at Helston Community Hospital, Liskeard Community Hospital, Newquay Community Hospital, Stratton Community Hospital and St. Mary's Community Hospital. None of the doctors we spoke with were aware of any formal processes for obtaining additional support or advice regarding patients at these hospitals. However, the majority of doctors had made their own arrangements. This was not ideal as if they were away and/or locum doctors were covering, that specific advice was unavailable.
- The trust had access to a telephone based frailty advice line which was available for all clinical staff across all community hospitals seven days a week, 9am to 5pm. This service was provided by a local acute trust and enabled staff to contact geriatricians for support to prevent admission into acute hospitals and assist with decision making.

Therapy Cover

- Occupational therapy and physiotherapy was unavailable seven days a week. Across all community hospitals, occupational therapy and physiotherapy was provided Monday to Friday, 9am to 5pm only. There was limited cover provided on weekends or out of hours. Therapist-led patient rehabilitation was unable to take place across a whole week, which staff felt had the potential to affect patient recovery and therefore outcomes. However, patient rehabilitation was supported on the weekends by nursing and healthcare assistant staff, as each patient had a personal rehabilitation plan which was delivered by all staff.

Managing anticipated risks

- Potential risks were considered when planning services. We saw evidence of an escalation plan which would be followed in the event of an emergency. The plan was detailed and assessed what impact increased pressure on the service would have across the trust, and the local acute NHS trust. Staff knew where to access the plan and could explain the actions to be taken in the event of an emergency.
- The community inpatient service did manage risk and took action when patient safety was a concern. For example, there were safety risks identified at Edward Hain Community Hospital which affected patient evacuations from the inpatient ward, in the event of a fire. A risk assessment was carried out and it identified remedial works were required in order to ensure patient safety. As a result, the service closed inpatient beds at the hospital while remedial works were being carried out. Patients requiring a bed in the community were admitted to other community hospitals within the service.

Good

Are services effective?

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

Summary

We rated effective as good because:

- Staff followed evidence based treatment and adhered to National Institute for Health and Care Excellence (NICE) guidance.
- Patients' pain was routinely assessed and reviewed with treatment provided to ensure comfort.
- The nutritional and hydration needs of patients were consistently assessed and reviewed.
- Patient outcomes were monitored and performance data was used to improve practice.
- Multidisciplinary working on wards was effective. All staff communicated clearly and assisted each other to enhance patient care and treatment.
- There was a strong commitment to discharge planning which commenced upon admission.

However;

- It was not clear whether all staff were aware of when mental capacity assessments should be carried out, as staff failed to follow the trust's policy.
- There were no formal structured clinical supervision processes for nursing staff.
- There was inconsistent managerial supervision as one to ones did not always take place.
- Not all staff taking care of patients using the community hospital alcohol detoxification service had received appropriate training.
- Specialist training was not easily accessible to all staff.
- We saw no evidence that staff were using communication tools for assessing pain experienced by patients with communication difficulties.

Detailed findings

Evidence based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation was identified and used to develop how services, care and treatment were delivered. The trust had a policy for the identification, review, dissemination, implementation and monitoring of compliance with National Institute for Health and Care Excellence (NICE) guidance. The patient safety and compliance lead was responsible for developing and maintaining a work programme of forthcoming guidance which included related policies and training. The patient safety and compliance lead was also responsible for adding new guidance to the governance webpage and the NICE database, meaning it could be accessed by staff. NICE provide national guidance and advice to improve outcomes for people using the NHS and other health and social care services.
- During our inspection, we saw evidence that policies were developed in line with best practice and guidance from NICE. For example, the trusts policies for infection prevention and control incorporated guidance NICE (2014) Infection Prevention and Control (QS61) and we saw it being followed by staff on the ward.
- Staff told us they always followed evidence based practice and followed NICE guidance when applicable. We saw evidence of this when staff treated patients requiring stroke rehabilitation, i.e. stroke rehabilitation in adults (CG162). The service provided care to stroke patients at Camborne and Redruth Community Hospital and Bodmin Community Hospital where the care provided to patients was in line with national guidance.
- The community hospital alcohol detoxification service delivered care in line with NICE guidance. We saw the trust's alcohol withdrawal policy which incorporated NICE Guidance (QS11) Alcohol-use disorders: diagnosis and management. Staff were aware of the policy and adhered to guidance.

Pain relief

- Pain was assessed and managed effectively by staff at all community hospitals. We saw evidence of pain assessments being carried out, where applicable, in each patient record we reviewed. We also saw measures being taken to manage the level of pain experienced by patients. Patients told us they were regularly asked if they were experiencing pain, to what degree and how often. They told us they were offered and provided with pain relief when required. We also observed patients

being asked if they had any pain and offered pain relief on the regular medicine rounds. The medication administration records identified if patients had pain and any analgesia administered.

- Patients were prescribed pain relief appropriately. As described above, all community hospitals had varying degrees of medical cover from Monday to Friday. During these visits, either GPs or consultants prescribed patients with pain relieving medication as required. If prescriptions were needed out of hours, staff could access the out of hours GP service.
- Care plans identified any pain experienced by patients and the action staff were required to take to reduce the pain. For example, we saw one care plan that advised staff of where a patient experienced pain and actions to take to avoid increasing the pain during personal care. MAR charts reflected patients pain and medication provided. The MAR chart is the formal record of administration of medicines.
- It was not clear if the community inpatient service used any pain assessment tools which were specifically used for people with communication difficulties such as those living with dementia or a learning disability, as we did not observe any being used and staff were unable to tell us if there were any in existence.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed and met most of the time. Following a review of patient care records, we saw patient needs were assessed and management plans were developed. Compliance with the malnutrition universal screening tool (MUST) was good and we saw action was taken when issues were identified.
- There were large stocks of liquid meal supplements available on the ward. Staff advised that many patients were admitted with poor appetite and low weight, so the meal supplements were offered to many of the patients. This was following a doctor prescribing the supplement
- Community hospitals had access to speech and language therapists and dieticians when required. If staff required specialist advice regarding a patient's ability to eat or what their nutritional needs were, they could make a referral for assessment by a speech and language therapist or dietician. Advice was also available over the telephone when required. We saw evidence of referrals being made by staff when additional input was required.
- The quality of food at each community hospital varied. As stated above, in 2016, PLACE assessments had been undertaken at ten of the community hospitals. Of the ten sites, five scored below the England average (91.9%) for ward food. For example, Launceston Community Hospital scored the lowest with 73.9%. However, St Mary's Community Hospital and Liskeard Community Hospital both scored above the England average with 98.8% each. Patients at every community hospital said they were happy with the quality of the food.
- Patients were not always assisted or encouraged to eat when required. We saw two examples of patients not being offered any encouragement or assistance when meals were served. On both occasions meals were served to each patient but they had not eaten anything before being given their desert. The staff serving the meals failed to notice the patients had not eaten anything and did not offer any assistance. They also failed to ask the patient why they had not eaten or give them any encouragement to try and get them to try and eat.

Patient outcomes

- Information about the outcomes of patient care and treatment was routinely collected and monitored. Information was collected each month to enable improvements to patient care and treatment. Examples of data collected included average length of stay, delayed discharge and the reasons for delayed discharges. The information was used to feed into various quality assurance meetings and actions were taken if data showed a decrease in the level of performance. We saw data relating to length of stay and delayed discharges being used to improve access and flow into the hospital.
- The service also collected data by way of audit on a range of other topics including; cleanliness, pressure ulcers and falls. This data was used at various governance meetings and actions were taken to improve performance where required.
- Therapy teams routinely collected information regarding patient outcomes. On Lanyon Ward, at Camborne and Redruth Hospital, occupational therapists were using the Canadian Occupational

Performance Measure (COPM) to assess patient development and progress. COPM is an evidence-based outcome measure designed to capture a client's self-perception of performance in everyday living, over time. An recent audit, carried out by the occupational therapy team, collected data on how many home visits had taken place in a three month period. The audit was carried out to see if there was additional capacity to increase the amount, in an attempt to reduce delayed discharges, as patients could be discharged from hospital earlier and continue their therapy at home. As a result of the audit, a criteria and standard operating procedure for carrying out home visits had been drafted and was soon to be implemented.

- The physiotherapy used a falls assessment tool to record patient goals. For example, at Camborne and Redruth Community Hospital, patients were assessed by a physiotherapist regarding their mobility and falls risk, and together they came up with achievable goals. The assessment was reviewed by the physiotherapist and any progress was recorded.

Competent staff

- Most staff had the right qualifications, skills, knowledge and experience to do their job, however, in some areas, we were not assured staff had received training required to ensure competence with their role and staff were not provided with clinical supervision. Nurses and allied health professionals (physiotherapists and occupational therapists) belonged to their relevant professional bodies, to whom they had to provide assurances they remained clinically competent to remain registered. Nurses told us they were supported by their peers and supervisors when they were required to complete revalidation.
- Staff expressed mixed feelings regarding whether the availability of training met their learning needs. Some staff we spoke with felt training was appropriate and could be accessed when needed. They described being able to attend specific training for caring for patients with Parkinson's disease and cardiac conditions. However, others thought the training programme was delivered ineffectively as it was held at locations which made it difficult for them to attend.
- Encouragement and development opportunities were not available to all staff. Although most staff told us they had been given the opportunity to develop, there were some staff who felt their development was limited. An example of where staff had been supported to develop included the opportunity to complete an internal leadership course. We were told, the availability for the courses was currently limited to those in leadership positions and members of staff had to be nominated by the locality directors to access it.
- In some community hospitals, unregistered band two and three level staff felt they could assist with tasks if provided with the appropriate training. However, when they requested further training, they were either told it was unavailable or they were not updated on whether the training would be delivered. We were told training had been cancelled on multiple occasions and they had not been updated on when it would be rescheduled.
- Some staff had not been provided with relevant training to treat certain types of patients effectively. The community hospital alcohol detoxification service was run from Bodmin Community Hospital and Helston Community Hospital. At Helston Community Hospital, of the 17 staff who worked at the hospital, only ten had received the required training to treat patients using the service.
- The arrangements for supporting and managing staff varied across the community hospitals. Data showed the overall appraisal rate across the community inpatient service was 85%, which met the trust target of 85%. Staff at each hospital confirmed they completed the appraisal process for 2017.
- As part of the appraisal process, staff performance and competency was reviewed and discussed. Staff competency to perform their role was assessed by their supervisors and if issues were identified additional training was undertaken.
- The trust had a reflective practice and clinical supervision policy but it was not being consistently followed at the time of our inspection. The trust's policy says each operational line manager was responsible for ensuring their staff had access to and were participating in appropriate reflective practise/supervision for their role, which had to be evidenced. In addition, each professional lead was responsible for ensuring there were supervision systems and processes to meet professional governance requirements. The policy says staff received a minimum of one hour clinical supervision every four to six weeks. Both operational managers and staff confirmed practice was not in line with the policy as there was no embedded clinical supervision processes. It was confirmed staff were not

receiving a minimum of one hour of clinical supervision every four to six weeks. However, steps were being taken to introduce group clinical supervision. This involved group discussion on difficult cases, accomplishments and best practice to share learning across teams. We did not see any data showing compliance with the policy or records showing when clinical supervision had taken place.

- Systems and processes for managerial supervision varied across the community inpatient service which resulted in a lack of consistency. Managerial supervision was determined by local requirements and individual practitioner needs, which meant there was inconsistency in how staff were supervised. Staff were attending regular monthly one to one meetings with their managers at some community hospitals but at others, staff were told their line manager's door was always open and that they could discuss issues on an ad hoc basis.
- Poor and variable staff performance was identified and managed. Supervisors identified issues with staff performance using a variety of different methods, including incident reporting, appraisals and where applicable, one to ones. When issues were identified, supervisors addressed them by arranging further training, closer supervision and if appropriate, disciplinary action. Open discussions took place between supervisor and supervisee with actions plans created in partnership. We were given examples of staff being given short and long term additional support.
- The induction process within the community inpatient service was good. New nursing staff told us they had completed a two-week induction period which was detailed and made them feel confident before becoming part of the nursing rota. New registered nurses were supernumerary until confident to work as part of the rota.

Multi-disciplinary working and coordinated care pathways

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering patient care and treatment. Staff of different specialities were part of planning patients' care, and we saw evidence of this in-patient care records. We saw nursing and therapy staff working together to ensure patients achieved good outcomes.
- Daily multidisciplinary board meetings took place which were used to discuss patient care, safety issues and proposed discharges. We observed these meetings taking place and saw they involved all staff. Communication between all disciplines was clear and everyone provided input.
- Staff considered collaborative multidisciplinary team working on wards within all community hospitals was strength, and felt relationships between teams were effective.
- The progress coordinators within each locality liaised with health and social care professionals within the trust and externally to ensure the smooth and planned discharge of patients. They ensured communication and cooperation across all teams to reduce delays in patient discharge.
- Nursing staff working within community hospitals liaised with district nurses regarding care and treatment to enhance patient treatment following discharge. Both sets of staff were involved in discharge planning and communicated how treatment and care could be delivered.
- We saw effective working relationships between doctors, nurses and healthcare assistants. All felt they had positive working relationships and spoke highly of each other. We saw examples where nurses challenged doctors on certain issues which were received professionally. The opinions of all staff were considered and used to benefit patient care.
- We saw good working relationships between the local acute trust and medical staff across the stroke wards, at Camborne and Redruth Community Hospital and Bodmin Community Hospital. This enabled patients, who required review by an acute consultant/clinician, to be seen in the community hospital thereby avoiding travel to their local acute trust. There were also good links and liaison with the stroke wards at the local acute trusts to support effective patient care.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were due to move between teams or services, including referral, discharge and transition. At the point of admission, an estimated date of discharge was calculated. This was based on a patient's condition and treatment needs. The estimated date of discharge was recorded in patients' records and on an electronic system which

allowed all those responsible for patient treatment and those monitoring admissions/discharges to review and assess as required. The patient was informed of their estimated date of discharge and was updated if the date needed to be changed.

- From the point of admission, patients' needs upon discharge were assessed and actions were taken to ensure appropriate support and care was available. For example, if a patient required a place in a residential care home or required care in the community, referrals were made, and conversations took place with the appropriate services at the earliest opportunity.
- Staff on every ward in each community hospital had daily meetings to discuss patients who were ready/almost ready for discharge. If discharges were delayed, the reasons for those delays would be identified, and steps taken to speed the process up. However, staff told us the main reason why discharges were delayed was because of the lack of capacity in residential care homes and delays in arranging packages of care.
- Daily telephone conference calls took place between community hospitals, local acute hospitals and social services to determine capacity within services. Each service would share how many patients were ready for discharge and their level of capacity. As part of this process, attendees would identify the reason why patient discharges were delayed to monitor where action needed to be taken to improve performance across all services.
- When patients were discharged from a service, all relevant teams and services were informed only when ongoing care was in place. All relevant teams were aware of each other's capacity daily and knew what patients were being discharged, where they were being discharged to and what services they required.
- Staff could identify concerns early and make referrals when necessary. We saw evidence of staff identifying concerns regarding mobility and nutrition within patient care records. In each case, referrals were made to appropriate therapists.

Access to information

- All the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Nursing and medical patient care records within the community inpatient service were paper based. All risk assessments, care plans, case notes and test results completed by the ward staff were stored within locked cupboards on the ward. Staff said they did not have any difficulty accessing the information they required.
- Therapy teams including physiotherapy and occupational therapy teams used an electronic based patient records system. After completing assessments, care plans and case notes, they were printed and filed with the nursing and medical paper based records. However, the system relied on the therapists remembering to provide copies of their records to the nursing team, as only staff within the therapy teams had access to the electronic system. Some therapy staff on Lanyon Ward, at Camborne and Redruth Community Hospital, felt some information was not passed on by agency nurses. However, we did not see any data confirming this was a significant issue.
- The filing of patient care records was inconsistent across the community hospitals. We reviewed records at eight of the community hospitals and the method of ordering records was not done consistently across all of them. This presented issues for bank and agency staff as they would need to be trained on how to file records when working on wards they had not previously been on. This created safety and timing implications. If bank and agency staff were not trained on how patient care records were ordered, they could miss vital information or spend prolonged periods of time searching for documents.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- It was not clear whether all staff understood all the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We saw the trust's policy on consent which had been reviewed in September 2017 and developed in line with the Mental Capacity Act 2005, along with other relevant legislation and guidance. The policy was detailed and included a flow chart for staff to follow in the event a patient's capacity was in question. However, part of the policy required all staff to "comply with statutory requirements regarding the seeking of consent, and its documentation, using the necessary clinical record entries, and/or statutory forms." After reviewing 34 records, we saw staff had not recorded whether patients had consented to sharing information related to their care with other healthcare professionals.

Good

Are services effective?

In 17 out of 34 records the box had remained unticked and so it was not clear whether patients had consented to sharing their information. The service had not carried out any recent audits to review the service's adherence to the trust's consent policy, and we saw no reference to concerns regarding this in any of the governance meeting minutes we reviewed. It was, therefore, not possible to determine if the trust saw staff practice in relation to obtaining and recording patient consent as a risk.

- Most staff were aware of when a patient's capacity needed to be assessed, when someone lacked capacity and when it was appropriate to make best interest decisions on their behalf. In most records, we saw capacity assessments being recorded and entries which showed nurses challenged decisions on capacity when they disagreed with a doctor's assessment.
- Mental Capacity Act training was provided, but not all community hospitals had achieved the trust's compliance target. As described above, in the mandatory training section of the report, staff underwent a yearly mandatory training programme, part of which included Mental Capacity Act training. Data confirmed the training compliance, for the whole community inpatient service, between 1 April 2017 to 31 May 2017, was 92% against a target of 95%. Seven of the community hospitals had achieved 95% or above. Nine had not achieved the trust's target, with some hospital's completion rates lower than 85%. Newquay Community Hospital had achieved 100% compliance with Mental Capacity Act training. However, both Helston Community Hospital and St. Mary's Community Hospital had only achieved 83% compliance. Staff on Lamorna ward at Camborne and Redruth Hospital had only achieved a compliance rate of 82%.
- We saw inconsistency with adherence to the trust's consent and resuscitation policies across some community hospitals. For example, we saw failures to record the details of any discussions with the patient and/or relatives regarding resuscitation. The trust's treatment escalation plan (TEP) and resuscitation decision record (RDR) policy and guidelines for adults stated that these details must be contemporaneously documented on the proforma. However, we saw two examples where it had not been. It was not clear whether the views of family and carers were considered when making TEP/RDR decisions, as this was not consistently recorded in patient records or on the TEP documentation either. Stage two of the TEP form required completion if it was suspected that a patient lacked capacity. However, we saw two examples when a lack of capacity was suspected but the relevant parts of the form were not completed. We saw this had been previously been identified as an issue following the completion of recent audit.
- Staff understood the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty (DoLs). The community inpatient service submitted 96 DoLs applications to the local authority between 1 June 2016 and 31 May 2017. The trust's guidance on DoLs was contained in a policy and detailed the steps which must be taken if considering making an application to the local authority. Staff could describe the process they would follow and how they would make their decision, which was in line with policy.

Good

Are services caring?

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

Summary

We rated caring as good because:

- All levels of staff at each community hospital were compassionate, kind and sensitive to patient's needs.
- Patients, relatives and visitors were complimentary about the compassion and kindness they had been shown.
- Communication between staff and patients was clear. Patients were kept informed of their condition, progress and treatment.
- Patient's privacy and dignity was maintained throughout their treatment and most staff took all steps to protect patient confidentiality.
- Relatives and carers were kept informed of their loved one's care and were kept updated on any progress with regards to their condition.

However;

- Telephone conversations regarding patient matters could be heard when taking place at nurses' stations.
- There were occasions when patients were not assisted or checked on during mealtimes.
- When having discussions between themselves, staff would often refer to patients by their bed number.

Detailed findings

Compassionate care

- Staff understood and respected patient's personal, cultural, social and religious needs. Staff could describe how they would accommodate patients with different beliefs and provided leaflets showing the various services available for patients' needs. Patients had access to a chaplaincy service and there were multi-faith rooms at several, but not all community hospitals.
- Staff at each community hospital took the time to interact with patients and those close to them in a respectful and considerate manner. We observed many conversations between patients and staff which were often instigated by staff. On each occasion, staff addressed patients by their preferred names and showed interest in what was being discussed. Staff introduced themselves by name and told patients what their role was.
- Patients were encouraged and supported by staff. We saw staff encouraging patients to mobilise and encouraged them to integrate with other patients. For example, on Lamorna ward, the staff had encouraged patients to socialise within the day room and supported them to get there. Patients using the day room commented that they enjoyed being out of their rooms and having conversations with different people.
- Patients were assisted and supported to eat; however, on occasion some patients were left without assistance or encouragement. We saw staff supporting patients by sitting with them and cutting up their food and staying with them until they had eaten. However, we saw two instances where meals were provided to patients but were left uneaten. Patients requiring assistance were identified at safety briefings or board meetings at the start of shifts. The patients required assistance or encouragement to eat but the staff members provided the meals and left to continue serving meals to other patients.
- Patients told us they were happy with their care and treatment. We spoke with 21 patients and all had been complimentary about their treatment. They all said staff at all levels were kind and had treated them well.

Understanding and involvement of patients and those close to them

- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. We saw notices in each community hospital highlighting the availability of advocates, the process for which staff were aware of. Staff told us they would endeavour to source any additional support patients required. They were aware of how to access the translation services available to them, but we did not see any patients who required any additional support during our inspection.
- Patients could access further information and ask questions about their care and treatment. Staff were available to answer any questions about their care and responses were open and honest. Patients told us that if they had any questions they could discuss them with

the nurses or healthcare assistants. Patients could tell us why they were admitted, what treatment or rehabilitation they were undergoing and when they were likely to be discharged.

- Time was taken to involve patients in the planning and decision making about their care and treatment. Patients were asked where they would like to eat their meals, and were offered support in mobilising to their desired location. Patients were also asked what they would like to achieve when setting goals and objectives for their rehabilitation.
- We saw staff adopting caring, sensitive and understanding attitudes to patients. During our inspection a transgender patient was admitted to a community hospital. Staff were understanding of their needs and treated them with dignity and respect. Their information was kept confidential and staff ensured they were comfortable and accommodated in the ward of their chosen gender.

Emotional support

- Staff understood the impact patients' care, treatment and condition had on their wellbeing. On Lamorna ward, the dining room had been moved to an area which was closer to patient rooms. Staff had recognised patients on the ward had mobility issues, therefore action was taken to minimise the distance a patient would have to travel if they decided to eat their meals away from their beds. Staff told us the change in location had increased the number of patients using the dining room and encouraged additional mobilisation and socialising.
- Patients were empowered and supported to manage their own health, care and wellbeing to maximise their independence. Patients were asked for their thoughts and feelings regarding treatment plans and had direct input into setting their individual goals and objectives.
- There was a relative's room located on some wards at the community hospitals which provided a quiet and private space for relatives to relax, meet with their loved ones or health professionals.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- The planning and delivery of services was designed to meet patient needs.
- There are a number of community hospitals within the service which gives patients living in the county good access to community inpatient services.
- The availability of day case beds at two community hospitals offered patients the opportunity to undergo treatment closer to their homes. An alcoholic detoxification service was available to patients at three community hospitals which reduced patient travel.
- All staff were committed and working to ensure patients had access to the right care and treatment at the right time.
- Complaints within the service were low but were investigated thoroughly.
- Most of community hospitals used dementia friendly signage.

However;

- There were occasions where staff did not respond to patient needs.
- There were limited posters or displays notifying patients and/or relatives on how to make a complaint.
- Not all staff felt they had the required skills or training to care for patients living with learning difficulties.
- Not all staff were aware of how to access printed information in different languages or braille.

Detailed findings

Planning and delivering services which meet people's needs

- The community inpatient service worked with other health and social care providers to meet the needs of people in the area, particularly those with complex needs, long-term conditions or life limited conditions. Daily multidisciplinary telephone conference calls took place to share information and assess capacity within acute trusts, community hospitals, adult social care accommodation and the availability of packages of care. This enabled the service to manage patient expectations regarding discharges. It also enabled the service to manage and plan admissions and discharges with minimal delay.
- The service reflected the needs of the local population and ensured flexibility and choice. There were a wide range of community hospitals across the county, including on the Isles of Scilly. This enabled people, living across in the county, to access community inpatient services in many different locations.
- Within Bodmin Community Hospital and Helston Community Hospital, there were day case beds which gave local patients the opportunity to have treatment at a location close to their homes, instead of traveling to the nearest NHS acute trust. Patients using the day case bed could undergo treatment such as blood transfusions.
- An alcoholic detoxification service was provided by the community inpatient service which was provided at Bodmin Community Hospital and Helston Community Hospital. The service included one bed at each hospital and could be utilised by patients undergoing alcohol detoxification within the surrounding areas.
- Each hospital which had wards on more than one level had a lift so patients requiring the use of wheelchair or who had difficulty using stairs could access all required areas.

Equality and diversity

- Services were planned to take account of the needs of different people. During our inspection, a transgender patient was admitted to one of the community hospitals we visited. They were admitted in an area of their chosen sex. We were unable to find reference to whether this was in line with policy as the trust's equality policy did not contain any information regarding transgender patients. We were told the trust's equality policy was currently being refreshed and the review was being led by the trust's equality steering group. The trust confirmed they had identified a gap in their equality policy and were working to address transgender issues for their patients. However, the trust did have guidance related to the management of transgender patient's

health records. The guidance and associated forms gave transgender patients the option to advise the service on how they would like their information to be managed and shared.

- Access to the community hospitals was good. There was disabled parking available at all sites. All sites we visited were accessible to people who used a wheelchair or other mobility aids.
- Staff had equality and diversity training during induction which then had to be updated every three years. Equality and diversity training was part of the trust's mandatory training programme and was included in their two essential learning packages. Compliance with these training packages across the service was 91% and 92%, against a trust target of 95%.
- Arrangements were in place to access translation services. The community inpatient service had access to a telephone based interpretation service. Staff were aware of how to access interpreters but none of the staff had used it recently.
- All leaflets within community inpatient services were printed in English. Not all staff were aware if leaflets could be printed in other languages or braille. Staff told us they did not encounter many patients who did not speak English. We reviewed the trust's equality policy and it is unclear as to how patients could access printed information in different languages or braille. However, one member of staff told us they would contact the patient advice and liaison service if they needed to access information in different languages.

Meeting the needs of people in vulnerable circumstances

- Services within the community hospitals were planned to take account of the needs of different people, including those living with dementia. The trust had recently appointed a specialist dementia nurse consultant who worked alongside the dementia liaison service. This appointment was made in response to the organisational safeguarding action plan detailed in the safeguarding section of the report. The role was to work across all areas of the trust and provide clinical advice, guidance and support to the community hospitals. Staff knew the appointment had been made and felt confident in being able to access additional guidance and support when required. The role was newly implemented so the impact had not yet been felt within the service.
- Most community hospitals we visited had recently appointed link nurses and healthcare assistants with an interest in dementia care. Almost all the sites we visited had dementia friendly signage which aided patients in locating different areas of the hospital. We saw pictures being used on doors to show where facilities were, for example, toilets and showers. Clocks were located throughout patient areas which were large and clear to read and showed the day and date. At Falmouth Community Hospital there was a reminiscence area in the dayroom.
- Dementia awareness training had been introduced as part of the organisational safeguarding action plan. We were not provided with data confirming the exact compliance rate but most staff we spoke to told us they had completed the training. However, therapy staff at Newquay Community Staff had not completed the training.
- However, there was a lack of planning in services to take account of the needs of patients with a learning disability. Staff had not received any additional training in how to care for patients with a learning disability, and there were no aids or tools to help with communication. Staff at Camborne and Redruth Community Hospital told us of a patient with a learning disability who had been admitted on to their ward. The patient had complex needs but they felt unable to provide the care required as they did not have the skills or training to do so. Staff said referrals had been made to the trust's learning disability service for advice, guidance and support but this was not provided promptly. Staff were unaware if this matter was being addressed to improve the team working across the services. Staff felt more support should have been given but it was not forthcoming.
- Most facilities and premises were appropriate for the services that were planned and delivered. All premises had wide corridors and doors which made it easy for patients with mobility problems to move around the wards. However, some of the community hospitals we visited were not well suited for caring for patients with dementia. There were areas on the some of the wards which made line of sight difficult so nurses could not always see patients who required additional assistance with mobilisation or at risk of a fall.
- Activities were available on the ward which were age appropriate. These included colouring books and crayons, dominos and bingo. We saw staff spending

time talking to patients and helping them with activities. At Stratton Community Hospital we saw a patient living with dementia, being joined by a member of staff to help complete a jigsaw and later we saw staff looking at a reminiscence book and discussing the content with the patient.

Access to the right care at the right time

- Access to community hospitals was not always available. Data provided by the trust showed that bed occupancy levels for each community hospital, between 1 April 2016 and 31 March 2017, was consistently over 85%. There were four occasions when bed occupancy reached 100% at Fowey Community Hospital (August 2016), Lamorna Ward (July 2016), Lanyon ward (November 2016) and the Woodfield Stroke Unit (February 2017).
- Delayed discharges from the service were high. The trust provided information on numbers of delayed discharges across all community hospitals, between 1 June 2016 and 31 May 2017. There were 1,325 delayed discharges across the whole service over that period, which amounted to 31% of all discharges. The ward with the highest proportion of delayed discharges was Edward Hain, which reported 79% of all discharges being delayed. Although delayed discharges were high, the main causes were out of the service's control and the service was making effort to ensure improvements were made where possible. The trust had a target, set by NHS England of, of having a maximum of 23 delayed discharges per month. In August 2017, the trust had 53 delayed discharges. However, this was a significant improvement on the month before during which there were 84, and August 2016 where there had been 72.
- The average length of stay during the period between 1 April 2016 to 31 March 2017 and across all community hospitals, ranged between 1 and 54 days across all wards. Length of stay was monitored by the matrons at each community hospital. The high bed occupancy levels and increased length of stay meant some patients requiring admission to a community hospital would have been unable to access care at the right time. In August 2017, the average length of stay across all community hospitals was 23.1 days. The hospital with the lowest average length of stay between the months of April to August 2017 was Liskeard Community Hospital with 18.1 days. The hospital with the highest average length of stay over the same period was Helston Community Hospital with 34.8 days.
- Matrons and locality directors told us the main reason for increased length of stay and high bed occupancy was due to the lack of adult social care beds, and delay in accessing packages of care through social services. Within each locality, head of flow managers had been employed to improve access and flow into and out of the service. A measure introduced to address access and flow involved flow managers and matrons dialling into daily telephone conference calls with local acute trusts, social services and councils. The purpose of the telephone call was to identify the numbers of patients ready for discharge and the admission capacity within each service. Matrons and ward managers told us they thought the process had improved flow into the service; however, we did not see any data confirming this. We listened in on conference calls and saw all parties involved were committed to reducing delayed discharges and admissions and supporting each other.
- There were clear admission criteria for patients within the community inpatient service which was followed. The criteria set out that treatment was provided to patients who required medical, nursing and therapeutic input, and had received an acute hospital or GP review and required a period of multidisciplinary focused intervention. The community inpatient service also had clear discharge criteria which was appropriately applied to assess when a patient should be discharged which all staff adhered to.
- Patients could access physiotherapy and occupational treatment Monday to Friday, 9am to 5pm, at all community hospitals but therapy services were limited or not available at weekends. Staff could access occupational therapy and physiotherapy during the week and we saw the services at most community hospitals were good. However, staffing levels, at the time of our inspection, on Harbour ward at Bodmin Community Hospital were low and so the service offered to patients was limited. To address this, therapists working on the stroke unit and Anchor ward at the hospital would provide a limited service to patients on Harbour ward. Physiotherapy and occupational treatment plans were in place for patients and so, when appropriate, nurses could assist patients with their treatment when specialist services were unavailable.

Good

Are services responsive to people's needs?

- The community inpatient service had piloted a seven day physiotherapy service at Camborne and Redruth Community Hospital but there was no funding to extend services on a permanent basis.

Learning from complaints and concerns

- Some of the patients we spoke with said they did not always know how to make a complaint but were aware how to raise concerns. Patients told us they would speak to the nurses or healthcare assistants taking care of them, if they encountered a problem. Senior staff told us they encouraged staff to address patient concerns when raised. There were leaflets available for patients detailing the complaints procedure and contact details for the patient and advocacy liaison service (PALS). However, there were limited posters detailing the complaint process on wards and patients were unable to tell us if they had seen any. Patients were unable to tell us how they would make a complaint as they had not seen any guidance within the hospital.
- The number of complaints received by the community inpatient service was low. The service had received 17 complaints between 1 June 2016 and 31 May 2017. Of those complaints, one was fully upheld, eight were partially upheld, five were not upheld and three were still under investigation at the time of our inspection. The most common theme was related to patients' clinical treatment.
- We reviewed the complaints process which was clear, simple and easy to follow. As well as having leaflets, information on how to make a complaint was available on the trust's website.
- Complaints were handled effectively and confidentially, with complainants being updated regularly. We reviewed complaint documentation and could see complaints were investigated thoroughly and shared appropriately with those involved and those investigating it. The average time it took to investigate a complaint was 110 days. However, complainants were kept updated on the development of their complaint.
- The outcome of a complaint was explained appropriately to the complainant. Upon review of the complaint documentation, we saw clear explanations given as to how outcomes had been reached and detailed information on what lessons were learnt.
- Lessons were learned from concerns and complaints and where appropriate, actions taken to improve the quality of care. Lessons learned from complaints were shared at ward meetings and with individuals when appropriate to do so.

Requires improvement

Are services well-led?

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

Summary

We rated well led as requires improvement because:

- Senior leadership visibility was inconsistent across the community inpatient service.
- Not all significant risks within the service had been recorded on the trust's risk register and action was not always taken to mitigate them in a timely manner.
- Important information regarding changes to services at community hospitals was not always communicated to staff by the senior management team.
- Decisions were taken by the senior management team without engaging the staff affected.
- Staff did not know what the vision, strategy and specific values of the community inpatient service were.

However;

- Staff felt local leadership within the community hospitals was good as leaders were approachable, supportive and visible.
- The service had clear governance structures which allowed issues to be discussed in a variety of different forums.
- The culture within the community hospitals promoted safe care and treatment.
- Morale on most wards was positive and staff were happy in their roles.
- Most staff were confident that their managers and supervisors would address any concerns they raised.

Detailed findings

Leadership of this service

- Leaders had the skills, knowledge, experience and integrity required at the time of appointment and on an ongoing basis. We spoke with most of the matrons responsible for the management of the community hospitals, and all had experience in managing inpatient wards. Those we spoke to had the knowledge and skills to ensure the hospitals provided a service which was safe for patients. However, there was some who felt information and actions from the senior management team were not being communicated promptly, which led to uncertainty.
- The service was committed to ensuring leaders had the required skills. The trust had made internal leadership courses available to appropriate staff. Most ward managers and matrons had either completed or were enrolled on the internal leadership course.
- Most leaders had the capacity to lead effectively. Matrons and ward managers were positive about their capacity to perform their leadership roles effectively. However, there were some who felt they required further assistance in managing their responsibility. For example, to assist with safety and capacity issues, the trust decreased beds in some of the community hospitals to enable roles to be performed efficiently, and to ensure the safety of patients and staff.
- Most staff felt local leaders within the community inpatient service were visible, approachable and supportive. Staff were complimentary about the matrons and ward managers within the community hospitals we visited. However, some said that the senior management team had only just started visiting them or did not visit enough. Staff felt there was limited senior management team presence and visibility at St Mary's Hospital, on the Isles of Scilly. As a result, they said they felt like they had been forgotten.
- Local leaders encouraged appreciative and supportive relationships among staff. The locality directors oversaw community hospitals and the integrated care managers oversaw the community health teams. As both services were all managed by the same individual, it allowed oversight of the problems faced by both and promoted cooperation between them which benefitted patient care.

Service vision and strategy

- There was a trust vision and set of values with quality and safety a top priority, however, there was no specific vision for the community inpatient service. Although the vision and strategy had been created in partnership with staff, not all staff were unaware of what the vision for the trust was and did not know how the service was going to be delivered in the future. Some staff were concerned about the recent hospital closures and did not know if or when they were going to be reopened.

Requires improvement

Are services well-led?

- The values of the trust were achieving high standards, respecting individuals, empowering people and compassionate services. Staff were unable to tell us exactly what the values of the trust were, but did say they involved putting the patient first. The values of the trust had been displayed around each of the community hospitals we visited.
- Workshops, centred on the trust's vision and strategy had been delivered, which many staff had attended. Staff told us the workshops had taken place but could not recall specific details on how the vision and strategy related to the service.

Governance, risk management and quality measurement

- There were effective governance frameworks to support the delivery of strategy and good care. We saw evidence of governance meetings taking place, at which risk and quality were discussed.
- Within the community inpatient service, there were three locality directors who oversaw the community hospitals in the north east, central and west parts of Cornwall. Each was responsible for disseminating information to the matrons, integrated care managers and business support supervisors at quality assurance meetings each month. Each locality held quality assurance meetings. The meetings followed a set agenda and minutes were taken. The areas of discussion included but were not limited to risks, incidents, safeguarding, infections and complaints. We saw minutes of these meetings and saw they varied in detail across localities. Attendees discussed specific incidents which had occurred at community hospitals and any associated learning.
- Following quality assurance meetings, matron meetings were held once a month, at which information shared at the quality assurance meetings was discussed. This allowed information to be shared horizontally between matrons operating at the same level and promoted dissemination of good practice and issues within all community hospitals. We reviewed three sets of matron meeting minutes and two of the three were detailed. For example, we saw detailed discussion regarding performance, recruitment, complaints, incidents and safeguarding. The minutes showed what actions had been taken to address areas of concern. The matrons also had an agenda item to discuss what was going well, what was not going so well and things matrons needed help with, for each hospital.
- At each community hospital, there were different systems of governance for disseminating information from the matrons to ward managers and all other staff. At some community hospitals there were weekly meetings between matrons and ward managers, whereas at others, there were monthly ones. Following either monthly or weekly meetings, the ward managers would hold monthly nursing and health care assistant meetings where information discussed at the various meetings described above would be shared.
- As part of the governance process, as described in the safety performance section of the report above, performance reports were prepared every month. The reports outlined the performance across adult community service within each locality. The reports were reviewed and shared by the locality directors. Areas requiring improvement were discussed and actions implemented appropriately. We saw the performance report for August 2017 and could see incidents, complaints, safeguarding, audit results, safety thermometer data, risk and patient feedback were included.
- There were arrangements for identifying, recording and managing risks, issues and mitigating actions. However, identified risks were not always contained on the risk register. Matrons told us, each community hospital recorded their risks on one of the three locality risk registers which fed into the trust risk register. As described above, risk was discussed at all governance meetings.
- We reviewed the trust's risk register and found many of the risks discussed by management and staff were present. Each risk had a severity rating but not all had actions taken to mitigate risks. For example, the lack of portable suction equipment in all clinical areas had been identified as a risk in April 2016. However, there was no record of actions being taken to reduce the risk to patients or whether any progress had been made.
- All management staff believed the biggest risk to the service was staffing levels and difficulty recruiting, which was discussed in detail above in the staffing section of the report. However, there were significant risks which

had been identified by staff at community hospitals which were not present on the register and immediate actions were not always implemented to address potential risk.

- We saw no reference to the closures of St. Barnabas Community Hospital or Edward Hain Community Hospital on the trust's risk register. It was unclear whether their closures were risk or impact assessed and whether any actions had been taken to mitigate any risk or impact before the decision was taken to close the hospitals. However, we saw the closure of Fowey Community Hospital on the risk register.
- There was no reference to the low registered nurse staffing levels during night shifts at St. Austell Community Hospital. This had been identified and escalated by staff at the hospital as low levels of staff meant the nurse to patient ratio was regularly 1:22. We saw no evidence this matter had been risk assessed or mitigated. However, we saw the specific risk of low nurse staffing at Bodmin Community Hospital recorded on the trust's risk register.
- Staff at St Mary's Community Hospital had been without a dishwasher for eight weeks due to break down. Staff felt the issue was not being dealt with in a timely way and there was no clear plan for addressing the problem. The dishwasher was used to clean dishes used by patients, so staff had to clean dishes by hand. Staff at the hospital felt this was a risk in terms of infection prevention and control and had escalated the issue. However, we did not see the lack of a dishwasher at the hospital on the trust's risk register or an action plan to address the issue.
- The trust's risk register outlined the lack of pharmacist and pharmacy technician input at some community hospitals as a risk to the service. Hospitals, with no pharmacy cover, were not highlighted which made it difficult to see which hospitals had been impacted. Actions had been outlined to address the issue but they were long term solutions including recruitment of additional pharmacy staff. There was no mitigation to reduce the immediate risk of prescribing errors. We saw evidence that a risk assessment was carried out in April 2016 regarding the lack of pharmacy support across the service. However, we saw no evidence a risk assessment had been carried out regarding the withdrawal of pharmacy support at Bodmin Community Hospital. There was no reference on the trust's risk register to the potential risk or impact the withdrawal of the service would have on the hospital, staff or patients.

Culture within this service

- Most staff felt respected and valued. Most staff told us they enjoyed working within the community inpatient service and thought their supervisors were appreciative of the work they carried out. However, there was a small group who felt that their potential was not being fully utilised. Some staff felt they could contribute more if given the opportunity, but were being prohibited by the lack of development opportunities.
- The culture of the service was centred on the needs and experience of patients. Service leads identified the culture among staff as an issue following the increase in safeguarding alerts. Part of the organisational safeguarding action plan was to introduce a care charter to highlight the expectations of staff and the standards of care expected. Although all the aims of the charter had not been fully achieved at the time of our inspection, staff felt the culture within the service had improved and gone back to basics with staff being fully focussed on patient care and safety.
- Action was taken to address behaviour and performance inconsistent with the vision and values, for example, following the increase in safeguarding alerts related to the conduct and practice of staff at some community hospitals. As a result, investigations took place and if conduct was found to be poor or inappropriate, staff faced disciplinary action. Data provided by the trust showed that between 1 June 2016 and 19 June 2017, there were 16 cases where staff had been either suspended or placed under supervision. Of those 16 members of staff, 15 were suspended and one was placed under supervised practice.
- There was a culture which promoted openness and honesty. Leaders within each community hospital encouraged staff to be open and honest with patients when things went wrong. Staff told us they felt comfortable approaching colleagues, supervisors and managers if something had gone wrong and were supported in dealing with issues. As part of the organisational safeguarding action plan the service was actively encouraging scrutiny of staff conduct and performance. This took the form of dignity in care unannounced visits to wards, which were undertaken by

lay people and managed by the clinical commissioning group. There were also monthly visits of wards, undertaken by non-ward based colleagues focussing on patient experience. Feedback from patients and visitors was collected and fed into matron and ward manager meetings.

Public engagement

- People's views and experiences were gathered and acted on to shape and improve the service. Most staff within the community hospitals commented on their League of Friends and fundraising communities which had helped to improve the service they were able to provide. For example, through fundraising, a second end of life inpatient room had been opened on Anchor Ward at Bodmin Community Hospital.
- People who used services and those close to them were actively engaged and involved in decision making. As part of the recruitment days, when interviewing new nurses and healthcare assistants, patients were invited to become members of the panel. Many patients had been involved in the process and their feedback was used when deciding on which candidates to recruit.
- The service sought out and acted on feedback from people who use services. The trust was engaged with the friends and family test (FFT) and results were displayed for patients and visitors to see. We saw notices advertising the need for responses and staff encouraged people to participate. We also saw friends and family results for August 2017 which showed at six of the community inpatient hospitals, 100% of patients would recommend the service. The hospital with the lowest result was Falmouth Community Hospital with 90.9%.
- The service also collected more detailed feedback using patient experience questionnaires on each ward. Examples of questions patients were asked included, but were not limited to, the quality and amount of the food served, cleanliness of the ward and rooms, staff hand hygiene, call bell response times, privacy, treatment from staff, pain, approachability of staff, the feedback was processed and recorded and discussed at quality assurance meetings, matron meetings and ward meetings. We saw results for Harbour Ward at Bodmin Community Hospital which were detailed and clearly showed if patients had a positive or negative experience. The results showed all patients felt they had enough food and drink, their pain was well managed and they had enough privacy. However, 12.5% of patients did not like the food and thought they were not always given enough time to eat and drink. We did not see what actions were being taken to address patient concerns.
- Feedback from patients and their representatives was sought by holding carers forums throughout the year in varying locations. We saw a notification of these events in the relatives' room at Stratton Community Hospital together with information on the purpose of the forum.

Staff engagement

- There was limited evidence to show staff views were gathered and acted on to shape and improve services at a trust level. Ward staff, affected by changes, told us they had not been consulted on a number of issues before decisions were made about how services were run at the community hospitals they worked in. There were multiple examples where information had not filtered through from the executive team to staff on the ward. There had also been little to no engagement with staff before or after decisions were taken by the senior management team. Staff felt they had not been kept updated and did not feel their views had been sought. For example:
- Staff had not been told when or why pharmacist and pharmacy technician staff had stopped providing a service to some community hospitals, specifically at Bodmin Community Hospital. The decision was made by the senior management team and neither the matron or ward managers had been involved in the process. The effect of this was registered nurses or trained healthcare assistants had to take on the work previously carried out by the pharmacist/pharmacy technician. This impacted on their capacity to perform their other roles.
- Neither local management nor ward staff knew when Camborne and Redruth Community Hospital was going to return to its original management structure. The plan had not been effectively communicated and the process of formulating the plan did not take the views of all those involved into account.
- Staff at St Mary's Community Hospital had been given conflicting and unclear information about when they would be receiving a new dishwasher. The hospital had been without one for eight weeks and staff were told

they would be receiving a new one. However they had also been told they would be receiving the dishwasher currently located at Edward Hain Hospital. The situation had not been resolved at the time of our inspection.

- Ward staff told us they did not know when or if St. Barnabas Community Hospital, Fowey Community Hospital and Edward Hain Community Hospital would be reopened. Staff were directly affected by this as some had been transferred from those hospitals to those which had remained open. In addition to this, if all or some of the hospitals reopened, staff were unaware if they were going to be transferred back. If staff were to be transferred back, no one knew if beds would be reduced or if additional staff would be recruited to account for those who would be returning to the previously closed hospitals. We were provided with conflicting evidence from the senior management team who told us individual meetings had taken place with managers, human resources and each member of affected staff. We were also told staff were aware the closures of the hospitals were continuing on a temporary basis and were kept informed of this through regular meetings and briefings from senior managers.
- Staff at service level were kept informed of some matters related to the trust. Staff received some information through ward meetings, e-newsletters and online bulletins. Staff said that the information provided was good but they did not always have time to read all the information emailed out to them.
- The community inpatient service had recently implemented an online staff survey which was used to collect feedback on the culture within community hospitals. The survey was implemented as part of the organisational wide safeguarding action plan. Those who compiled the results of the survey felt the culture within the community hospitals had improved.

Innovation, improvement and sustainability

- The Age UK day centre manager attended the multidisciplinary team meeting once a week at Falmouth Community Hospital to offer day centre option for patient care after hospital. In August 2017 four patients had been offered places but the scheme had not yet impacted length of stay.
- The community inpatient service had implemented new ways of recruiting new staff. They had started to hold recruitment days on weekends to encourage more applicants. As part of the process group interviews and practical based tasks were used to identify the most suitable and competent candidates.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part.** The provider was unable to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons across the whole service. The staffing numbers within the community hospitals were inconsistent and there were hospitals which could not always provide safe staffing levels. We reviewed data which demonstrated a high number of registered nursing and healthcare assistant shifts were consistently filled using agency and bank staff or left unfilled. In total, 19.5% of all registered nursing shifts and 19.9% of all heath care assistant shifts, across all community hospitals were left unfilled or filled by bank and agency staff. The community hospital with the most unfilled registered nursing shifts was Stratton Community Hospital with 8.7%. The community hospital with the most unfilled healthcare assistant shifts was Liskeard Community Hospital with 12.5%. The registered nurse staffing levels on Harold White ward at St. Austell Hospital during night shifts were unsafe, regularly leaving one nurse looking after 22 patients. Data shows, between January 2017 and September 2017, registered nurse staffing levels had been lower than 80% on six out of nine months. There were months were filled registered nursing shifts were as lower than 55%. Regulation 18 (2) (a)

This section is primarily information for the provider

Requirement notices

The provider was not providing appropriate support, training, professional development, supervision and appraisal to staff as is necessary to enable them to carry out the duties they are employed to perform.

There was no embedded system of clinical supervision for relevant staff. Supervision, both managerial and clinical, was inconsistent across the community inpatient service.

Not all staff had been provided with specialist training to treat patients admitted to the community health alcohol detoxification service. Only ten out of 17 patients had completed training at Helston Community Hospital.

Regulated activity	Regulation
Nursing care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 2 (b) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The provider's system for recording risk did not always identify current risks and measures were not always taken to reduce or remove risks within a timescale that reflects the level of risk and impact. It did not appear risks were always escalated within the organisation and there were times when risks did not appear to be continually monitored.

We saw risks had not been included on the trust's risk register and measures had not been taken to address immediate risks. For example, the risks associated with two hospital closures and a broken dishwasher were absent from the provider's risk register. The trust had failed to implement measures to reduce the risk of prescribing errors and infection prevention and control risks to patient safety.

This section is primarily information for the provider

Requirement notices

Regulation 17 (2) (e) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services.

The provider did not always actively seek the views of staff about their experience of, and the quality of care and treatment delivered by the service.

There was an ineffective system of seeking feedback or consultation from staff at ward level on service delivery. There was a breakdown in the flow of information from senior level staff to those on the ward. For example:

- At Bodmin Community Hospital the pharmacy cover, provided by a pharmacy technician had been withdrawn by the trust. Staff had not been asked to consult on what the impact of withdrawing the service would be and the communication of the decision to withdraw the support was delayed.
- At Camborne and Redruth Community Hospital the management of the two wards was split between two matrons due to previous safeguarding concerns. Neither matron nor staff on either ward had been updated on when the situation would return to the original structure.
- Staff employed at Edward Hain, Fowey and St. Barnabaus Community Hospitals, but transferred to other community hospitals, were unaware whether the hospitals would be re-opened.
- Staff at St Mary's Community Hospital had been given conflicting and unclear information about when they would be receiving a new dishwasher. They had been told they would be receiving a new one, but also told they would be receiving the dishwasher currently located at Edward Hain Hospital. The situation had not been resolved at the time of our inspection.