

University Hospital of South Manchester NHS
Foundation Trust

RM2

Community health inpatient services

Quality Report

Wythenshawe Hospital
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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)
RM2X4	Wellington House Ringway Mews		
RM214	Buccleuch Lodge		
RM2X2	Dermot Murphy Centre		







This report describes our judgement of the quality of care provided within this core service by University Hospitals South Manchester. 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 University Hospitals South Manchester and these are brought together to inform our overall judgement of University Hospitals South Manchester

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

We rated this service as good because:

The staff teams were positive and proud of the service they provided for the local community. The nurse staffing levels were found to be appropriate to meet the needs of patients at the time of our inspection.

We saw that good multidisciplinary working was in place. The units had input from therapists and dedicated pharmacists. Access to dieticians and speech and language therapists were available and staff were positive about their working relationships.

Patient care, including managing patients' nutritional and mobility needs and pain relief, were well managed.

Staff were observed talking to patients in a kind, sensitive and caring manner. Staff used the Friends and Family test as a formal tool to obtain feedback from patients or their relatives as well as using locally devised surveys.

Staff were familiar with incident reporting procedures. The majority of staff were up to date with mandatory training. Records and medicines were appropriately audited. Information was available in different languages, staff stated they could access an interpreter as necessary and patient's cultures were respected and supported.

The units were visibly clean, in a good state of repair and staff were observed following appropriate infection prevention practices.

Pain relief and nutrition and hydration needs were assessed appropriately. Patients at Dermot Murphy

Centre stated that they were not left in pain. Records relating to patient care were detailed to identify their individual needs but legibility was not consistent. Medical cover for the community units was provided by the consultant geriatrician team, the patients General Practitioners (GP's) or out of hour's provider, if required. Reviews of patients' progress, including multidisciplinary reviews which monitored their progress and ensured planned care, were relevant.

Patients reported they felt safe and confident in the skills of staff.

However:

Medicine administration was not always a protected activity and staff could get distracted which posed a risk of medication errors.

There was a lack of storage areas at Wellington House which presented a risk of tripping or falling to patients. Substances hazardous to health were found unattended on a cleaner's trolley in an unlocked toilet.

There was a dressing trolley left in a corridor which contained creams, elastic bandages and scissors which could be accessed by patients. There were damaged dining room chairs at Buccleuch Lodge which carried a risk of cross infection, substances hazardous to health accessible to patients, a lack of PAT testing of equipment and at Buccleuch Lodge there was a fire door in a bedroom which was poorly fitting.

Summary of findings

Background to the service

University Hospitals of South Manchester NHS Foundation Trust has three community inpatients units, including Wellington House, Dermot Murphy Centre and Buccleuch Lodge. The inpatients units are part of the community services directorate.

Wellington House provides respite care for up to 28 adults and aids recovery as a transient service before the patient can return to the community. The average stay at Wellington House is six weeks. The Dermot Murphy Centre is a continuing healthcare facility which provides nursing and medical care for up to 22 adults with complex physical needs. Some people using the service

also have learning disability and mental health needs. Buccleuch Lodge is an intermediate healthcare facility which provides rehabilitation and nursing care for up to 14 adults with physical or sensory disabilities. It has an average stay of 20 days.

The community hospitals provided a less 'acute' environment, although medical care was provided by the trust's consultants for elderly care. These wards were for patients of any age, but usually older people, either following an acute hospital stay, or to prevent an acute hospital stay, by focusing on rehabilitation and restoring functional abilities.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Team Leader: Lorraine Bolam, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a newly qualified nurse and an occupational therapist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of University Hospital South Manchester NHS Foundation Trust.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between January 26 and 29 2016. During the visit we spoke with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

Summary of findings

What people who use the provider say

We spoke with 15 patients and five relatives on the units who all expressed their satisfaction with the service provided and made positive comments about the care they received. One person mentioned staffing levels and had made a complaint which had been satisfactorily resolved.

Patients told us that the staff were all very kind and supportive and one patient described them as “wonderful.” Patients said that the service provided to them could not be faulted. One patient said “This is the best establishment I have ever been in”. One patient said to us “We are really well cared for. It’s so nice.”

All of the people we spoke with said that staff were efficient, kind and very helpful. Many of the people we spoke with said that there was nothing that could be done to improve the services they received, and that they felt well looked after. One person said “The treatment is first class.”

Compliment letters and thank you cards were displayed in the reception areas and on notice boards.

One relative we spoke with said “It is really good. They are there when you need them. They treat her well.”

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

MUST:

- The trust must ensure all services are provided in suitable environments and that monitoring systems are robust and highlight any issues and risks in a timely manner.

- The trust must ensure that the nurse call bell system is fit for purpose and are readily available for all patients in each of the units.

SHOULD:

- The trust should improve data collection for GP compliance with mandatory training.
- Consider an activities programme for patients at Buccleuch Lodge to ensure appropriate stimulation is offered.

University Hospital of South Manchester 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

The nurse staffing levels were found to be appropriate to meet the needs of patients at the time of our inspection. However at the Dermot Murphy centre the call system was seen to be not fit for purpose and, in some cases, did not work. There was no audit trail regarding the response to call bells.

Staff recorded and reported incidents, completed risk assessment and risk management plans. No serious incidents had been reported which were attributed to the units in the last 12 months.

Performance information was displayed on the ward which demonstrated that care provided was within acceptable ranges. Staff confirmed this was discussed at team meetings.

We observed a number of environmental hazards including a lack of storage areas at Wellington House which presented a risk of tripping or falling to patients, damaged dining room chairs at Buccleuch Lodge which carried a risk

of cross infection, substances hazardous to health accessible to patients, a lack of PAT testing of equipment and at Buccleuch Lodge there was a fire door in a bedroom which was poorly fitting. The design of Wellington House was not fully suitable for patients living with dementia. Portable Appliance Testing (PAT) testing was not consistently applied across the units.

The units were visibly clean, in a good state of repair and staff were observed following appropriate infection prevention practices.

Safety performance

- The Dermot Murphy Centre and Buccleuch Lodge used the NHS Safety Thermometer to monitor safety information which recorded and analysed data about patient safety. This is a recognised tool used nationally by NHS organisations to measure risks including the frequency of falls, catheter acquired urinary tract infections and pressure ulcers.

Are services safe?

- Data supplied by the trust showed that between November 2014 and October 2015, there were 58 falls resulting in harm, 26 pressure ulcers and three catheter acquired urinary tract infections (CAUTI).
- An overview of the safety thermometer showed there had been incidents such as scalds to patients and lessons were learnt including advice to staff providing patients with drinks. Following any patient falls on the ward the support of the falls team was accessed and daily monitoring of numbers of falls was commenced.

Incident reporting, learning and improvement

- Incidents were reported using a trust wide electronic system. We viewed a list of recently reported incidents. Staff gave us an example of an incident involving a fall which was recorded on the system within the same day.
- Between November 2014 and October 2015, there were 1232 incidents reported across community services, of which 431 were reported for community inpatients services. Of these incidents 424 were reported as low or no harm.
- At Wellington House the majority of falls occurred overnight. This was discussed at the safety huddle (part of the ward handover meeting) and an action plan was put in place including 15 minute observations of all patients at risk of falls during the night.
- Staff were aware of what was required to be reported as per the policy.
- We saw that incidents were investigated fully and lessons learnt were shared with staff to improve safety.

Safeguarding

- The multidisciplinary team and ward staff had a good understanding of the need to protect patients and ensure vulnerable people were safeguarded. Staff also knew how to respond to concerns.
- There were no safeguarding incidents reported on the quality boards in the 12 months prior to our inspection.
- The name of the trust lead for safeguarding was displayed on the team information board and staff were familiar with who this was.
- Safeguarding and mental capacity act training was mandatory for staff and we saw from training records that the majority of staff had completed safeguarding adults and children training. Plans were in place for those who were unable to attend the recent training.
- Staff confirmed the onsite face to face training was beneficial.

- Trust safeguarding adults training was reported as 82.48% compliant which was worse than the trust target of 85%.
- We were told some patients could be verbally abusive to staff and this could give rise to complaints about staff responses. We saw details of a full investigation following which the family accepted the findings of no grounds for harm.

Medicines

- Staff followed the trust medicines management policy which was available on the intranet. Staff were aware of this including the procedure for self-medication.
- A Medical Registrar was based on Wellington House and visited Buccleuch Lodge daily to prescribe medicines and monitor their usage. Each patient had a medicine management care plan to advise staff how to support them and the time and dosage of each medicine required. This was updated regularly at each unit. Local pharmacy prescriptions were used to ensure medicines could be collected very quickly by staff. When patients were transferred from the Accident and Emergency department or other hospital wards they brought a seven day supply of medication to ensure continuity of care.
- Pharmacists visited each unit to monitor the use of medicines and order stock. The local pharmacy supplied emergency medicine and antibiotics which ensured a speedy response to the patient's condition. The pharmacists were also working at reducing the volume of medications given to each patient and the amount stored. Medicines were securely stored, and administered by qualified nurses. We observed medicines being given to patients in line with Nursing and Midwifery Council guidance.
- Systems were in place to monitor and record fridge temperatures daily. We saw that medicines were stored appropriately.
- A record of all controlled drugs (CD) that were stored and given were held in a register. Two members of staff had signed each entry in line with policy. CDs were handled, stored and recorded appropriately. A spot check on the ward demonstrated compliance.
- There was a specimen signature list available of staff who administered medicines.

Are services safe?

- We observed that staff members could be disturbed during the medicine rounds particularly at Wellington House, distractions for staff administering medicines may pose a risk of errors occurring.

Environment and equipment

- Systems were in place for the maintenance and checking of equipment; however checks varied across the units.
- The building where Wellington House was located was rented from an independent provider and was not designed and built for the purpose for which it is used. Staff told us up to 75% of the patients admitted might be confused or living with dementia. We saw long symmetrical corridors with plain walls and minimal signage. There were no colours to differentiate between doors to help patient's orientation. The lights were low in the corridors and tended to flicker. The staff told us the design of the unit heightened the risk of falls because of the distance between bedrooms and bathrooms and the nursing areas. The service was considering themed decoration to improve stimulation and orientation for patients. A 15 minute walkabout had been introduced at night as most falls had occurred between 2am and 7am.
- Store cupboards at Wellington House were found unlocked and we observed a patient wandering into one of them. The electricity cupboard was found unlocked on our first visit to the service however management immediately requested support from maintenance. This was rectified within 24 hours and three times daily checks were initiated on the electricity cupboard.
- Substances hazardous to health were found unattended on a cleaner's trolley in an unlocked toilet. This was reported to staff and we were assured that, in future, they would be locked in a sluice when not in use.
- At each unit we saw labels to indicate PAT tests had not been completed on equipment in the last 12 months which we raised with staff at the time of the inspection.
- There was a lack of storage facilities at Wellington House. There were many walking frames, wheelchairs and other walking aids in the central part of the day room. We also saw wheelchairs, hoists and blood pressure monitors in corridors.
- There was a dressing trolley left in a corridor which contained creams, elastic bandages and scissors which could be accessed by patients. This was a potential risk

- to any confused patient who might ingest the medication or the bandages or hurt themselves or others with the scissors. We reported this to the service and it had been removed at our second visit.
- A nurse call bell system was in operation at the Dermot Murphy Centre, which involved the call bell activating a pager. However, staff were unable to say who held the pager. Patients told us that they frequently did not have an accessible call bell or they didn't use it due to the time taken for it to be responded to. No audits had been undertaken in terms of nurse call bell response times.
- At Buccleuch Lodge there were long distances between bedrooms, the day area and the nurses station. This raised the risk of potential falls. However, closed circuit television and wall rails had been fitted. Wheelchairs were in use for those too frail to cover the distance.
- At Buccleuch Lodge we saw eight old and damaged dining chairs were in use. Additionally one fire door in a bedroom was poorly fitting.

Quality of Records

- Paper held patient records were in place which were securely stored in locked cabinets at Wellington House and Buccleuch Lodge. During the inspection we found records left unlocked and unattended in the staff area on one wing at the Dermot Murphy Centre. Some patient information charts were kept at the end of the patient's bed so they could be readily accessible to the staff, for example food and fluid charts and observation charts.
- Staff told us that fifteen records were audited each month by the trust. We saw the audits indicated sections of the documentation which required completion. We were not provided with any subsequent action plans.
- During our inspection we reviewed the medical and nursing records for six patients. Most of the records were fully complete, legible and included a range of documents assessing and identifying risks to patients such as the potential for falls and pressure ulcers. We advised staff at Buccleuch Lodge that forms were illegible in the two files we reviewed including the care and communication form and were not fully completed with patients details and a clear signature from staff. The service advised us they would raise the issue with the team.

Are services safe?

- Records were up to date and contained information from the multi-disciplinary team, where appropriate. Records also contained appropriate referrals to other professionals.

Cleanliness, infection control and hygiene

- All the units within community inpatients were visibly clean and tidy.
- We viewed records indicating that most staff (excluding GP's) were up to date with training in infection prevention and control. All three units had a compliance rate of 96% which was better than the trust target of 85%.
- Cleaning schedules and checklists were in place to assist cleaning staff with required tasks.
- At Wellington House we observed a member of staff cleaning bedrooms and bathrooms. The cleaning trolley being used contained various substances hazardous to health and was left in an unlocked bathroom. When questioned about this practice we were told that the substances could not be left in a locked sluice because the keypad code had been changed by the landlord. The domestic, employed by the landlord, was not knowledgeable about The Control of Substances Hazardous to Health Regulations 2002 (COSHH). The ward leader demonstrated good knowledge of COSHH management.
- Steps were in place to prevent Legionnaire's Disease. We reviewed this record and saw that the checklists for it were completed on a regular basis.
- We saw that weekly figures of patients with methicillin-resistant staphylococcus aureus (MRSA) and Clostridium Difficile were provided to a central point in the trust. The units had not identified any incidence since 2014.

Mandatory training

- A training policy was in place which outlined the training staff were expected to complete. Training was carried out either via e-learning modules or face-to-face sessions. Compliance was 96% across the three units against a trust target of 85%.
- Training included: moving and handling, basic life support, fire safety, mental capacity act, and infection, prevention and control.
- For some training it had proved difficult to release staff to attend due to staffing numbers particularly at Buccleuch Lodge.

- We were told that a number of GP's were contracted to the trust. The training figures for Buccleuch Lodge showed the one medic had undertaken six of the 14 subjects including safeguarding adults and children to level two. However they had not undertaken fire safety, infection prevention, information governance, manual handling, conflict resolution, Dementia or LD awareness training.
- The trust did not provide training information for medics at either Dermot Murphy Centre or Wellington House.
- Senior staff told us the GP's would have received training in the organisations they predominantly worked for such as local GP practices, however this information was not available at the time of the inspection.

Assessing and responding to patient risk

- Admission procedures included appropriate risk assessments of key areas of health and personal care needs including; tissue viability, nutrition screening, moving and handling, infection, continence and risk assessments for falls. We saw that the risk assessments were regularly reviewed according to the level of risk and appropriate action was taken in response to the risks identified.
- We reviewed the risk register with the unit managers. One risk included increased admissions at teatime. The units tried to get patients transferred during the day to allow for orientation before darkness. However, at the time of the inspection, staff told us the majority of patients arrived on the units at teatime which was problematic. Managers had asked for an operations meeting including senior therapists and the Head of Nursing to respond to this issue.
- During our inspection at Buccleuch Lodge we saw a newly admitted patient in their bedroom who appeared unwell. She had no call bell to hand or fluids within reach. We raised this with staff who told us a doctor was on his way to assess her. A drink was provided and the call bell placed close to her hand.
- Staff at the Dermot Murphy Centre were conscious that when the unit was running at full capacity the response time to call bells could be excessive.
- Patients were reviewed, by doctors on the units each day as and when they required it. At Dermot Murphy

Are services safe?

Centre, GPs from the local surgery visited every day to see any patients about whom staff had concerns and the Consultant visited once each week. There was on call cover out of hours if required.

- Patients who were identified as being at risk of falls were monitored regularly and had sensor mats and cord and clip. A cord and clip is a device clipped to a patient's clothing which detects untoward movement and sends a warning signal to staff. Fifteen minute observation was in place during the night at Wellington House to reduce the risk of incidents occurring, for example patient falls. Staff reported this was a positive step for patient care.
- There were daily handover meetings where any changes in a patient's condition were discussed at Wellington House and Dermot Murphy Centre. However, at Buccleugh Lodge there were three handovers per day at each shift changeover and a daily handover meeting for therapy staff between Monday and Friday. In addition, there were weekly multidisciplinary reviews of patient risks and their progress, to ensure planned care was still relevant and patients were making suitable progress. We listened to a handover of patient details from one shift to another and we saw evidence that staff were aware of the needs of patients and how to help them both with care and wellbeing. For example, plans for mobility assessments were discussed and the needs of patients who were going to be discharged.

Staffing levels and caseload

- Generally staff on the units felt the staffing levels were safe to meet the needs of patients and staffing rotas reflected this. However, staff at Buccleugh Lodge raised concerns that they felt there were insufficient staff to meet people's needs as the full complement of nursing

staff on duty often dropped to one registered nurse plus the Unit Manager. We saw evidence of this from the staffing rotas we inspected. We were told recruitment had recently occurred to fill vacant nursing posts.

- Staffing levels at Wellington House were one registered nurse to seven patients, at Buccleugh Lodge, one to seven patients and at Dermot Murphy Centre one to three patients. If there were difficulties meeting these numbers, bank or agency staff were employed.
- Patients at Dermot Murphy Centre had highly complex needs and four patients required three to one support for moving and handling.
- Staff sickness rates and causes of sickness were monitored. Buccleugh Lodge had a sickness rate of 3.96% and Dermot Murphy Centre 5.4% against a trust target of 4.4%.

Managing anticipated risks

- Within six hours of admission to Wellington House and Buccleugh Lodge a Waterlow score (the Waterlow score gives an estimated risk for the development of a pressure sore in a given patient) was completed and, if necessary, an airflow mattress was ordered. Staff told us supply of these mattresses was very rapid.
- Buccleugh Lodge had a well supervised lounge directly adjacent to the nurses' station. Following falls risks training during 2015, the distance between the patients' bedrooms and the nurses' station was identified as a potential falls risk. The service subsequently brought in the use of sensor pads and cord and clips in patients' rooms. Additionally the service introduced discussion of all incidents at safety huddles; part of the daily handover meetings and at three monthly unit meetings and appropriate action was agreed. A learning file had been created for all staff to read incident reports and be aware of outcomes.

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

Staff were clearly patient focused and worked towards achieving good outcomes for the people they cared for. There was some measurement of patient outcomes; the units were involved in the Patient-Led Assessment of the Care Environment (PLACE) to measure the patients' environment. We saw evidence that audits were carried out and any issues identified were actioned. Assessments for patients were completed and outcomes were recorded.

Staff worked well as a multidisciplinary team with timely access to physiotherapy and occupational therapy on admission. Staff had received appraisals with managers. Pain relief was well managed and patients' nutrition and hydration needs were appropriately assessed. Clear management structures were in place and staff were familiar with this.

Evidence based care and treatment

- Staff had access to the trust's policies and procedures in both paper form and electronically using the intranet.
- Assessments and care plans for patients were comprehensive and included patients' health and social care needs. Care plans were regularly reviewed and updated. Care and treatment was planned and delivered in line with evidence based guidelines. Patients and those close to them, where relevant, were able to tell us about their care and how it was being delivered to meet their needs.
- Therapists assessed new patients within a timeframe and set goals, for example for mobility, with the aim of promoting the patient's independence for them to return home within a reasonable time. This information was recorded in an admission booklet and within patient records.
- The unit managers carried out regular audits including, hand hygiene, and falls. Record audits were carried out by the trust and 15 care records were assessed monthly. We saw action had been taken where any issues were identified, for example introducing a number of link roles and introducing 15 minute observations during the night.

- We saw patients who had been assessed as being at risk of developing pressure sores and pressure redistribution equipment had been provided in a timely manner.

Pain relief

- Medication for pain relief was prescribed by the either the doctor based on the unit, or the patient's GP. Patients indicated that they received pain relief medication when they required it. However, one patient said there could be a delay due to staffing levels.
- Staff observed and monitored the condition of all patients. Prescribed pain relief medication was administered appropriately, by nursing staff.
- Nurses at Wellington House and Dermot Murphy Centre (the two units most likely to care for patients at the end of their life) confirmed anticipatory prescribing was put in place for patients who were assessed as being at the end of life. Patients and their families were given choice over the location of this care and there was support available to staff and families from Macmillan nurses and a local hospice.

Nutrition and hydration

- Staff were notified of general nutritional information and advice and this was displayed on information boards in the units. This included a copy of the 'Procedure for identifying nutritional risk in adult community teams' (April 2015). Guidelines on different food and drink consistencies also provided advice to staff.
- Patients were screened for malnutrition and the risk of malnutrition on admission to hospital using a recognised assessment tool. We found that the Malnutrition Universal Screening Tool (MUST) scores had been completed regularly and referrals to dietician made when required.
- Patients were weighed according to their assessed need and this was well documented in the patient's records.
- Nutrition and fluid intake charts had been completed appropriately.
- Mealtimes were protected at Wellington House and Buccleuch Lodge and relatives were encouraged to assist with mealtimes, where appropriate, at the Dermot

Are services effective?

Murphy Centre. Patients were referred to the speech and language therapist when they had swallowing difficulties. Staff were observed supporting and encouraging patients sensitively and skilfully to stimulate patient's swallowing. We saw a patient who required thickeners in their drinks, which had been prescribed appropriately and were being given to the patient in line with the prescriber's instructions.

- Patients had choice of where to eat their meals. Patient's we spoke with said the food was good and they always had a choice.
- One patient relative told us the kitchen staff had spoken with them on admission to discuss their relative's preferences.
- We saw meals served in a cheerful atmosphere with several staff present which encouraged social interaction. A NHS Friends and Family Survey on one unit had indicated that people were not fully satisfied with the food provided and a seasonal menu had recently been introduced.

Patient outcomes

- Physiotherapists and occupational therapists told us their response times to assessing new patients were monitored. Two of the units used the safety thermometer. Outcomes that the unit measured were for harm free care, for example, the number days since the last fall on the ward.
- Discharge planning was inconsistent across the inpatient sites. Each patient at Buccleuch Lodge had set goals from the point of initial assessment and discharge planning began with the patient and family. Progress against these goals was monitored weekly, sometimes daily. Staff told us that multi-disciplinary meetings ensured the best patient outcomes were achieved. At the Dermot Murphy Centre discharge planning began much later into the patient's admission.
- Patient-Led Assessment of the Care Environment (PLACE) programme was used at two of the units and focused on the environment in which care was provided, as well as supporting non-clinical services in areas such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity was supported. The 2015 PLACE results showed there were no scores under 93% and all were above the national average.

Competent staff

- Informal support from managers and senior staff including practice based educators was effective and staff told us this was provided when they required it.
- New nurses had supernumerary time as part of their induction programme. One recently recruited staff member confirmed this and said their trust induction had been comprehensive. Onsite orientation was delivered by the managers and registered nurses.
- Systems were in place for regular staff meetings which included some group supervision. Unit managers received face to face supervision with their line manager. Staff at the units did not receive one to one clinical supervision apart from one registered mental health nurse who received external supervision.
- All staff received annual appraisal using a competency framework which helped them to identify their training needs and plans for personal development. Compliance for staff appraisal was better than the trust target of 85% at the Dermot Murphy Centre (96%) and at Buccleugh Lodge (100%). However the rate was lower than the trust target at Wellington House (78%).
- Recent additional training attended by staff was dementia training; stoma care and percutaneous endoscopic gastrostomy (PEG) feeding which staff told us had made them feel more confident in their role
- Staff talked of using reflective practice, recent examples included a session with a training facilitator which had looked at "What if's?" to encourage discussion about their previous experience and support them to consider strategies for future practice. One nurse discussed the reflective accounts they were producing to present as part of their nursing revalidation.
- Buccleuch Lodge used staff volunteers to help support patients. The volunteers attended the trust induction programme and received supervision by the Volunteer Coordinator.

Multi-disciplinary working and coordinated care pathways

- We saw evidence of a multi-disciplinary team (MDT) approach to care for patients on the units. We observed an integrated approach to care delivery which involved nursing staff, occupational therapists, physiotherapists, medical staff and pharmacy. We spoke with a physiotherapist and an occupational therapist who promoted self-care. We saw assessments and recommendations from speech and language therapists, dieticians, podiatrists and dentists.

Are services effective?

- We talked with therapists about MDT meeting which included detailed discussions about discharge arrangements and plans to improve discharges.
- We observed a physiotherapist and occupational therapist providing mobility support and encouragement for a patient who required rehabilitation in a competent and sensitive way.
- Staff reported multi-disciplinary working was good. MDT meetings were held weekly where social work input was discussed.

Referral, transfer, discharge and transition

- Referrals to the units came primarily from the accident and emergency department or elderly care wards; however some referrals came from GPs if patients required additional care or rehabilitation from living in the community. We saw that the level of information provided by the referrer was good and included the patients' medical and social history, a summary of the admission and medication regime.
- On admission, patients had timely access to physiotherapy and occupational therapy at Buccleuch Lodge and Wellington House. Patients at Dermot Murphy Centre saw therapy staff by referral.
- There were early discussions regarding each patient's progress and discharge arrangements. This included good MDT working in respect of discharge planning which included regular meetings, individual case reviews, and family meetings. However, some relatives told us that they felt patient discharge was too quick and were concerned whether they would manage to cope at home
- Staff reported potential communication problems between the MDT and the social worker could mean a delay in discharge. A diary had recently been introduced to improve this.
- The average length of stay on the units varied. At Wellington House it was six weeks and at Buccleuch Lodge it was 20 days. In both cases the length of stay was affected by social services care packages in the community, availability of 24 hour care and equipment such as rails for the home. Patients remained at Dermot Murphy Centre long term due to the needs of the patients in the centre. Staff told us there was no limit to a length of stay and discharges were rare as patient's had highly complex nursing needs and the unit was regarded as a long term home.
- There was evidence of plans to facilitate a timely, safe and person-centred discharge for patients involving social workers as deemed necessary. However discharges were often delayed due to lack of support for community care packages, in particular overnight care. Discussions were underway with social services staff to try to resolve this
- Buccleuch Lodge offered a home pathway whereby patients received support from therapists for a two week period post discharge. Dermot Murphy Centre discharged patients in a gradual way and remained involved with the person post discharge to offer support.

Access to information

- The units had well-established links with local GPs for any results or past medical history.
- Some patient information was held for each patient in the nursing office, for example mobility, pressure relief and nutrition so information was clear for staff who were providing the care.
- We saw that a range of patient risk assessments were in place to assist staff in supporting patients.
- Staff described policies and procedures which they could access on the intranet or in hard copy on the units.
- Computer systems were available on the wards for the relevant staff to access patient's details.
- Discharge letters were written in a timely way.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff were aware of the requirements of the Mental Capacity Act (MCA). We saw evidence that staff were trained to assess mental capacity and could involve a psychiatrist to undertake the assessment, if they had any concerns. Documentation was completed ensuring best interests were assessed and recorded. Details were recorded such as who had assessed the person, who had been consulted, whether any restrictive practice was used, what decision had been made and the nature of the person's impairment.
- Independent mental capacity advocates were available to support the best interests of patients on the unit and we saw the effective use of this service with a patient.
- Staff at all three units were able to tell us when a Deprivation of Liberty Safeguards (DoLS) application may be required.

Are services effective?

- Dermot Murphy Centre had three patients with a DoLS in place on the day of our inspection. We saw that these applications had been made appropriately and all documentation was in place. Staff told us, although DoLS applications were submitted in a timely manner, there were patients whose application had been submitted in April 2015 and the DoLS team had not yet made a formal response. These applications had been followed up on several occasions. This risk was identified on the corporate risk register.
- Interviews with staff highlighted they understood patient consent and when it should be obtained. We observed staff clearly asking patients for their consent and explaining what they were going to do before carrying out any treatment or personal care.
- We saw that one person was receiving covert medication. A best interests decision was recorded to support this practice.

Are services caring?

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

Summary

Medical, nursing and allied health staff treated people with kindness, dignity and respect. Patients reported they felt involved in their care, and were provided with emotional support. This was supported by the positive patient experience surveys, for example the NHS Friends and Family test for all three units.

There was little evidence of any planned or organised activities for patients to participate in to promote their independence and mental functioning.

Compassionate care

- We spoke with 15 patients and five patients' relatives. Patients and relatives were positive about their experience on the units
- People who used the service and those close to them were treated with respect, felt well-cared for and supported. Patients reported the staff were caring, kind and compassionate.
- From observations made it was evident staff had healthy relationships with patients and those close to them. Staff were seen to respond to patients' needs in a timely way. We heard that staff would arrange transport for relatives to visit if they had mobility problems. At the Dermot Murphy Centre families were encouraged to stay overnight if their relative was at the end of their life.
- We observed staff supporting patients with their meals and talking with them to create a happy and relaxed atmosphere.
- Curtains were used to respect patients; privacy and staff were observed respecting privacy when supporting patients with personal care. Patients told us they were called by their preferred name and encouraged to be as independent as possible.
- Patient experience feedback was recorded in the NHS Friends and Family test. This test is used nationally to capture how patients felt about the care they received. It covers elements of care such as courtesy and respect, confidence in the services provided and whether the views and wishes of friends and family were considered when caring for people.

- The results of the NHS Friends and Family test were displayed on the performance noticeboards and all findings were positive. One hundred percent of people responded positively to the question "would you recommend this service to others?" at Wellington House in December 2015 winning them first place in the trust survey and Buccleuch Lodge achieved a 97% score for the same period. Dermot Murphy Centre used a locally devised survey and scored 100% for both "involvement and information" and "staff relationships".

Understanding and involvement of patients and those close to them

- We saw patient case notes confirming that those close to a patient had been involved in the patient's care. Key questions had been asked to help make the care plan person centred. Staff wrote guidance to families at Buccleuch Lodge on white boards in the bedrooms as to how best to support the patient. At the Dermot Murphy Centre staff had a communication board for families entitled "Dear family please supply the following item..." which kept relatives informed of the patients' practical needs.
- During the two week assessment period on admission to Wellington House a short stay care plan was co-produced and a family meeting arranged at the completion of the assessment. The family were encouraged to consider the issues most concerning them and a home visit was carried out at that point.
- When patients were washed and dressed this was recorded on a chart in the patients' room to reassure families when this support was being given. The unit had been nominated for a trust diamond award for this work.
- Patients and relatives we spoke with confirmed they knew who had been caring for their relative on that day and who they could approach for information
- Therapists said each care goal was discussed with the patient or their relative so they were aware of the objectives.
- Staff at the Dermot Murphy Centre described six monthly families meetings to discuss the patients care.

Are services caring?

The unit manager encouraged families to access her whenever they wished to. There was no family forum in place at the time of the inspection although there were plans underway to restart it.

Emotional support

- Staff showed an understanding of patients' needs in terms of wellbeing and emotional support. For example Buccleuch Lodge had established coaching conversations with a volunteer trained in psychology for patients who were expressing anxiety or poor engagement with the team.
- We heard nursing staff taking time to explain to patients and relatives about their medical condition and how

this may affect their progress. One relative at the Dermot Murphy Centre expressed appreciation to staff who had supported them emotionally with serious health problems.

- We saw evidence in care plans of where staff recorded communication with the patient and their relatives.
- Despite set visiting times at Wellington House and Buccleuch Lodge there was the option of some flexibility, if required, to enable patients to maintain family contact.
- Patients reported to us how approachable the staff were. Patients or relatives did not raise any concerns during our inspection and praised the care of all staff they encountered.

Are services responsive to people's needs?

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

Summary

The service was responsive to people's needs in the South Manchester area and to patients out of the area at times of need. Nursing care was delivered in a person centred way. Staff showed awareness of people in vulnerable circumstances and gave examples of how to make care more accessible to them. Complaints were dealt with primarily at local level and escalated to the trust's formal process, if appropriate. Information was available for people whose first language was not English and there was access to an interpreter, if required.

Planning and delivering services which meet people's needs

- Patients were admitted to the inpatient facility from either a nearby acute trust, care home or from their own homes referred by their GP. The reason for the patient's admission would be assessed, using specific referral criteria, namely the patient requiring nursing or medical care.
- Staff told us that care was given to patients on a person centred basis, assigning patients to a particular staff member. Staff assured us that they are able to maintain a personal approach with each patient.
- Staff had started to make improvements to the environment for people living with dementia at each unit, with the exception of Wellington House, and people had picture cards to support patients who had difficulty communicating.
- Staff were aware of the use of hospital passports for patients with learning disabilities.
- Patients at Buccleuch Lodge had single rooms and the layout of the furniture could be adapted to mirror the layout of their room at home.
- A stand of leaflets were made available to patients and relatives which included signposting for agencies who provided dementia support and helping to prevent infections.
- Chaplains from the local community were available to patients who wanted them, in order to provide emotional support. Staff told us they supported patients of different cultures to stay in contact with their own community such as a male carer escorted one patient to

his local synagogue. Adequate parking was available at each unit. The units provided locally based services for the community and patients and relatives were positive about the locations as they were accessible using public transport and within the Wythenshawe and Withington community.

Equality and diversity

- Staff told us they met the needs of people from different cultural backgrounds. However, we were concerned that, on one unit, staff were unclear how they would meet the needs of a vegetarian patient if one was admitted. Patients' cultural and religious beliefs were well documented and we saw evidence that they were acted upon.
- We looked at the information leaflets available in the reception areas and corridor. Staff told us they could access information for patients where English was not their first language and we saw leaflets in another language on display.
- Staff were aware of how to access a translator, if required, available via the trust intranet.

Meeting the needs of people in vulnerable circumstances

- We saw evidence that staff were aware of the needs of patients with disabilities. For example, we saw that a call bell for a patient who had limited hand movement had been adapted by the unit to improve their access to it.
- We saw one patient who was unable to perform any of her own dental care had poor dental hygiene. She had been seen by a dentist but we saw no plan to manage this need.
- Staff explained how they worked in the 'best interests' of patients and had regular contact with patients' next of kin, particularly if patients were unable to make decisions for themselves. Staff were able to access advocacy services to support patients, if required, and we observed where this was in place for one patient.
- The environment was being improved to aid people living with dementia, bold colours had been introduced and themed decoration was planned to stimulate interaction. We observed that clocks on one unit, which

Are services responsive to people's needs?

supported people living with dementia, were incorrect and indicated it was nighttime. Staff training in supporting people living with dementia was in place at all three units. The matron for dementia had supported staff to develop appropriate plans of care.

- We saw no evidence of an activity planner for patients to participate in to promote their independence and mental functioning at Buccleuch Lodge. However there was a day room which patients could choose to sit in and socialise and staff told us group activities were organised such as reminiscence, quizzes and crafts. There were books and games available but patients told us they would like more stimulation.
- At Wellington House staff told us activities such as bingo, cards, chair exercises and films were used to stimulate patients. We saw no information describing the schedule.
- At the Dermot Murphy Centre there was a social event coordinator but this post was currently vacant. Families spoke with us about garden based events in the summer, accompanying people on trips to Blackpool, local pubs and Christmas markets and pet therapy dogs visiting the unit. There were also trips to cafes and shopping. Staff told us there were plans to take some patients on a short holiday in the summer.

Access to the right care at the right time

- Staff told us that all patients who were admitted to the units met the admission criteria. There was a waiting list of ten patients for Wellington House on the day of our inspection.

- If patients required medical input out of hours staff contacted the out of hours services or 999 for emergency medical care. The patient would then be transferred, when necessary, to Wythenshawe hospital emergency department.

Learning from complaints and concerns

- We saw information in the patient information leaflet and on notice boards which signposted people who had any concerns to a staff member or a helpline, if they preferred, to raise any issues outside the unit.
- Staff told us they would try to resolve any complaint themselves and would refer the patient or family to the Unit Manager. The complaint would be recorded on the trust incident system. The complainant would be signposted to PALS (Patient Advice and Liaison Service) if the complainant required support with a concern or a complaint.
- Buccleuch Lodge and Wellington House had received no complaints in the last year and Dermot Murphy centre had received one complaint.
- Patients and relatives told us they would raise any concerns with the unit staff, if they needed to, and they felt the staff were approachable. We spoke with one patient who told us they had made a complaint and it had been resolved successfully. The patient had alleged that her buzzer was not being answered due to staffing shortages. Additional staff had been recruited since this incident.

Are services well-led?

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

Summary

The trust values were clearly displayed and staff were aware of these and a statement of purpose for each unit was evident. Staff had not seen members of the board locally but felt supported by their local managers and since the appointment of a matron they felt part of a wider team.

There were local governance procedures in place to monitor and address risks and the ward performance was monitored and areas for improvement highlighted to staff.

Managers were implementing gradual change and improvement to services. There were plans underway to improve the experience of people living with dementia.

Risks in the environment at Wellington House had not been assessed and minimised due to confusion regarding responsibilities. This was in relation to environmental hazards being identified.

Service vision and strategy

- The values of the trust were clearly displayed on the unit notice boards and reception areas.
- Staff were concerned that local reorganisation was bringing more change to the services and they were concerned whether community care would improve to allow more effective discharge home for patients.

Governance, risk management and quality measurement

- Locally held risk registers had been reviewed and updated to reflect the current situation and had been assigned to a named lead who had responsibility for the risk. Senior staff on the units were aware of what was on their risk register.
- Risks to the service had been identified and actions were in place to address them. Examples of this included recruitment of trained nurses, delayed discharge in terms of Local Authority care packages and training uptake. However, risks in the environment at Wellington House had not been assessed and minimised due to confusion regarding responsibilities.

- Staff commented that the risk of insufficient trained staff to meet patients' needs had been reported but no feedback had been received.
- Staff told us it was not easy to arrange meetings with the long day shift system but we saw regular team meetings were held and staff felt confident to share concerns with their unit manager. Staff signed to confirm they had read the minutes of meetings they could not attend.

Leadership of this service

- The unit managers and registered nurses were visible in the clinical areas and had a strong focus on the needs of the patients and what the staff team required to do to deliver a good service. Staff said they worked well as a team.
- Staff said there had been much change in personnel on Buccleuch Unit in particular, mainly due to nurse retirement. This had led to a need to rebuild teams.
- The units had a newly appointed matron and staff reported this had made them feel part of a wider team. The unit managers felt well supported by this person and said they were accessible and provided monthly supervision sessions with them.
- Staff said the consultants to the units were supportive and accessible for advice and visited the units on a weekly basis as a minimum. They commented that they never felt alone in managing the service because there was always someone to help.

Culture within this service

- Within each unit, we observed a good culture with good multidisciplinary working evident both within the team and the wider trust.
- We observed staff interacting positively with the visiting GP's and trust medical staff.
- Staff told us the units had improved over the past 12 months and they were happy to work there and proud of the standard of care provided for the patients.
- One member of staff described their experience of returning to work after long term illness. They were given support to return gradually, initially on a supernumerary basis and were given time to attend appointments to help their recovery.

Are services well-led?

Public engagement

- The trust collected patient feedback using the NHS Friends and Families test, a single question survey that asks patients “How likely is it that you would recommend this service to friends and family?” Results from the test in December 2015 showed all areas to be positive. The results of the survey were displayed on the noticeboard.
- Following a local survey at Buccleuch Lodge the menu was improved to include seasonal options.
- We saw that a patient experience comment box was available with examples of previous positive comments. There were no examples of improvements made such as “you said...we did”.
- We saw many examples of compliment letters and thank you cards displayed in the units on notice boards. Both patients and relatives told us they had a high opinion of the care provided.

Staff engagement

- Staff talked of the ‘safety huddle’ where they got together after handover meetings to discuss incidents, accidents, complaints, new policies and procedures, and reflective practice which would bring about improvement to the services. Examples of these discussions were the introduction of the 15 minute observation schedule during the night at Wellington House to try to reduce incidence of falls by patients.

Innovation, improvement and sustainability

- Plans were underway at Wellington House to improve the services for people living with dementia by providing clear signage and introducing colour indicative doors for toilets.

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

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

We found store cupboards at Wellington House that were unlocked and we observed a patient wandering into one of them.

Substances hazardous to health were found unattended on a cleaner's trolley in an unlocked toilet.

At each unit we saw labels to indicate portable appliance tests had not been completed on equipment in the last 12 months.

At Buccleuch Lodge we saw eight old and damaged dining chairs were in use.

We found the nurse call bell system was not fit for purpose.