

The Rotherham NHS Foundation Trust

RFR

# Community health inpatient services

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RFR30	Breathing Space	Unit	S65 2QL
RFRPA	Rotherham General Hospital	Unit	S60 2UD




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

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

The Rotherham NHS Foundation Trust provides community in-patient services in two locations; Oakwood Community Unit and BreathingSpace. These were two very different units in the way they were run and managed.

Incident reporting was used routinely and lessons were learned from the incidents raised. The knowledge of duty of candour and staff receiving safeguarding training varied between the units. Staffing levels in the Oakwood Community Unit were acceptable; when necessary flexible or agency nursing staff were used although further medical support was required at times. Storage of confidential waste in the Oakwood Community Unit was not always appropriate. There are no national guidelines for community inpatient nurse staffing levels. There was a system in place for staff to escalate any concerns about patients dependency and staffing levels.

Policies and procedures had been developed in line with national guidance and care pathways were in place for patients with specific diseases. Outcomes for patients at BreathingSpace compared very well with other services provided nationally.

Assessments for social care and continuing healthcare were sometimes delayed and there was a lack of consistency in how people's mental capacity to make decisions was assessed. Although training had not been a high priority in the recent past in the Oakwood Community Unit, plans were in place to address this. All permanent staff in BreathingSpace were highly skilled and knowledgeable.

Staff treated patients with compassion, dignity and respect. Patients told us they felt emotionally supported by the staff. Staff communicated very well with patients and their relatives and supported them to be as independent as possible. Patients felt informed about their discharge arrangements. The care provided at BreathingSpace was exceptionally good and nursing staff were very knowledgeable about the care they were providing.

BreathingSpace was a specialist unit for patients experiencing an acute phase of a chronic respiratory illness. Both services acknowledged patients different needs although patients could become socially isolated. Access to specialist packaging for patient's medication to take home could cause delays. Patients' concerns and complaints were dealt with at unit level by a senior member of staff and discussed at unit meetings.

Community inpatient staff varied in their vision of the future direction of the units they worked in. Whilst the majority of staff in the Oakwood Community Unit knew of the changes to the service, in BreathingSpace senior staff were concerned about the unit's future despite it being very successful and held in high esteem by the patients it served. Staff felt able to raise issues with managers, if required. Senior managers from the trust visited the units on occasions. Staff felt well supported by their line managers and were proud of the service they worked in.

# Summary of findings

## Background to the service

The Rotherham NHS Foundation Trust provides community in-patient services in two locations.

The Oakwood Community Unit was situated in the grounds of the acute hospital and was currently funded to provide up to 20 step up/step down beds as an alternative to admission to, or timely discharge from, the acute hospital. A set of admission criteria was in place to facilitate appropriate placements. People could be referred by GP's, district nurses and the acute hospital. The trust's web site advertised the unit as providing care and rehabilitation for patients diagnosed with a neurological illness. At the time of our inspection this was in transition.

Care was delivered by nurses and support staff with allied health professionals providing therapy as and when it was required.

BreathingSpace was a unique nurse-led service that provided care for people with chronic lung disease including treatment with non-invasive ventilation (NIV). Patients could refer themselves to the service if they were already known to BreathingSpace. Other referrers could include GP's, community matron, ambulance service and the acute hospital.

Care was delivered by highly skilled specialist nurses, therapy and support staff. All patients were nursed in individual rooms.

During the inspection, we spoke with 31 staff, including nurses, medical, therapy and domestic staff. We also spoke with 21 patients and 3 relatives. We observed interactions between patients and staff and we reviewed 12 sets of care records and medication charts.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Jane Barrett, Chair Thames Valley Clinical Senate

**Head of Hospital Inspections:** Carolyn Jenkinson, Head of Hospital Inspection, Care Quality Commission

The team included two CQC inspection managers, 12 CQC inspectors and a variety of specialists including: consultant surgeon, consultant in respiratory medicine, a consultant paediatrician, consultant intensivist, a GP, a

student nurse, two midwives, two executive director nurses, a governance expert, an occupational therapist, a speech and language therapist, a matron, two community adult specialist nurses, one health visitor, one school nurse, a physiotherapist, a head of children's nursing and a dentist. We were also supported by two experts by experience who had personal experience of using or caring for someone who used the type of services we were inspecting.

## How we carried out this inspection

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

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

- Is it well led?

Before our inspection we reviewed a wide range of information about The Rotherham Hospital NHS Foundation Trust and asked other organisations to share the information they held. We sought the views of the Clinical Commissioning Group (CCG), NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

# Summary of findings

We held a listening event in Rotherham on 17 February 2015 where members of the public shared their views and experiences of the trust. Some people also shared their experiences of the trust with us by email and telephone.

The announced inspection took place between 23-27 February 2015. We held focus groups with a range of staff, including nurses, medical staff, administrative and clerical staff, and allied health professionals. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas, outpatient's services as well as in the community services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 7 March 2015 at Rotherham Hospital. The purpose of our unannounced inspection was to look at the children's ward and the medical assessment unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment delivered by the trust.

## What people who use the provider say

We spoke with over 40 people who attended our listening event. Some people were very positive about the care they had received at the trust. Other people were less positive about their care.

The NHS Family and Friends (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care.

The trusts performance in all of the NHS Friends and Family tests in January 2015 was largely positive.

- The trust scored higher than the England average of 96% for the inpatient FFT, with 98% of patients recommending the inpatient services provided by the trust. a total of 361 patients responded to this question.
- The trust scored slightly lower (worse) than the England average of 87% for the A&E FFT, with 73% of patients recommending the service. A total of 997 patients responded to this question.
- The trust scored higher (better) than the England average of 96% for the antenatal question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the birth question in the maternity NHS FFT, with 99% of women recommending this service.

- The trust scored higher (better) than the England average of 93% for the post natal ward question in the maternity NHS FFT, with 100% of women recommending this service.
- The trust scored higher (better) than the England average of 97% for the post natal care in the community question in the maternity NHS FFT, with 100% of women recommending this service.

From April 2014, the staff NHS Friends and Family Test (SFFT) was introduced to allow staff feedback on NHS services based on recent experiences to be captured. Staff were asked to respond to two questions. The "care" question asks how likely staff are to recommend the NHS service they work in to friends and family. The "work" question, asks how likely staff would be to recommend the NHS service they work in as a place to work.

The trusts scores in this test were lower (worse) than the England average. Fifty seven per-cent of staff would recommend the trust for care and 43% would recommend as a place to work. The England averages were 77% for the care question and 61% for the work question.

The trust had a total of 29 reviews during 2013-14 on the NHS Choices web site. Fifty nine per cent of these were positive and 41% negative. On the Patient Opinion website there were 133 reviews, of which 70% were positive and 30% negative. In February 2015, the Patient

# Summary of findings

Choices website gave the trust an overall rating of 3.5 stars out of a possible five which meant patients had rated this hospital as they would be “likely to recommend” it.

The CQC Adult Inpatient Survey was carried out between September 2013 and January 2014. A total of 367 patients responded to the survey. The overall score for the trust was about the same as other trusts. There were ten areas of questioning in this survey and nine out of the ten areas were about the same as other trusts, but the questions relating to the hospital and wards scored worse than other hospitals. This was due to the response to the questions relating to food quality, food choice and single sex accommodation.

In the Survey of Women’s Experience of Maternity Care (CQC 2013), the trust performed about the same as other trusts in all of the four areas. The survey asked women a number of questions relating to their labour and birth, the staff who cared for them and the care they received in hospital following the birth.

The National Cancer Patient Experience Survey 2012/2013 was designed to monitor national process on cancer care. The trust was performing within the top 20% of trusts for 16 of the 34 areas, the middle 60% of trusts for 13 areas and in the bottom 20% of trusts for five areas. The areas where it was performing well better were:

- Patients not been given conflicting information
- Privacy when discussing condition/treatment
- Being able to discuss fear
- Treated with respect and dignity
- Given clear information
- Feeling they were given enough care
- Health got better or remained about the same while waiting for treatment

- Seen as soon as necessary
- Given a choice about the types of treatment
- Given the name of the nurse in charge of their care, given information of who to contact post discharge
- GP was given enough information
- Had confidence in the doctors treating them
- Did not feel doctors talked in front of them as if they were not there
- Had confidence in ward nurses
- Saw GP once or twice before being told they had to go to hospital.

The areas they scored in the bottom 20% were:

- Hospital staff told patient they could get free prescriptions
- All staff asked patient what name they preferred to be called
- Staff definitely did everything to control side effects of chemotherapy
- Hospital staff gave information about support groups
- Staff gave complete explanation of what would be done.

The patient-led assessment of the care environment (PLACE) programme are self-assessments undertaken by teams of NHS and private/independent healthcare providers and include at least 50% members of the public. They focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The outcomes of the patient led assessments of the care environment for 2014 showed that the trust was rated worse than the England average for all areas.

## Good practice

BreathingSpace provided exemplary care to the patients it cared for due to the highly skilled and knowledgeable staff working on the unit. Staff were caring and

compassionate and continued their caring role by supporting families after the loss of a loved one. It was an example of an innovative community service that met the needs of the population very well.



# Summary of findings

## Areas for improvement

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

#### **Action the provider MUST take to improve:**

- The provider must ensure there are sufficient medical and nursing staffing levels in place to meet patient's needs at all times.
- The provider must ensure that mental capacity assessments are made in accordance with the Act.

#### **Action the provider SHOULD take to improve:**

- The provider should review the care being provided in the Oakwood Community Unit so that patients have the opportunity to engage in social activities as well as promoting their independence.
- The provider should review the reasons for staff working in the community in-patient areas feeling isolated and distanced from the senior leaders in the trust.
- The provider should review the delay in discharges caused by lack of access to prompt assessments for receiving social care and continuing healthcare and lack of availability of specialist packaging for medicines.

# The Rotherham NHS Foundation Trust

# Community health inpatient services

## Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires improvement 

## Are community health inpatient services safe?

By safe, we mean that people are protected from abuse

The safety of the service required improvement.

Nurse staffing levels in BreathingSpace were in need of review. This had been highlighted as a risk in 2013 on the risk register.

Incident reporting was used routinely and lessons were learned from the incidents raised. Suitable arrangements were in place to minimise risks to patients including pressure ulcers, falls and malnutrition. There was good use of safety quality dashboards to monitor performance in key areas of patient safety.

### Incident reporting, learning and improvement.

- The trust had been focused on increasing the number of incidents reported across all areas and staff knew what and how to report. Four staff we spoke with had used the system for reporting issues related to patient safety, for example low staffing levels for the provision of their services and patient falls.
- Staff informed us they received feedback from incidents and this was disseminated to other members of their team during team meetings, lessons learned were identified. We saw examples of team meetings where this happened.
- A safety 'dashboard' was on display in both units. This meant patients and their relatives could see how the units were performing in relation to patient safety. The data included, for example, the number of patients who had acquired pressure ulcers during their stay and the number of patients who had an assessment of the risk of acquiring a venous thromboembolism (VTE). A VTE is a blood clot that can form in the veins and can cause harm to patients. On the Oakwood Community Unit we saw some of the scores had fluctuated considerably. For example the risk assessment for acquiring a VTE had been 58.3% in May 2014 but had risen to 100% in October 2014 which meant all patients had their risk assessed. In BreathingSpace the scores had been consistently high across the same time period, for

example the assessment of acquiring a venous thromboembolism had been 100% between September and December 2014; in January 2015 the score had been 94.4%.

### **Duty of Candour**

- Staff we spoke with were confident about reporting incidents and were aware they needed to be open and transparent with patients and their relatives if anything went wrong with their care. Staff were aware they needed to inform relatives of any incidents that had occurred.
- In BreathingSpace we spoke with a senior member of staff who informed us of an incident where a complaint had been made about a patient's care. They had met with relatives and discussed the issues with them.
- The nurse in charge on the Oakwood Community Unit told us staff had not received any training on their responsibilities under duty of candour although the incident reporting system allowed for comments under the duty of candour.

### **Safeguarding**

- We were informed staff received training in protecting vulnerable adults and children as part of the mandatory training programme and this was updated on a regular basis. A member of staff in the Oakwood Community Unit told us they hadn't received safeguarding adult training for five years and had not received safeguarding children training at all. At BreathingSpace we saw all members of staff had either undertaken the training or were booked onto a course within the next six months..
- Staff we spoke with demonstrated an understanding of safeguarding their patients and were able to describe the steps they would take if they had concerns or suspected abuse. However on the Oakwood Community Unit one member of staff was unsure of when they should raise a concern with their safeguarding lead or the local social services safeguarding team.
- Contact telephone numbers to report concerns was displayed in the units.

### **Medicines management**

- We found overall there were systems and processes in place for the safe supply, storage, administration and disposal of patients' medications. However we identified some concerns that required improvement.

- At the Oakwood Community Unit, medicines were stored securely in a locked trolley. Staff informed us if a patient wanted to self-administer their own medication they would use the trust's risk assessment to ensure they were safe to do so. If a diabetic patient wanted to draw up and administer their own insulin, processes were in place for this to be checked by a qualified nurse first. There were no patients self-administering their own medicines during our visit.
- We observed medicines administration on the Oakwood Community Unit on two occasions. On the first occasion the practice was in line with current Nursing and Midwifery Council good practice guidance. On the second occasion we found three drugs had not been signed for by the administering nurse; they had been administered to the patient one hour earlier. We brought this to the attention of the nurse in charge of the unit who dealt with it immediately.
- Staff informed us they sometimes had to wait all day for medicines to be prescribed for patients at the Oakwood Community Unit. There was a nurse prescriber working in the unit, but they were absent at the time of our inspection. Two consultants and a registrar from the main hospital site in Rotherham provided cover for the unit and could be contacted by staff to provide pain relief prescriptions. Following the inspection, the trust confirmed that all patients would be prescribed Paracetamol for use on a "as required" basis before they were transferred to the unit. In addition, following personal development reviews, a number of nurses would undergo nurse prescribing courses. The unit had an Advanced Nurse Practitioner role for the unit but this was vacant and the trust had been unable to recruit someone into this role.
- We found the room for storing oxygen in the Oakwood Community Unit was unlocked although a key code lock was in place. Unsecured used oxygen bottles were stored in the room as well as dirty linen in a wire cage. The door at the rear of the room was also unlocked. This door led out to a car park and public areas. A sign denoted the door should be left open for porters to access the room externally. A member of domestic staff informed us they had been told to leave the door open to enable portering staff to access dirty linen. We raised this issue with senior members of staff who were unaware the practice was occurring. This was rectified immediately.

- In BreathingSpace all patients had their own locked storage facility in their room and patients were assessed to self administer. We checked a patient's medicines in their locker and found them to all be in date.
- We checked six medicine administration records and found they were complete with no unexplained omissions.
- Controlled drugs were stored appropriately in both units.
- Appropriately trained and competent staff undertook intravenous drug administration.
- At BreathingSpace, emergency drugs were available. These were not kept locked because of staff requiring quick access to them in an emergency. However, they were not easily visible to visitors.
- The pharmacist visited the Oakwood Community Unit on an ad hoc basis and checked controlled medicines and disposed of unwanted medication.

### **Safety of equipment**

- Portable appliance testing was evident in both units; this included the electrical profiling beds.
- Mattresses were checked at each admission to ensure they remained fit for purpose and did not increase the risk of cross infection or pressure damage to patients.
- There were systems in place for the reporting and removal of broken or faulty equipment. Any additional equipment required for patients, for example air-flow mattresses, were hired in if the trust could not meet those patients needs from their own equipment bank.
- Despite BreathingSpace being a specialist respiratory unit a maximum of 50% oxygen could be offered to patients via individual oxygen cylinders because it did not supply piped oxygen to patients' rooms.
- The nurses desk in the Oakwood Community Unit was too high for staff to use the computers safely. The chairs provided were too low to sit at an acceptable height to ensure the health and safety of staff. We were informed this had been brought to the attention of senior managers but staff told us it had not been addressed and the issue still remained. This had been raised twice as a level 10 (high risk) and level six (moderate risk) on the unit's risk register in December 2014 by two separate members of staff. the trusts senior leaders told us there was a risk assessment in place for this and staff should not use the desks but use the mobile computers which had been provided.

### **Records and management**

- Both units used a combination of paper records and an electronic record software system which was designed for primary healthcare, (health care provided in the community).
- In the Oakwood Community Unit paper records were available for patients admitted from Rotherham Hospital. In addition, the unit also used an electronic record software system for all their record keeping. The senior nurse on duty informed us they had realised the electronic record software system was not appropriate for use in an in-patient setting.
- Some of the staff working on the Oakwood Community Unit did not have access to the electronic record software system, for example an agency nurse. We observed one nurse writing the results of observations from one patient on a piece of paper and putting it in their pocket. There was a risk the information could get lost before being recorded in the appropriate place.
- In BreathingSpace we were informed the electronic record software system did not meet the needs of their patients so they used paper records as well. We looked at three sets of records and found them to be comprehensive, up to date and reflective of patients' needs. They included falls and nutritional assessments.
- In the Oakwood Community Unit we found an unlocked storage room contained bags of confidential documents awaiting shredding. The key code lock for the door was not being used. The door at the rear of the room was also unlocked. This door led out to a car park and public areas. A sign denoted the door should be left open for porters to access the room externally. We spoke with a member of domestic staff who informed us they had been told to leave the door open to enable portering staff to access dirty linen that was also being stored there. We raised this issue with senior members of staff who were unaware the practice was occurring. The doors were locked and the confidential waste removed as soon as this was highlighted.

### **Cleanliness, infection control and hygiene**

- Both units we visited were seen to be clean and tidy but we found items of equipment not stored appropriately in the Oakwood Community Unit. Several bed-pan liners, a toilet seat riser and shower chair were stored in one of the toilets and bags, aprons and bed pans were stored on the sluice floor.

- There had been one case of Clostridium difficile in Oakwood Community Unit in October 2014 and one case in BreathingSpace in February 2015.
- Signage highlighting good hand hygiene was evident and we saw staff using gel or washing their hands between patients and using personal protective equipment, for example gloves and aprons.
- Hand-washing facilities were readily available and we observed staff adhering to the trust's 'bare below the elbow' policy.
- There were procedures in place for the safe handling and management of clinical waste and "sharps," (needles).
- We observed equipment was cleaned and labelled as clean and ready for use.

### **Mandatory training**

- The majority of staff had either undertaken all their mandatory training or were scheduled to receive it within the next three months. It included fire, moving and handling, infection control and equality and diversity.
- Staff we spoke with either confirmed that they were up to date with their mandatory training or that dates had been scheduled for them.

### **Assessing and responding to patient risk**

- Four care records we reviewed on the electronic record software system in the Oakwood Community Unit demonstrated risk assessments had been completed. These included pressure ulcers, falls, and MUST (Malnutrition Universal Screening Tool). We saw evidence of actions taken as a result of assessments to reduce the risk.
- Staff in the Oakwood Community Unit used the STOP pressure ulcer day documentation for patients. The event is held world wide and highlights the early prevention, detection and treatment of pressure ulcers.
- Patient repositioning charts were in use for patients unable to move themselves; we saw they were completed appropriately.
- In one patient's notes at the Oakwood Community Unit we found a moving and handling risk assessment was not accurate. The information stated they were mobile for short distances; we found the patient was being

nursed in bed and did not get out. This could have been a risk to the patient as it did not reflect their needs. We brought this to the attention of the nurse in charge and the assessment was updated within twenty four hours.

- Staff in both areas were aware of what caused pressure ulcers, for example immobility and the use of wheelchairs and could access appropriate equipment when necessary. Data showed no patients had developed an avoidable pressure ulcer on both units between April 2014 and February 2015. This would indicate staff identify and respond to risk.
- Routine observations such as heart rate, temperature and blood pressure were recorded to monitor patients' physiological conditions.
- Intentional hourly rounding charts were in use. This is a system to regularly check patients are comfortable. This ensured all patients were checked on a regular basis and their needs met.
- In both areas we visited we were informed that if patients became acutely unwell and medical help was either unavailable or not available in a timely way, the staff would summon emergency assistance via 999 and patients would be taken to the emergency department at Rotherham Hospital.

### **Staffing levels and caseload**

#### **Breathing space**

- The unit in BreathingSpace was led by an experienced specialist respiratory nurse consultant supported by a weekly visit from a respiratory consultant. The consultant nurse and their deputy were present in the service from Monday to Friday generally during office hours but regularly undertook additional duties to ensure safe care for their patients.
- A staffing review was undertaken in early 2014 which identified a specialist respiratory nurse post needed to be reintroduced. Staffing levels in the unit for its twenty beds had remained unchanged since October 2008 although the skill mix had changed with a reduction of nurses at Band 7 (sister/charge nurse level) and an increase of band 5 nurses (staff nurse level).
- No formal acuity levels/dependency levels of patients had been undertaken although it was acknowledged by staff we spoke with acuity levels had increased in that time. Patients could be admitted at any time of the day or night with the admitting nurse completing all the admission procedures that would be undertaken by a

junior doctor in the acute hospital. Any concerns about staff shortages or the requirement for additional staff as a result of higher patients needs were discussed at the daily staff huddle. At weekends and out of hours, there was always a senior nurse bleep holder whom staffing concerns could be escalated to.

- There is no national guidance for the numbers of staff in community in-patient areas, or those specialising in respiratory care. During weekdays, two qualified nurses had responsibility for twenty patients over two floors with two healthcare support staff. This equated to ten patients per registered nurse. However, in addition the nurse consultant and their deputy provided support during weekday day times. Out of hours and at weekends the staffing levels were lower because the nurse consultant and deputy were not present. Staff we spoke with felt the situation was not always safe and could pose a risk if a patient became acutely unwell or two or more patients were on Non Invasive Ventilation (NIV). NIV is a procedure to provide ventilation (breathing) for a patient without the need of a tube being inserted into the lungs. The British Thoracic Society recommends one nurse to two patients when commencing NIV therapy as a minimum. BreathingSpace could not always achieve this. The senior leaders in the organisation told us that a patient whose condition became more acute would be transferred back to the main Rotherham Hospital site.
- Because of their concerns over weekend and out of hours staffing levels, senior staff had put a business case forward eighteen months prior to our visit to increase staffing levels to three qualified and three unqualified each day with proposed night staffing levels remaining the same. Staffing levels had remained unchanged.
- Unplanned sick leave for qualified staff was generally covered by a nurse from the acute hospital.
- The unit's team meeting dated 9 February showed there were 3.4 whole time equivalent (WTE) Band 5 vacancies and 1.0 Band 6.
- During the month of our inspection (February 2015) we saw there were 49 qualified nurse shifts that required filling. Their own staff had volunteered to fill 23 of those with a further 26 being filled by 'flexi' staff. Flexi staff are staff who work for the trust and who undertake additional shifts as and when they are required. They may have no experience of nursing respiratory patients.
- Two incidents had occurred (August 2014 and February 2015) when inexperienced or agency qualified staff had

been sent to BreathingSpace to care for patients without experienced support. An incident on 25 August 2014 resulted in only one qualified nurse on duty overnight.

- Senior staff often remained late to ensure patients were safe but this is not sustainable in the long term.
- Although one senior member of staff's job description included undertaking research projects, we were informed this had not occurred as there was insufficient time to do this.

### **Oakwood Community Unit**

- In the Oakwood Community Unit one medical geriatric consultant was on duty between 9am and 5pm during the week. His role included undertaking a daily ward round, writing prescription charts for patients being discharged and reviewing medicine charts as well as undertaking visits to patient's homes when requested to do so by GP's. The latter meant there was not always a doctor present in the unit. We were informed weekend medical cover was 'difficult'. If a patient became unwell, arrangements were in place to request a medical registrar to visit the patient from the acute hospital. Staff we spoke to told us of concerns about the responsiveness of medical staff, but we had no other evidence to corroborate this. An agency nurse we spoke with also raised their concerns with regard to lack of medical input on the unit when it was requested.
- The unit was made up of all single rooms. This meant it was more difficult for staff to observe patients. Although the number of falls was not high, the number of un-witnessed falls was higher compared to wards nursing patients in bays.
- The staffing levels for the unit were three registered nurses and three healthcare support workers during the day and two registered and two support workers at night. This meant the ratios of staff to patients were one registered nurse to seven patients during the day and one to 10 patients at night. At times of sickness or annual leave, flexi or agency staff were used. We were told at times they had needed to work below the planned staffing levels. From the evidence we saw, we did not find this was a regular occurrence.
- There are no national guidelines in place for minimum staffing levels in community inpatient settings.

- If a patient required 1:1 care, for example if they were confused or near the end of their life, a request could be made for additional staffing. The trust provided a pool of healthcare support workers who could be requested to help.
- When we spoke with staff about the level of staffing provision on the unit they told us that as long as the established level of staffing was attained they felt the level of care was acceptable and during our visits we saw patients appeared well cared for.

### **Managing anticipated risks**

- There was a business continuity plan in the Oakwood Community Unit to obtain additional staff in the case of adverse weather conditions, for example flooding.
- Staff felt confident in raising concerns or risks with their immediate line manager. We saw the most recent version of the local risk register in each of the units we visited.

### **Major incident awareness and training**

- The major incident plan did not include either of the community in-patient units. We spoke with a senior member of staff in the Oakwood Community Unit who told us that as far as they were aware they were not part of the contingency plan.

# Are community health inpatient 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.

The effectiveness of the service required improvement.

In the Oakwood Community Unit a number of the patients were living with dementia or were suffering confusion due to infections. Not all of the staff we spoke with were clear about when they should determine a patient's mental capacity.

Policies and procedures had been developed in line with national guidance and care pathways were in place for patients with specific diseases. Pain relief was not always available in the Oakwood Community Unit.

Patients were supported by staff to maintain adequate nutrition and hydration and nursing staff worked with therapists when appropriate to ensure effective care for patients.

Assessments for social care and continuing healthcare were sometimes delayed on Oakwood Community Unit which meant patients could wait longer on the unit for a transfer of care to the community.

All permanent staff in BreathingSpace were highly skilled and knowledgeable and were providing a service that demonstrated outcomes for patients that were much better than the England average.

## Evidence based care and treatment

- Hospital policies and procedures were developed in line with national guidance; they were available for all staff to access on the hospital's intranet site.
- We saw evidence that the National Institute for Health and Care Excellence (NICE) guidance, such as the clinical guidance on the prevention and management of pressure ulcers, was followed in both units.
- Tissue viability nurses were available for advice and visited when requested to do so.
- Patients were assessed and received treatment in line with evidence based practice. In BreathingSpace care pathways were in place for specific diseases, for example chronic obstructive pulmonary disease (COPD). These were followed and appropriate care and treatment was given.

- Patients were assessed using nationally recognised risk assessment tools. For example the tool used for the assessment and prevention of pressure damage was the Waterlow score. Care was given appropriately according to the results of the scoring system which included the provision of suitable equipment.

## Pain relief

- Pain assessments were undertaken when it was necessary and patients informed us they received pain relief when it was required.
- There were four nurse prescribers in BreathingSpace which meant suitable pain relieving medicines could be prescribed quickly. In addition, one nurse was undertaking the prescribers course when we inspected and another was due to start the course shortly.
- In the Oakwood Community Unit, staff told us they felt obtaining a prescription for effective pain relief could be a challenge. Although no patient in the unit was in pain or requiring pain relief during our inspection, the staff told us it did happen on some occasions. We did not find any evidence that this was being monitored so we were unable to determine any actual impact on patients. Following the inspection, the trust took steps to make sure all patients were transferred to the unit with a prescription for Paracetamol, should it be required. Additional nursing staff identified they wanted to train to become nurse prescribers and the trust planned to support this.

## Nutrition and hydration

- The malnutrition universal screening tool (MUST) was used to identify those patients who were at risk of malnutrition. When a risk was identified appropriate actions were taken to ensure patients received adequate nutrition and fluids to promote their recovery.
- From the care records we reviewed, the MUST screening tool had been used appropriately for those identified as being at risk.
- When required, fluid balance charts and food records had been completed.
- Patients told us food was of good quality and they were able to make choices about what they ate.



# Are community health inpatient services effective?

- Water was always available for patients and staff ensured they had access to it.
- We saw patients could eat without interruption and that staff were available to support them when it was required in a relaxed and dignified manner.

## Approach to monitoring quality and people's outcomes

- In BreathingSpace one of the outcomes to monitor the effectiveness of care and treatment for patients was the British Thoracic Society's (BTS) key performance indicators for chronic obstructive pulmonary disease (COPD). A care bundle is a structured way of improving the processes of care and patient outcomes and is a small, straightforward set of evidence-based practices that when put together have been proven to improve patient outcomes. The unit had consistently achieved more than the 80% target of the use of the COPD care bundle. Over a five month period between September 2014 and January 2015 the average was 92%.
- Deaths from COPD were 30% lower in BreathingSpace than the national average for 2014. This would suggest that patients were receiving evidence based care.

## Competent staff

- We were informed newly recruited trust staff received a structured trust induction but we did not speak with any new member of staff to corroborate this.
- We spoke with an agency nurse on the Oakwood Community Unit who told us they had not received a formal introduction to the unit; they had been given a tour and then started their shift. The unit did have a check list for agency staff to complete during their first placement on the unit although this had not been used.
- All permanent staff in BreathingSpace had received a variety of on-going training to support the patients they cared for. Over the previous two years courses completed included non-malignant palliative care degrees, COPD foundation, electrocardiograph (ECG), atrial fibrillation, smoking cessation, bronchiectasis and asthma. This meant they were knowledgeable and competent staff who could meet the individual needs of their patients in a confident manner. All staff in the unit had received an appraisal within the previous twelve months.
- At the Oakwood Community Unit, the interim manager was working closely with their matron to put together a

training programme in order to ensure staff were well equipped to deliver a safe service to the new client group they were about to admit. They had recognised training had not been a high priority in the recent past. In addition, appraisals had either been completed or were being undertaken.

## Multi-disciplinary working and coordination of care pathways

- In BreathingSpace each patient received a three day review of their plan to ensure patients were achieving the optimum care and treatment. This was altered if appropriate to reflect changing needs. If medical support was required at any time for patients, the respiratory medical consultant was contacted for advice and guidance.
- For patients nearing the end of their lives staff received good support from the local hospice and its consultant.
- Therapy staff in the Oakwood Community Unit provided treatment to patients and guidance to staff when appropriate.

## Referral, transfer, discharge and transition

- The admission criteria for the Oakwood Community Unit had been completely reviewed and the Care Co-ordination Centre (CCC) based in the unit had become the primary means of monitoring and reviewing all referrals to the unit. The revised process commenced in March 2014 and provided increased scrutiny and challenge to the requests for admission to the unit. The use of the CCC had the added advantage of enabling the patient transfer team to be aware of all approved requests for transporting patients from the acute area to the community unit.
- Although the Oakwood Community Unit worked with other teams to promote timely discharge when appropriate, nursing staff were frustrated at the lack of timely input with regard to assessments for both social care and continuing care. Delays could occur whilst patients waited for social care placements, for example residential care.
- A member of staff told us social workers were no longer able to complete continuing healthcare assessments on the unit; that was now the responsibility of nurses to undertake the role which led to delays because of workload pressures. Only four qualified members of nursing staff on the unit could undertake the

# Are community health inpatient services effective?

assessments. The delays were corroborated by the patients' whiteboard on the unit which tracked what was required for each patient. We saw four patients had assessments that were waiting to be completed.

- Home assessments for patients, for example to assess their mobility in their own environment prior to discharge, could be undertaken by a member of the therapy staff when required. This process ensured any equipment or additional support could be arranged prior to their discharge.
- Patients were referred appropriately to community services, for example community nursing teams to ensure their needs continued to be met.
- In BreathingSpace patients could be admitted at any time of day or night. As long as a bed was available that could meet the patients' needs, admissions could be prompt with highly trained nurses able to assess patients very quickly and put a plan of care and treatment in place.
- Discharges from BreathingSpace were well co-ordinated with patients referred appropriately to community services to provide support following discharge.

## Availability of information

- In the Oakwood Community Unit, patients arrived from the acute hospital with their paper records that detailed their recent care and treatment.
- Staff had access to patients' records for those patients who arrived from the community using the electronic computer system. The Care Coordination Centre also

received information from the referrer of the patient which provided additional information to the unit's staff. Staff could request and access their previous medical records promptly. We saw the paper records for patients on the unit. They included medical records and diagnostic results. This enabled staff to care for patients safely.

- Discharge summaries were produced for patients discharged home. GP's could access patient information via the electronic computer system.
- In BreathingSpace many patients were frequent attenders to the unit and staff knew their previous care, treatment plans and individual needs well. For those referred from elsewhere, the patient arrived with a referral letter which provided additional information to the staff. Discharge summaries were provided for GP's.

## Consent

- During our observations in both units we saw staff involved patients in their care and they obtained verbal consent before carrying out any personal care or treatment.
- In the Oakwood Community Unit, a number of the patients were living with dementia or were suffering confusion due to infections. Two staff we spoke with were unsure of when they should determine a patient's mental capacity. We found the senior staff were aware of capacity and consent, but more junior staff lacked an understanding of their role in this. The managers of the service acknowledged more training was needed in this area.

# Are community health inpatient services caring?

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

We rated the caring afforded to patients was good.

Staff treated patients with compassion, dignity and respect. Patients told us they felt emotionally supported by the staff. Staff communicated very well with patients and their relatives and supported them to be as independent as possible. Patients felt informed about their discharge arrangements.

There was some very good practice in BreathingSpace to encourage patients to socialise and increase their independence. Opportunities were less evident at the Oakwood Community Unit and patients stayed in night clothes and did not have the opportunity to use the dining or lounge facilities on the ward.

## Dignity, respect and compassionate care

- In the Oakwood Community unit we observed patients' names, diagnosis and level of mobility displayed on the outside of their room doors on whiteboards. This meant visitors would know who was in the unit and compromised patient's dignity and respect.
- In BreathingSpace information relating to the patient was in their room and not able to be seen by visitors.
- All the interactions we observed in both units between staff and patients were undertaken in a quiet, dignified and compassionate way. For example, we saw a patient in the Oakwood Community Unit becoming upset. A member of staff saw this, spoke quietly to them and held their hand until they felt better. The patient thanked them.
- Patients we spoke with in both units told us generally they did not like their room doors closed. However when staff were attending to their personal needs or giving them treatment, room doors were routinely closed to protect their privacy.
- Outcomes of an audit undertaken in BreathingSpace for the month of January 2015 showed 100% of patients stated they were treated with dignity and respect and 91% would be extremely likely to recommend the service to friends and family if they needed a similar service.

- Outcomes for the Oakwood Community Unit showed 100% of patients stated they were treated with dignity and respect and 58% would be extremely likely to recommend the service to friends and family if they needed a similar service.

## Patient understanding and involvement

- In BreathingSpace we observed staff explaining to patients their plan of care and explaining treatment to them with time given for patients to ask questions. For example one patient was given an explanation of their reduction of oxygen administration. We also saw a nurse and therapist discussing a patient's plan of care in relation to their mobility and how they could be supported and reassured.
- A patient in BreathingSpace told us how staff had explained why they felt so weak and poorly; this had helped the patient understand their illness much better.
- Some of the patients in BreathingSpace attended the unit on a regular basis. One of those patients recalled how staff were always there for them no matter when they were admitted. They told us their discharges were well organised and they were aware of the plans.
- Outcomes of an audit undertaken in BreathingSpace for the month of January 2015 showed 85% of patients stated they were involved in decisions about their care and treatment as much as they wished to be. A further 15% of patients stated they were either mostly or sometimes involved in decisions about their care and treatment. 85% of patients in BreathingSpace stated they had enough time to discuss their condition with a health professional and 87% of patients knew what number to telephone out of hours if they needed support.
- In the Oakwood Community Unit, 76% stated they had enough time to discuss their condition with a health professional and 65% of patients knew what number to telephone out of hours if they needed support.

## Emotional support

- We spent time in both areas talking with patients and observing interactions between patients and staff. Staff were seen to talk with patients, empathising with them if they were distressed.

## Are community health inpatient services caring?

- We saw staff welcoming relatives to both the units. It was clear staff had built a good rapport with them and made themselves available to answer any questions they may have in a way that could be understood.
- We saw examples of 'thank you' cards, expressing the gratitude of patients and relatives for the care and support they had received whilst an in-patient or visiting the units. .
- A chaplain was available for patients in either unit if they or their relatives asked for it. Staff could also access leaders of other faiths if it was required.
- Staff in BreathingSpace always sent relatives a condolence card following the death of a patient in the unit.
- A short annual memorial service was held in BreathingSpace for relatives of those who had died in the unit over the previous twelve months. It was always held the day before Remembrance Sunday and we were informed it was well attended.
- Staff and patients told us it was always very moving and had been very well received. Relatives also had the opportunity to put a message on the unit's Christmas tree each year in memory of their loved one.
- The majority of patients in the Oakwood Community Unit wore night clothes which meant patients preparing for discharge home had missed opportunities to promote independence and well being.
- Patients admitted to the unit from home, for example for the administration of intravenous antibiotics, wore day clothes.
- In BreathingSpace patients were encouraged to dress in day clothes and to self-care as much as possible.
- We observed patients in the Oakwood Community Unit take their lunch in their rooms; no-one ate in the unit's large dining room.
- In BreathingSpace patients were encouraged, with assistance when required, to go to the ground floor in the lift to eat in the restaurant. This promoted mobility and socialisation with other patients. Where necessary small mobile oxygen cylinders were provided for patients to take with them. This was an area of good practice.
- When it was required and appropriate staff supported patients to eat and drink in a caring and sensitive manner.
- Therapy services were provided on an 'as and when necessary' basis.

### Promotion of self-care

# Are community health inpatient services responsive to people's needs?

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

The responsiveness of the service required improvement.

Community in-patient services provided two different facilities for patients. The Oakwood Community Unit offered a service for recovery and rehabilitation following an acute episode of illness or to prevent people from being admitted to hospital. The service was in a changing phase and was going to care solely for patients who were frail and elderly. At the time of our visit The Oakwood Community Unit was not responsive to patient's social needs. Patients spent 24 hours a day in their single rooms in night clothes even though a large communal area was available. There was a risk of isolation and lack of social interaction particularly for those patients who were in hospital for some time.

Breathing Space responded to individual patient's needs and were encouraged to self-care and dress in day clothes. They had the opportunity to mix socially.

Patients' concerns and complaints were dealt with at unit level by a senior member of staff and discussed at unit meetings.

## Detailed findings

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

- The Oakwood Community Unit provided up to 20 beds for two types of patients. The first group of patients were those requiring step up/step down beds as an alternative to admission to, or timely discharge from Rotherham Hospital. A list of criteria was available to ensure patients admitted were being cared for in the right environment. One of the criteria stated that patients should not be admitted who were at a high risk of falls. Staff informed us that at times senior managers had overridden the criteria due to pressure on beds in the acute hospital.
- The second type of patients were those admitted for an assessment of their needs (discharge to assess) as part of an eight bedded pilot project and who were generally over the age of 80 years. Patients in the first category could be referred by GP's, district nurses and the acute

hospital. Those in the second category were admitted from the acute hospital. The length of stay for each patient varied from a few days to in excess of four months.

- Plans for developing the Oakwood Community Unit were on-going as part of the trust's Community Transformation Project. Senior staff informed us the unit would care for 20 elderly frail patients in the very near future because of the current lack of placements for this group of patients and in the future would be nurse-led with an appointment of a nurse consultant. The remaining five beds would be utilised for patients requiring rehabilitation for neurological conditions. Recruitment of nursing and permanent therapy staff had already commenced.
- Following the inspection the trust confirmed that new criteria for transfer to the Oakwood Community Unit were in place and that referrals were direct to the unit to ensure that bed utilisation was optimised with patients in the right setting.
- BreathingSpace was a unique 20 bedded nurse-led service that provided care for people with chronic lung disease including treatment with non-invasive ventilation (NIV). Patients could refer themselves to the service if they were already known to BreathingSpace. Other referrers included GP's, community matrons, the ambulance service and the acute hospital.
- Ten per-cent of patients receiving care in BreathingSpace came from outside of Rotherham. The average length of stay in the unit was five days.

### Equality and diversity

- Equality and diversity training was delivered to staff as an on-line module as part of their mandatory training.
- Staff informed us interpreting services were available for patients when they were required although we did not meet with any non-English speaking patients during our inspection.
- Patients with special food requirements to meet cultural and religious needs were catered for on request, for example Halal or Kosher.
- We spoke with one patient on the Oakwood Community Unit who liked to smoke. Staff supported them to have a cigarette outside the unit. In

# Are community health inpatient services responsive to people's needs?

BreathingSpace patients were not permitted to smoke. However if required, smoking cessation aids were prescribed for them and support was offered on discharge.

## Meeting the needs of people in vulnerable circumstances

- The trust had developed a core of nurse dementia champions. Both units had designated dementia champions who had completed specific training for their role and were able to support other staff to care for patients with a dementia.
- Some other staff on the units had not received any dementia awareness training, although we saw this was included in the training matrix for the training year commencing in April 2015.
- The trust's 'forget me not' scheme for patients living with dementia was used mainly on the wards in the acute hospital and was not embedded in the Oakwood unit.
- There were no specific care pathways in use for patients living with dementia. Due to the electronic record system that was used for care planning there was little opportunity to document personalised care. Discussions had occurred in the trust with regard to adding a flagging system to ensure pathways for people living with dementia were smoother. This was not yet in place.
- Staff we spoke with were very aware of the individual needs of their patients, for example their preferences and choices.
- For some patients living with dementia there was a risk of isolation and lack of social interaction if they were being cared for in the Oakwood Community Unit as they were not using the communal lounge. Additionally, there was no provision for patients to take part in activities. One patient told us they were very bored because there was nothing to do.
- BreathingSpace was using the 'This is Me' document for people living with a dementia. We saw there was a notice board near the nurses station explaining its use.
- Patients' specific dietary needs were met by the staff that were supporting them.
- Patient toilets in the Oakwood Community Unit had the ability to be allocated for use by either men or women by the use of a movable sign on the door.

## Access to the right care at the right time

- In the Oakwood Community Unit, care was overseen by a consultant physician during office hours. Outside of those hours requests for medical care went to the acute hospital, a short distance away. Staff informed us there could sometimes be delays. A member of staff told us of a situation when a patient fell and it had been a long time before any medical assistance had arrived to assess the patient. We did not find any evidence that this was being monitored so we were unable to determine how often this occurred. There was a process in place for staff to get medical assistance out of hours. In the event of a life threatening situation, staff were to obtain support through dialling 999. following our inspection, the senior managers told us this process was reiterated to staff.
- In BreathingSpace the unit was overseen by one consultant during weekdays and a medical registrar from the acute hospital when intervention was needed out of hours. If emergency care and support was required the unit utilised the 999 service.
- Therapy services in the Oakwood Community Unit were provided on an ad hoc basis. The unit did not have its own designated therapy staff although it was acknowledged a number of patients in the unit did not require therapy support.
- Speech and language therapy (SALT) services were available when requested by staff but BreathingSpace informed us that SALT staff were not always able to respond quickly.
- Patients requiring disposable weekly medication packs, specifically designed for use by community patients who have difficulty using boxes of medicines for their take home medicines had to wait between 24 and 48 hours for their medication to be dispensed. This caused a delay in their discharge. Where possible, staff tried to pre-empt which patients would require these in order to reduce delays.
- Staff informed us of the difficulty obtaining continuing healthcare and social care assessments for patients in Oakwood. Staff described how patients often had to wait for social assessments prior to discharge.

## Complaints handling (for this service) and learning from feedback

- The complaints policy was displayed in each unit and staff we spoke with knew the process and how to advise patients and their relatives when necessary.

## Are community health inpatient services responsive to people's needs?

- Patients we spoke with in each unit told us they had no need to make a complaint as they were looked after so well.
- In BreathingSpace we saw two complaints had been received in 2014. One had been resolved to the complainant's satisfaction and the other was on-going; we saw the information relating to them. The nurse consultant informed us they always met with patients and/or relatives about the issues they had raised.
- We saw evidence of outcomes from complaints in both units was shared with staff at regular meetings with changes to practice made when it was necessary.

# Are community health inpatient 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.

The leadership of the inpatient service at the Oakwood Community Unit required improvement

Community inpatient staff varied in their vision of the future direction of the units they worked in. The majority of staff in the Oakwood Community Unit knew of the imminent changes to the service. In BreathingSpace staff were concerned about the unit's future despite it being very successful and held in high esteem by the patients it served.

The trust had identified that the leadership at the Oakwood Community Unit needed further development and had recently appointed an interim clinical lead. BreathingSpace had strong local leadership that was inclusive and firmly established

Staff felt able to raise issues with managers, if required. Senior managers from the trust visited the units on occasions. Staff felt supported by their immediate line managers although staff in both units felt senior staff within the trust did not see community services as important as those provided on the acute side. The trust had a transformation programme in place and was investing in community services. Senior leaders in the trust were aware more needed to be done to improve staff engagement and were working hard to address this.

## Service vision and strategy

- Some staff we spoke with felt the community services within the trust had not been seen as important as the acute side; this had led them to feeling frustrated.
- BreathingSpace had been established for ten years, in part due to Rotherham having 5% more people with chronic respiratory disease than the national average. The nurse consultant leading the unit had been in post for eight of them.
- We were informed the unit had no mission statement but their aim was to provide exemplary care for all the patients that attended the unit.
- Senior staff were concerned for their patients in regard to the future of the service; they had been informed it was too expensive to maintain. Senior staff were aware

there was a drive to introduce specialist respiratory nurses into the community but there was insufficient staff to do that. There was a concern by staff this could replace BreathingSpace.

- Senior staff and managers informed us that the Oakwood Community Unit was going to become a service to care for frail elderly patients in the very near future. However, the message had not been communicated to all staff as some we spoke with were unaware of this; one staff member thought it was going to close.

## Governance, risk management and quality measurement

- Quality measures, for example hand-hygiene audits were visible on noticeboards on each unit. This enabled patients, staff and visitors to see how the units were performing in those areas.
- We saw minutes of unit meetings that covered areas such as audits, incidents, complaints and risks. Individuals were allocated actions to be taken forward.
- The governance framework for the two areas was part of the trusts medical directorate governance system which had been recently reconfigured. A series of governance meetings had been put in place that ranged from local unit meetings held monthly involving all levels of staff to trust wide medical directorate governance meetings held bi monthly. This looked as if it would be a good governance system but it was too early to comment on its effectiveness at the time of our inspection.
- We saw the minutes from the first clinical governance group meeting for the directorate of medicine dated 13 November 2014. Items on the agenda included quality improvement, patient safety, clinical effectiveness and items requiring escalation to the directorate governance meeting.

## Leadership of this service

- The community transformation project paper presented to the trust board November 2014 identified there had been insufficient investment in clinical leadership at the Oakwood Community Unit. There was an interim



# Are community health inpatient services well-led?

manager in place; the substantive post was being recruited to at the time of our inspection. It was recognised there was a lot of work to be done to facilitate the unit's change of use with training and care-planning a high priority. Staff felt supported by the manager but knew they were extremely busy.

- The matron for the Oakwood Community Unit had a number of different areas of responsibility including the stroke unit and the respiratory ward in the acute hospital. They were new in post having transferred from another directorate within the trust. They understood the changes that were required to the unit going forward. Staff in the Oakwood unit told us they felt supported.
- Local leadership in BreathingSpace was well embedded. Staff respected the nurse consultant and their deputy for their inclusive leadership style and total commitment to the patients and the staff who cared for them.
- Senior trust staff had visited both units on occasions. The trust Board was aware before our inspection that staff working in some of the community services did not feel as engaged as staff working in the acute part of the trust. They had taken a number of steps to try and improve staff engagement but this was still work in progress.

## Culture within this service

- Staff we spoke with informed us they understood the trust's whistleblowing policy and would use it if it were necessary.
- Staff in BreathingSpace told us the culture within the service was open and honest and they always put the patients first. Staff told us how good the team working on the unit was.
- Although only 2.5 miles from the acute hospital, some staff we spoke with sometimes felt isolated.

## Public and staff engagement

- Patients and relatives were asked for their views about the care they received in the units. These were reviewed by the manager. We were told of issues that had been addressed in Oakwood as a result of feedback. For example waste bins being more readily available and provision for recycling domestic waste.

## Innovation, improvement and sustainability

- BreathingSpace was an innovative nurse led unit. The unit had been visited by members of parliament as well as interested parties from across the UK, Japan, China and Belgium.
- The nurse consultant had presented papers at both national and international conferences focussed on respiratory illnesses.
- BreathingSpace was an excellent example of an innovative nurse led service that was meeting the health needs of the population it served.

# 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

Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities)

Regulations 2010 Staffing

**The registered person must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of patients.**

### Regulated activity

### Regulation

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA 2008 (Regulated Activities)

Regulations 2010 Consent to care and treatment

**The registered person must ensure all staff understand their role in relation to the Mental Capacity Act (2005) and its associated code of practice.**