Sirona Care & Health C.I.C.

1-290660061

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)
1-297412138	Paulton Memorial Hospital		BS39 7SB
1-290660061	St Martin's Hospital	<Placeholder text>	BA2 5RP
1-1333619227	Thornbury Hospital	<Placeholder text>	BS35 1DN

This report describes our judgement of the quality of care provided within this core service by Sirona Care & Health C.I.C.. 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 Sirona Care & Health C.I.C. and these are brought together to inform our overall judgement of Sirona Care & Health C.I.C.

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

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

We rated Community Inpatients to be Good. This was because:

- Safety performance was good. Staff understood their roles and responsibilities to report incidents and lessons were learnt and shared widely when an incident occurred. The duty of candour was upheld for serious incidents and being open and honest was the culture throughout the hospital.
- Day to day risk management of patients' needs was good. This included for the management of a deteriorating patient and for medical emergencies. Care plans were comprehensive, patient centred and were reviewed appropriately.
- Care was delivered and coordinated with a range of different staff providing an effective multidisciplinary approach to care. This included from services outside of Sirona.
- Feedback from people who use the service and those close to them was continually positive. There was a strong person centred culture and inspectors observed staff showing kindness, preserving dignity, and building relationships between themselves, patients, and their relatives.
- We saw examples of where staff were helping people cope emotionally with their, or their loved ones stay in hospital and encouraged patients to manage their own health to maintain independence.
- Services were planned and delivered in a way that met the needs of the local population and took into account the different needs of people when planning and delivering the service. People living with complex needs had reasonable adjustments made to maintain their wellbeing. The use of reminiscence pods were an innovative idea to encourage engagement of people living with a cognitive impairment.
- We found that there was a clear statement of vision and values which was driven by quality and safety. This was reflected in the attitudes and behaviours of staff. Strong local governance processes ensured adequate oversight of local risk and performance which was monitored on a regular basis.

However:

- Not all staff were compliant in safeguarding level two training for adults and children. The biggest areas of non-compliance was Thornbury Hospital with under half of staff having up to date training.
- Medical records were not always stored securely
- here were multiple consumables, such as dressings, out of date at St. Martin's Hospital with some consumables being three years beyond its use by date.
- There were significant delays in discharge at St. Martin's Hospital and Paulton Memorial Hospital which were outside the organisation's control.
- The environment at Thornbury Hospital was not fit for purpose. It was cluttered, difficult to maintain patient privacy and was not set up to accommodate for people living with dementia.

Summary of findings

Background to the service

Sirona CIC provides community inpatient services with 79 inpatient beds across three community hospitals. These hospitals were all nurse led and had medical support from in-house doctors, support from local GP services, and support from local acute hospitals to provide consultant medical rounds. Therapies such as occupational therapy, dietetics, physiotherapy and speech and language therapy attended the wards to manage rehabilitation and end of life care.

During this inspection we visited Paulton Memorial Hospital (with 28 beds), St Martin's Hospital (with 31 beds), and Thornbury Hospital (with 20 beds). Eight beds at St. Martin's Hospital were designated for stroke rehabilitation. We visited Thornbury Hospital for a second time during an unannounced inspection. We spoke with 49 staff, 22 patients and their relatives and one volunteer during this inspection and collected 27 comment cards. An expert by experience telephoned an additional 7 patients. We also looked at 11 sets of patient records and 31 sets of medicines records across all three hospitals.

What people who use the provider say

- Patient led assessment of the care environment (PLACE) allow organisations to see how well they are meeting the needs of the patient and to identify where services can improve. We found that for privacy and dignity Paulton Memorial Hospital scored 93.5%, which is above the national average of 86%.
- We received consistently positive feedback from the 27 comment cards about the service. Comments showed a consistently positive experience from patient and their relatives showing a patient centred and caring culture. Comments included; “I have been looked after very well and treated like a queen”; “the staff are like family and so lovely” and; “the care of my sister has been excellent”. Another patient said, “nothing has been too much trouble. People are always willing to help and listen to my needs” and “Staff were caring at all times. I was treated with dignity and respect and offered help when needed”.
- Between April 2016 and September 2016, the community hospitals had received 269 friends and family responses with 99% of these recommending the service. The service consistently received a plethora of compliments and cards from patients and their relatives showing their appreciation for the care given. Between April 2016 and September 2016, the hospitals had received 103 recorded compliments.
- We spoke with a patient who had raised a complaint about the service. They said that they were supported by staff during this and found the process un-judgemental and positive. Another patient said that they “felt empowered by staff to make suggestions and raise concerns when necessary

Good practice

- The use of reminiscence pods in the community hospitals and scheduled activities to engage patients living with dementia. This had a positive impact on their levels of stimulation and wellbeing.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider MUST:

- Take action to improve compliance rates for level two and level three adults and safeguarding training in all three community hospitals.

The provider SHOULD:

- Improve the cleaning processes for storerooms at St. Martin's Hospital.
- Improve the systems in place to check the expiry date on consumables at St. Martin's Hospital.
- Review and improve systems to ensure that records are kept secure at St. Martin's Hospital.
- Should work to reduce the lengths of delayed transfers of care.

Action the provider COULD take to improve

Sirona Care & Health C.I.C.

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated Safe to be Required Improvement. This was because:

- Not all staff were compliant in safeguarding level two training for adults and children. The biggest areas of non-compliance was Thornbury Hospital with under half of staff having up to date training. However, when asked, staff were able to confidently describe their responsibilities.
- Medical records were not always stored securely at St. Martin's Hospital. We found that on several occasions during our inspection medical notes trolleys were left in corridors unlocked and unsupervised.
- At St. Martin's Hospital, we found that there were multiple consumables, such as equipment in the resuscitation trolley that was beyond its expiry date. We found some surgical masks in a cupboard, which were over three years out of date.
- The environment at Thornbury hospital was not fit for purpose. The ward was cramped which meant that there was not sufficient space for staff to safely carry out their duties. There was one example where a patient was out of reach of their call bell because their chair could not be put near their bed and another example where a patient would be obscured from view if other patients had their curtains closed. When equipment was required, such as a hoist, patients had to be moved from their bed bay to allow space.

However:

- Safety performance within the organisation was good with good levels of harm free care. Staff understood their responsibilities to report incidents and we found a good reporting culture. Lessons were learnt and shared when an incident occurred, and the duty of candour was always upheld. We saw examples of learning from incidents, which occurred in other organisations being discussed with learning being taken from them.
- Risks to people who used services were assessed, monitored and managed on a day-to-day basis. This included the management of deteriorating patients and medical emergencies. Risk assessments were person centred, proportionate and were reviewed regularly.

Requires improvement

Are services safe?

Safety performance

- Safety performance over time based on internal and external information was good. All three hospitals exceeded internal targets with Paulton Memorial Hospital and Thornbury Hospital achieving 93% harm free care, St. Martin's Hospital achieving 92% harm free care. However, the internal target was set at 75%, which was not challenging or promoting improvement.
- Safety thermometer indicators such as hospital acquired pressure ulcers, falls which caused harm, patients with new venous thromboembolisms and patients with catheters who developed a urinary tract infection were being monitored and the numbers of incidents were very low.
- The organisation benchmarked against similar services for falls and hospital acquired pressure ulcers. All three hospitals performed better than the England average for falls. Paulton Memorial Hospital performed slightly better than the England average for hospital acquired pressure ulcers.
- Safety goals had been set for many safety elements within the organisation and all three hospitals were performing well against targets. Safety performance was reviewed through a dashboard internally by the ward managers, matron and head of adult services and were externally scrutinised and held to account by the clinical commissioning groups. We saw evidence that where standards had dropped action plans had been introduced and were discussed in meeting minutes.

Incident reporting, learning and improvement

- Staff we spoke with understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses and how to report them internally and externally. We found that reporting levels were consistent over time in all three community hospitals with an average of 16 incidents being reported a month between the months of April 2015 and September 2016. A majority of these were near misses, insignificant or minor suggesting a good reporting culture. Serious incidents requiring investigation (SIRI) and reporting of injuries, diseases and dangerous occurrences reports (RIDDOR) were reported appropriately to the Care Quality Commission and the Health and Safety executive respectively. There had been one RIDDOR submitted where a staff member fell at Thornbury Hospital. There has been six serious incidents requiring investigation (SIRI) since October 2015. Three of these were falls resulting in a fracture (Two of which were at St. Martin's Hospital and one at Paulton Memorial Hospital). Two were Grade three pressure ulcers (In a grade three pressure ulcer, skin loss occurs throughout the entire thickness of the skin and the underlying tissue is damaged) with one at St. Martin's Hospital and one at Paulton Memorial Hospital. There was also one patient fall from height at St. Martin's Hospital. All of these incidents were reported on and investigated appropriately. We saw examples of where learning from these incidents had been shared with staff both in the hospital where the incident occurred and in the wider organisation.
- We saw multiple examples of how reviews from safety events fed into service improvement. For example, at Paulton Memorial Hospital a sharp object had been left on a worktop and not in a sharps bin. This was discussed in a team meeting and safe disposal of sharps audited as a result. Performance was seen to have improved. We also saw examples of where learning had been discussed, shared, and actions implemented as a result of events in other providers and organisations. However, one of the consultants at St. Martin's Hospital said they wished they were included more in the incident sharing process as they felt “out of the loop”.
- The service responded effectively to relevant safety alerts, inquiries, investigations and reviews. We saw evidence of multi-disciplinary meetings being held to discuss outcomes and learning from other organisations Care Quality Commission inspections and action plans created around these to improve service development.

Duty of Candour

- People who used services were told when they were affected by something that went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. This Regulation requires the organisation to notifying the relevant person that an incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we spoke with, from all levels in the organisation, had a good understanding of duty of candour and could describe when it would be used. They went on to describe the open and honest culture towards patients regardless of meeting the threshold for

Duty of Candour and could give example of lessons learnt and shared when something did go wrong. Staff could give examples where they had been open and honest when things went wrong.

Safeguarding

- The organisation required all staff to attend adults and children's safeguarding training every three years. However, we found that many staff working in the community hospitals had not received the required training. We found that although level one adults and level one children's safeguarding training had mostly been completed, there were many who required level two and three training who did not have it. At Paulton Memorial Hospital 91% of staff had level two adults training and children's safeguarding training. At St. Martin's Hospital only 51% of staff had level two adults safeguarding training and 53% children's safeguarding training. At Thornbury Hospital, only 43% of staff had adults safeguarding training and 36% had children's safeguarding training. At St. Martin's Hospital, one member of staff was required to have level three adults and children's safeguarding training but they had not done this. This meant that opportunities to identify and act upon safeguarding concerns may have been missed.
- Policies to safeguard adults and children from abuse that reflected relevant legislation and despite lack of up to date training staff understood their responsibilities and adhered to the safeguarding policies and procedures. At all three community hospitals staff told us about learning from safeguarding incidents. One of these incidents at Paulton Memorial Hospital had led to all band six members of staff being trained in assessing mental capacity. We were also told the safeguarding teams visited the hospitals every few months to provide informal safeguarding training and to update staff on learning from incidents.

Medicines

- Arrangements for managing medicines kept people safe at all three hospitals this included obtaining and prescribing of medicines . The supply of medicines was provided by a local NHS Trust. The organisation provided a clinical pharmacy service, discharge dispensing service and medicines governance support. The clinical pharmacist visited four times a week to St. Martin's Hospital and Paulton Memorial Hospital and twice a week to Thornbury Hospital to complete medicines reconciliation, answer enquiries, to order stock, and to manage individual medicines and discharge medicines. The recording of medicines kept people safe. We reviewed 31 medicines charts throughout the three hospitals. Prescriptions were well written, signed and dated and within British National Formulary, dosage ranges. The reasons for omitted doses were always recorded. Audits were carried out of controlled drugs, medicines storage and prescription chart completion. Further support was provided by a governance pharmacist who reviewed the audits, medicine incidents, pharmacist interventions and prescribing on external prescriptions (FP10s); these were reported to the medicines management committee. A medicines management newsletter was produced and distributed to all staff on a bi-monthly basis, which discussed the number of medicines adverse events and the learning from their investigations.
- The storage and security of medicines kept people safe. In all three hospitals, we found that the clinic rooms were clean and provided adequate security. At Paulton Memorial Hospital and St. Martin's Hospital, we found that the majority of medicines were stored in locked lockers by the patient's bedside. At Thornbury Hospital, medicines were stored and individually dispensed from a medicines trolley. We found that all fridge temperatures were being recorded appropriately. However, clinic room temperatures were not being recorded appropriately as required by the organisation's medicines management policy. There were also two out of date medicines in the medicines cupboard at St. Martin's Hospital and boxes of fluids being stored on the floor due to lack of sufficient storage space.
- Audits for missed doses were completed St. Martin's Hospital and Paulton Memorial Hospital from September 2016. Of the 715 doses audited only 24 (3%) were missed or delayed showing that there was a low level of missed doses with a majority of the missed doses being due to patient refusal. The audit also described that no critical medicines were delayed or omitted.

Environment and equipment

- The design, maintenance and use of facilities and premises at St. Martin's Hospital and Paulton Memorial Hospital kept people safe. There was ample space between patient beds to allow easy access with equipment and patients were always visible by a

member of staff. Staff at St. Martin's hospital were positive about a recent refurbishment of the ward saying that it had a "a positive effect to the staff and patients". However, the premises at Thornbury Hospital were not fit for purpose. At Thornbury Hospital although infection control was well maintained, we found that the ward was cramped meaning that there was not suitable or sufficient room for equipment, patient chairs, or adequate space around the beds to perform day-to-day duties. For example, there were beds in corners, which meant that if other patient had their curtains drawn they would be obscured from sight. Also, if a larger piece of equipment (such as a hoist) needed to be used patients in beds nearby needed to be moved to allow access. We also found that when some patients were sitting in chairs, they were out of reach of their bedside call bells. There were mobile bells but we found that one patient did not have one so could not call the nurse if they wanted assistance. Due to the close proximity of patients to each other it was also difficult to have a confidential conversation. We observed a conversation occurring between two members of staff about a patient in front of another patient. Staff we spoke with said that if they needed to have a difficult conversation with a patient they would move them to the day room or into the relative's room. We were told about an example where the patient was bed bound so unable to get into either of these rooms so they move the patients around them into the day room to preserve confidentiality.

- The maintenance and use of equipment did not always keep people safe. At St. Martin's Hospital, we found that there were multiple consumables, which were beyond their expiry date. For example: there were electrodes for an ECG machine which were 13 months out of date, catheter bag clips were 14 months out of date and surgical masks were three years out of date at the time of the inspection. Prior to the use of a patient hoist staff are meant to check that the equipment has an in-date service sticker on them to ensure that it is safe to use. At Paulton Memorial Hospital, we found that two hoists did not have clear markings on them of when they were last serviced. We found that at St. Martin's hospital the hoist did not have a sticker on it. Since the inspection, we received confirmation from the organisation to say they have reviewed processes and that the hoist has been replaced with one with a valid service sticker on it.
- Resuscitation equipment was available but was not always fit for purpose. We found at all three hospitals that there was no mechanisms in place to ensure that equipment had not been tampered with. At St. Martin's Hospital, we found that there was a sharps bin left on top of the resuscitation trolley, which had been left open. We also found that forceps and an airway tube were out of date. This means that there was no guarantee that the apparatus in the resuscitation trolley had been tampered with and that equipment in use was safe to use. Paperwork indicated that staff had recognised that these items were out of date but no action had been taken to replace them. At Thornbury Hospital, the responsibility of the resuscitation trolley was with the local acute trust and their policy was in use. The hospital was not working in line with this policy as equipment on the trolley was in different places (for example the sharps bin should be on the top and it was not) and that daily checking was not taking place. We also found that records for monitoring the resuscitation trolley checks were different in each hospital. We raised these issues at the time of the inspection. The out of date equipment was removed action had been put in place to get replacements. We made the matron aware of the concerns with the resuscitation trolleys at the time of the inspection.
- All three hospitals had appropriate equipment and space to perform occupational therapy and physiotherapy. The area at Paulton Hospital had recently been renovated providing ample space for bars, frames and practice steps. Staff told us that the gym used to be in the outpatient area rather than on the ward. Since the refurbishment, it was now easier for the patients and staff to access. The occupational therapy kitchen at Paulton Hospital was fully equipped and had counters, cooking equipment, tables and chairs in it.

Quality of records

- Individual care records were written and managed in a way that kept people safe at all three hospitals. We looked at 11 records and found that they were accurate, legible, up to date and mostly completed in full. However, we found that sometimes actions relating to assessments or observations were not always clearly explained. For example, one care record did not make it clear what actions should have been taken where weight loss had been identified.
- Notes were not always stored securely to protect patient confidentiality. For example in St. Martin's Hospital on several occasions, we found that the records trolley

(which was stored in the main corridor of the ward) was left open and unattended increasing the risk of theft or breach of confidentiality. We also found that one of these trolleys did not lock properly so could easily be opened even if the lock was secured. We also found that one of the doctors at St. Martin's Hospital left the computer unlocked with the Smart Card in the reader. This meant that confidential information could have been accessed by someone unauthorised to do so.

Cleanliness, infection control and hygiene

- Generally, standards of cleanliness and hygiene were well maintained. Patients we spoke with commented about how clean and hygienic the wards were. During observations, we found that all staff were cleaning their hands appropriately before and after patient contact. However, at St. Martins Hospital we found that in the treatment room some of the non-sterile consumables were stored in dirty containers. This was raised with staff and the items were disposed of to ensure they were not used.
- We were told in all three hospitals about the processes involved to reduce the risk and prevent cross infection in the hospital. All hospitals had an appropriate number of side rooms to ensure precautions for patients with an infection could be put in place. There were no cases of Methicillin-resistant Staphylococcus aureus or C-Difficile in the last 12 months.
- Assurance from cleanliness was obtained through hand hygiene audits; hospital cleaning audits and patient led assessment of the care environment (PLACE) audits were completed. At Thornbury Hospital, hand hygiene compliance was 99%, St. Martin's was 96% and compliance at Paulton Memorial Hospital was 96% from April 2016 to the time of the inspection. Hospital cleaning audits for St. Martin's Hospital showed compliance of 97% and 96% for Paulton Memorial Hospital. However, hospital cleaning audits at Thornbury showed results of only 86%. Staff we spoke with said it was difficult to be compliant due to the age of the building and the cleaning issues associated with that. PLACE audits allow organisations to see how well they are meeting the needs of the patient and to identify where services can improve. We found that for cleanliness St. Martins Hospital scored 99%, Paulton Memorial Hospital scored 97% and Thornbury Hospital scored 93%. Both Paulton Memorial Hospital and Thornbury Hospital were below the national average of 98% but were still positive results. Alongside audits, ad hoc spot checks were conducted by the matron, which were well documented. We saw results from most recent infection prevention and control spot checks conducted at all three community hospitals and found that compliance was good.

Mandatory training

- The organisation had introduced a one-day mandatory training session in June 2016 to increase attendance to training. This one-day session covered all required training such as manual handling, infection control and resuscitation training. The data showed that in the community hospitals the percentage of staff who had received training could have been improved. At Thornbury Hospital 91% of staff had completed mandatory training, at Paulton Memorial Hospital 85% of staff had completed mandatory training, and at St. Martin's Hospital only 81% of staff had completed mandatory training against a trust target of 90%. Staff we spoke with said that the one-day mandatory training did not equip them with the skills needed to work safely. Ward managers had introduced bespoke training to “fill the gaps” left by the training day such as a practical manual handling assessment. However, although many staff told us they were happening we found that these were not recorded.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for people who use the service and risk management plans positively managed risks and were developed in line with national guidance. Of the eleven records we looked at, all had a full holistic assessment of the patients’ needs and had clear and detailed care plans. Staff were identifying and responding appropriately to changing risks to people who used the service. We saw evidence of intentional rounding and repeat assessments being conducted based on the patient's national early warning score (NEWS) which is a method of recording information about a patient that clearly sets out how to recognise and respond to a patient whose condition was deteriorating and which is recognised as best practice by the National Institute of Clinical Excellence. We also found that for patients who were at risk of falls, pressure mats were introduced to alert staff when they were standing up. At Thornbury Hospital in one set of

notes, we saw than an individualised care sheet had been created for staff to be informed of the side effects of the patients chemotherapy and what was to be considered 'normal'.

- Although we did not observe a shift handover, paperwork indicated arrangements for handovers and shift changes kept patients safe. Paperwork was comprehensive and included detail about history and actions to be taken.
- There were appropriate arrangements in place to help assess and respond when a patient's condition was deteriorating. We were told about thresholds and standard operating procedures for contacting the local GP during the day, the on-call doctors out of hours (weekends and evenings) and to provide an emergency transfer to the local accident and emergency department. We saw an example where there was good care given when responding to a patient who felt lightheaded at Thornbury Hospital. The patient was quickly moved by the GP and a nurse back into their bed and observations and an ECG was conducted immediately. Audit information showed that 100% of the 28 patients who had deteriorated between February 2016 and July 2016 were reviewed within four hours.
- A clinical indicator required by the clinical commissioning group (CCG) was to monitor if a patient identified with sepsis is referred to the acute hospital in a timely way. In Thornbury Hospital, there was only one incident of sepsis, which was appropriately identified and referred.

Staffing levels and caseload

- The staffing establishment was based on the National Institute of Clinical Excellence 'Safer Staffing' standards, which was modified in line with the changing acuity of patient's on the ward. Managers told us that staffing levels were good and they found that access to additional staff was not burdensome or difficult to do. This ensured that people received safe care and treatment at all times. Patients said that they did not notice a change in quality or attentiveness of care between the day staff and the night staff and that staff always quickly came to assist them at any time of the day or night.
- Actual staffing levels were slightly lower than the budgeted establishment of staff. Information provided by the organisation showed that out of 108.1 whole time equivalent (WTE) which is the number of people required across all functions of the hospitals, there were 13.89 WTE vacancies. Half of these WTE vacancies were nursing (two at Paulton Memorial Hospital, three and a half at St. Martin's Hospital and one at Thornbury Hospital) and the other were support worker vacancies (two at Paulton Memorial Hospital, two at Thornbury Hospital and less than one at St. Martin's Hospital).
- At Thornbury Hospital, the fill rate of shifts was generally good. With an average nursing staffing of 100% during the night and 108% during the day between April 2016 and September 2016. Health Care Assistant shifts were filled 100% of the time at night although day shifts were only filled 93% of the time between April 2016 and September 2016. Similarly, at St. Martin's Hospital fill rates for night staff were good (with nursing levels at 100% and health care assistant fill rates at 99%). However, only 94% of healthcare assistant day shifts were filled. At Paulton Memorial Hospital fill rates were 112% during the day and 99% at night with care staff fill rate at 99% at night. Levels of care staff during the day were furthest below the 95% target at 88%. We were told that the organisation had access to bank staff to cover these shortfalls, which were selected by the managers based on experience.
- All three hospitals partook in a national bed occupancy benchmarking programme, which reviewed their caseload (bed occupancy) against other hospitals partaking in the audit and against a 91% target. All three hospitals performed well against other hospitals (with occupancy being significantly less than a large quantity of hospitals) but they were all above the target. Thornbury Hospital was performing at 92% bed occupancy, St. Martin's Hospital was performing at 96% bed occupancy, and Paulton Memorial Hospital was performing at 97% occupancy. Benchmarking was also done to compare the staffing mix of non-medical clinical staff (nurses and health care assistants) and found that they were comparable to the national results.

Managing anticipated risks

- Potential risks were taken into account when planning the service for seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing through comprehensive business continuity plans found at each of the community hospitals. These detailed

Requires improvement

Are services safe?

many possible situations, the risks as a result, and the mitigation actions in a clear and concise way for any member of staff to follow. These were found in the same place in each of the hospitals to improve continuity.

- We saw evidence of appropriate risk assessment and mitigation when an anticipated risk was identified. We were given an example at St. Martin's Hospital where the number of beds was reduced for a period to refurbish the ward areas. This was appropriately risk assessed and mitigating actions put in place to reduce risk to patients.

Good

Are services effective?

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

Summary

We rated effective to be good. This was because:

- Care and treatment reflected current evidence-based guidance, standards and best practice. This was monitored to ensure consistency of practice and new techniques were not introduced without rigorous monitoring and risk assessing processes.
- People had comprehensive assessments completed of their needs, which included physical health, wellbeing, nutrition, and hydration needs, which were identified. These were recorded in comprehensive care plans.
- Staff were qualified and had the skills they needed to carry out their roles effectively in line with best practice and staff were supported though timely supervision. However, appraisal rates could have improved.
- Care was delivered in a coordinated way from a range of different staff, teams and services. There were clear MDT processes in place, which involved all levels of the organisation. Staff worked together to understand and meet the range and complexity of people's needs.

However:

- There were significant delays at St. Martin's Hospital and Paulton Memorial Hospital in discharging patients to the most appropriate place although this was mostly outside of the organisations control.

Evidence based care and treatment

- There were multiple examples of how relevant and current evidence-based guidance, standards, best practice and legislation were identified and used to develop how care and treatments were delivered. We saw in all three community hospitals that the use of bed rails were prohibited and that all beds could be lowered to the ground and have crash mats to prevent someone injuring themselves if they fell. This was because recent research suggested that there was a higher risk of someone climbing over bed rails to get out of bed than no bed rails at all. We also saw evidence of how best practice of sepsis management and acute kidney disease had been used in the hospitals resulting in training and embedding of new processes.
- People had their needs assessed, their care goals identified, care planned and delivered in line with evidence based guidance, standards and best practice. Venous thrombolysis was audited against National Institute for Clinical Excellence (NICE) guidelines CG144 in all three community hospitals for 'the management of venous thromboembolic diseases and their role of thrombophilia testing'. Results showed that after sampling 19 patient records that compliance around assessment, diagnosis and treatment was good. Acute kidney disease was audited against NICE guidelines CG169 in all three community hospitals for the 'prevention, detection and management of acute kidney injury up to the point of renal replacement therapy. Results showed that after sampling 17 patients the hospitals were compliant with investigation and recognising risk factors accompanying them. The audit also showed that in 88% of patients with acute kidney disease had clear discharge summaries that indicated acute kidney injury.

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- Pain was assessed through the use of a pain assessment tool and pain management plans. However, the use of these were not always consistent. We found that out of the 11 patient records we looked in six did not have pain assessment or management plan. We also found one example where a pain score was only completed on admission.
- Despite this, all patients we spoke with commented that they had their pain well managed and were able to get analgesia when requested or required.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- Patient's nutritional and hydration needs were assessed through the use of a malnutrition universal screening tool (MUST) in each patient care plan. Of the 11 patient records we looked at, all had completed assessments. However, we did find that actions as a result of a patient losing weight were not always clearly documented. For

example, one patient with a goal to gain weight during their stay had lost 3kg instead. It was not clear if any changes were made to the patient's care plan as a result of this. MUST scores were audited on a quarterly basis and monitored by the organisation and the local Care Commissioning Group (CCG). Results for the time between April 2016 and August 2016 showed an overall score of 92% at Thornbury Hospital, which met the 90% target set by the CCG. The audit broke down information to show that 92% of scores were completed within 24 hours of admission and that of those that were not, they were all completed within 3 days. At Paulton Memorial Hospital and St. Martin's Hospital the combined score was 85% which was did not meet the target. It was identified that work could be done and this was being addressed by the matron including streamlining processes and raising awareness of its importance.

Patient outcomes

- Although limited, outcomes of people's care and treatment was routinely collected and monitored. Elderly mobility scales were recorded for all patients. These scales act as a tool for the assessment of mobility (considering locomotion, balance and key position changes) for frail patients. Audit results showed that 83% of patients had improved mobility and 79% having a substantial improvement in their mobility.
- The organisation participated in relevant local and national audits, benchmarking and research. All three community hospitals benchmarked as part of the national benchmarking for community hospitals. Although not all hospitals in England partook in this study it allowed the hospitals to compare how they were performing against the vast majority for the modified barthel score (a measure of performance in the ability to perform day-to-day activities). Results were better compared to the recorded England average for the vast majority of patients audited.
- At St. Martin's Hospital, plans were in place to introduce the Sentinel Stroke National Audit Programme (a national audit used to assess the quality of stroke care throughout a patients pathway) for patients who was admitted to the community inpatients ward after a stroke, to bring them in line with the community adults teams.
- At Thornbury Hospital, we were shown data from outcomes used by the therapists to justify their performance to the local clinical commissioning group. This was reported on a monthly basis and had very positive scores on individual outcome audits.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job. Staff consistently told inspectors they were given opportunities to develop and were encouraged to do so by their managers. We were given multiple examples of where staff had attended courses based on clinical need and benefit in the hospitals. Examples included physical assessment and clinical resourcing courses (delivered at the local university), end of life care courses (provided by a local hospice), and blood transfusion courses. Nurses received a comprehensive induction around medicines management and had access to training on individual topics such as care of peripherally inserted central catheter (PICC) lines, used as a form of intravenous access, the use of syringe drivers, and anaphylaxis training. However, senior staff had identified that they did not get general medicines update training once in post. The pharmacy service was in the process of developing workbooks to act as an update. Staff we spoke with did not feel they were missing out on training and could ask for any training if they felt they needed it.
- Learning needs were identified through appraisal and supervision. Arrangements for supporting and managing staff should include a yearly appraisal for non-medical staff and revalidation for medical staff. However this was not consistently being done. Appraisals and revalidation allows staff to recognise good practice, identify learning needs, and ensures all staff have sufficient line manager support to succeed. Based on information provided by the organisation prior to the inspection at Thornbury Hospital 22 of the 28 staff (79%) had received an appraisal at the time of the inspection. At St Martin's Hospital 40 of the 54 staff (74%) had received an appraisal at the time of the inspection. At Paulton Memorial Hospital 27 of the 35 staff (95%) of staff had received an appraisal at the time of the inspection. All four doctors employed by the organisation had an up to date revalidation.
- There was a standard operating procedure (a document detailing specific activities which need to be completed)

to ensure that all staff working in the wards had clinical supervision. This included both clinical and non-clinical staff. These were scheduled to ensure attendance and encouraged reflective practice. One member of staff at St. Martin's Hospital said it was "so nice to talk through things and have someone listen to me"

- New staff we spoke with felt well supported during their induction and felt appropriately supervised. We were given examples where support had a positive impact on the staff members wellbeing and confidence.

Multi-disciplinary working and coordinated care pathways

- We found that all necessary staff, including those in different teams and services, were involved in the assessing, planning and delivery of people's care and treatment. Each patient was discussed in a multi-disciplinary meeting (MDT) on a weekly basis where each discipline (medical, occupational therapy, physiotherapy, and nursing) rated progress against goals. This was then discussed a second time at a smaller MDT to discuss further progress. Action plans were created from these meetings to progress patients to discharge.
- We found that care was delivered in a coordinated way with different teams and services involved through several initiatives in conjunction with the community hospitals, clinical commissioning groups, and acute hospitals. Processes known as the community hospital 'SAFER' patient flow bundle were introduced for all patients to improve the journey of patients when they are admitted. This bundle ensures that all patients, will have an expected discharge date within 72 hours of admission, have regular and well-recorded consultant ward rounds, will be discussed as an MDT twice a week, and will try to be discharged before midday. The 'SAFER' bundle also set out the processes to ensure flow through the community hospitals. Processes included appropriate circulation of capacity to the acute hospitals before 9am, to provide an update by 11am (to discuss allocated beds, remaining capacity and predicted discharges over the next 24/ 48 hours), internal feedback to managers by 12am and an end of day report being sent to local providers by 4pm.
- 'Discharge to assess' had been introduced across both counties where the community hospitals receive patients from to improve flow in the acute hospitals for patients who are medically fit but require additional rehabilitation, reablement or recovery. Data from the organisations quality account states that 76% of patients on this pathway do not return to the acute trust, therefore improving flow for other providers. This has acted as part of several pathways, which resulted in 38 additional discharges from a local acute hospital a week. This helped reduce the risk of secondary complications associated with long stays in hospital such as deterioration, muscle weakness, and reduction in functional ability.
- All team members were aware of who had overall responsibility for each individual's care through a combined care record. All members of staff involved in a patient's care used one care record to ensure an MDT approach to care
- At Paulton Memorial Hospital if patients with complex care needs required therapy a member of staff from the re-enablement team attended to support, provide assistance and advice. The stroke team at St. Martin's Hospital worked closely with the local acute trust to ensure continuity of care and expertise. One consultant we spoke with had regular communication with the clinical lead for stroke at the acute trust for advice or additional information. Where specialist skills were not at one hospital we saw that hospitals sent staff across sites when requested. For example, we were told at Paulton Memorial Hospital that a patient who required additional neurological rehabilitation was supported by staff from St. Martin's Hospital.

Referral, transfer, discharge and transition

- The organisation was experiencing growing pressure from the combination of increasing volume and acuity of demand for community health and social care services. These pressures were observed in the extended length of stay and the numbers of delayed transfers of care. St. Martin's Hospital and Paulton Memorial Hospital had their capacity limited due to delays in patient discharge. Between 10 April 2016 and 29 September 2016 there were a total of 328 patients whose discharge had been delayed resulting in a total of 1331 bed days (an NHS unit used to quantify the availability or use of beds over time) being lost. Of these bed days, 120 were lost due to the internal factor of awaiting further therapy. However, 97 days were lost due to patient's waiting funding, 485 days were lost due to patients awaiting assessment and 351 days were lost due to patients awaiting social services input. In the

week of the 29 September 2016, the discharge of 12 patients at St Martin's Hospital had been delayed by more than 28 days. During the inspection, we found that one patient had been waiting 40 days for social care placement.

- When people were discharged from the service this was always done at an appropriate time of day with most discharges occurring before midday and the remainder being done before 5pm. Audit information from September 2016 showed that at Paulton Memorial Hospital 73% of patients were discharged before midday, at Thornbury Hospital 80% of patients were discharged before midday and at St. Martin's Hospital 53% of patients were discharged before midday.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between services. All patients were discussed at a weekly MDT (with medical staff, nursing staff, therapy staff, and social workers) and actions were put in place to ensure a safe discharge. At St. Martin's Hospital, the stroke rehabilitation team worked closely with local acute trusts to ensure that patients who were admitted to the ward were appropriate and had positive rehabilitation potential. Plans were in place to set up a weekly meeting with the acute trust to further plan the use of the stroke beds. The consultant also did home visits to prevent admission into the community hospital. We were given examples where stroke care was provided at the patients preferred place and staff went the extra mile to ensure safe high quality care at this time.

Access to information

- All of the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Risk assessments and care plans were all stored at the end of the patient's bed, which ensured easy access for staff providing the care. Patient case notes were stored on the ward. At St. Martin's Hospital, we were told that after discharge care records were sent to Paulton Memorial Hospital for storage. However, these notes were not easily retrievable therefore, a new set of notes was created for each admission and were joined with the old set later. Nurses said that this disrupted joined up care and consistency between services.
- Test results were available on computer systems for authorised staff to access. Staff at St. Martin's Hospital commented that they sometimes found it difficult to access information about service users when they needed it. There were only three computers on the ward, which were often in use by doctors, or allied healthcare professionals so made it difficult for nursing staff to get time to access a computer.
- We were told that generally there were embedded systems in place to manage care records between providers. Staff we spoke with said that when patients were admitted to the ward from an acute provider they were always provided with a photocopy of the acute notes, which ensured a consistent transition between services.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. All patient records we looked in had appropriate consent recorded and how people were supported to make decisions was detailed in the notes.
- Staff we spoke with could give examples where patients lacked the capacity to make a decision and best interest decisions were made (in conjunction with the Mental Health Liaison Team) in accordance with legislation. One example was around the Deprivation of Liberty Safeguard request placed with the local authority because a patient wanted to leave the hospital to live in unsafe premises. Management of this was using an MDT approach with the organisation, social workers, local authority and acute hospital. Learning from this issue was shared between staff in all three community hospitals and resulted in additional training.
- We saw examples in therapy session where verbal consent was gained before performing any procedure.

Good

Are services caring?

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

Summary

We rated caring to be good because:

- Feedback from people who used the service and those close to them was continually positive about the way they were treated by staff. Patients were telling inspectors that staff went the extra mile and the care they received exceeded their expectations.
- There was a strong person-centred culture. We observed staff showing kindness to patients and always preserved their dignity. Relationships between people who use the service, those close to them and the staff was always caring and supportive.
- We received 27 comment cards which were consistently positive regarding the compassionate care, the involvement of patients and those close to them, and emotional support always provided by staff at all levels.

Staff helped people and those close to them to cope emotionally with their care and treatment. People's social needs were understood and were supported by staff to manage their own health and care when they can and to maintain independence.

Compassionate care

- We observed interactions in all three community hospitals. We saw that staff took the time to interact with people who use services and those close to them in a respectful and considerate manner. We received comment cards, which were consistently positive. Patients we spoke with commented that "I have been looked after very well and treated like a queen" and "the staff are like family and so lovely".
- Staff made sure that people's privacy and dignity was always respected. This included during physical and intimate care. We saw that when care was being delivered curtains were always pulled across at all three of the community hospitals. At Thornbury, hospital staff explained the difficulties when managing difficult conversations in a cramped ward and said that they would go to the lengths of moving other patients away when they wanted to have a sensitive conversation with a patient. We also received comment cards, which were consistently positive. Comments included "staff were caring at all times. I was treated with dignity and respect and offered help when needed".
- Patient led assessment of the care environment (PLACE) allow organisations to see how well they are meeting the needs of the patient and to identify where services can improve. We found that for privacy and dignity St. Martin's Hospital scored 82.84%, Paulton Memorial Hospital scored 93.53% and Thornbury Hospital scored 80.15%. Only Paulton Memorial Hospital scored above the national average of 86.03%.
- An observational snapshot audit was conducted by the organisation at all three community hospitals to see if dignity was preserved and appropriate support given during meal times. The audit showed that catering and health care assistance were attentive, cheerful and encouraged patients to eat their food. A good camaraderie was identified between staff and patients. The audit/observation also showed that the patients were checked by a member of staff regularly during meal times and that assistance was offered with cutting food and help with eating.
- We received consistently positive feedback from the 27 comment cards about the service. Comments showed a consistently positive experience from patients and their relatives showing a patient centred and caring culture. Comments included; "I have been looked after very well and treated like a queen"; "the staff are like family and so lovely" and; "the care of my sister has been excellent". Another patient said, "nothing has been too much trouble." People are always willing to help and listen to my needs" and "Staff were caring at all times. I was treated with dignity and respect and offered help when needed".
- Between April 2016 and September 2016, the community hospitals had received 269 friends and family responses with 99% of these recommending the service. The service consistently received a plethora of compliments and cards from patients and their relatives showing their appreciation for the care given. Between April 2016 and September 2016, the hospitals had received 103 recorded compliments.

Good

Are services caring?

- We were told in all of the community hospitals that when there was significant events (such as football or the Olympics) the patients, visitors and staff all sat in the day room and watched it together building relationships between them. We were told that staff joined patients for Christmas dinner at Thornbury Hospital.

Understanding and involvement of patients and those close to them

- In all of the community hospitals, every patient was given a computer tablet prior to discharge to complete the friends and family test on. We saw results from the friends and family test for the last 12 months and found them to consistently be 100%.
- One relative at Paulton Memorial Hospital said that "the care was excellent and staff were supportive" and went on to say "all decisions are shared with me and I feel involved with the care my mother is receiving".
- One patient we spoke with said, when talking about the staff, "nothing feels like a chore to them, they are always happy to help and provide support to me and my family".
- We observed a therapy session with a patient who was being encouraged to try walking with aids. The physiotherapist was very polite, engaged with the patient, and encouraged independence. We also saw that the patient was included in the decision making process. Inspectors spoke to the patient after the session who said that the care was "amazing" and was extremely positive
- The stroke service at St. Martin's Hospital encouraged all patients and carers after discharge to go to a local support group. Every two weeks, information sessions were offered to patients and their relatives with the consultant and psychologist to offer advice and support.
- At St. Martin's Hospital, they had a side room, which had space for a second bed. This allowed a relative to stay with a patient when they were coming close to discharge to trial independent living. This process fully involved the carers and relatives of the patient and increased their confidence. If necessary, they were still able to call on the nurses for assistance.

Emotional support

- At Thornbury Hospital, we observed a patient deteriorating and feeling light headed. We observed that the GP spoke to the patient in a calming way and reassured them that everything was ok. It was clear that the staff reduced the patients anxiety during a stressful time. We also saw an example at Thornbury Hospital where a relative got upset. The Ward Manager and a senior nurse saw this and quickly escorted her to a side room for a private and meaningful conversation.
- At Thornbury hospital we discussed with the doctors and nurses how conversations about ceilings of care and discharge packages were managed. Staff understood the sensitive nature of these conversations and described how they would approach these difficult conversations with compassion. Emotional support was provided for both patient and their relatives. We were told about how these were a proactive and supportive conversation with the patients, relatives, nursing and medical staff.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive to be good. This was because:

- We found that services were planned which took into account the needs of the patients. This included specialist care from stroke consultants.
- People living with complex care needs had reasonable adjustments made to ensure high quality care was maintained at all times. The service proactively maintained the wellbeing of these patients through additional therapy sessions.
- People we spoke with said they knew how to complain. There was openness and transparency in how complaints were dealt with and complaints were always taken seriously, responded too in a timely way and listened too. Improvements were made to the quality of care because of learning from complaints.

However:

- People were generally getting access to the right care at the right time including from consultants, GPs, doctors, and some therapists. However, due to the demand of the physiotherapy team not all patients were seen when they should have been leading to less than optimum rehabilitation care for patients.
- Thornbury Hospital's PLACE assessments scored 55.3%, which was significantly lower than the national average of 74.5% for making adjustments for patients living with dementia.

Planning and delivering services which meet people's needs

- Other providers and relevant stakeholders were involved in the planning and delivery of services. The service worked well with other health and social care providers to plan and meet the needs of people in the area, particularly those with complex needs, long-term conditions, or life limiting conditions. Each of the three hospitals had a consultant ward round on a weekly basis with a consultant from one of two local acute trusts and were fully involved with the patients care. At St. Martin's Hospital, there were eight designated stroke beds, which provided step down rehabilitation for the local acute hospital. These beds were managed by a stroke clinical nurse specialist and had two consultant ward rounds each week. We observed a ward round at Thornbury Hospital, which was being conducted in corroboration with the patient, the nurse, the visiting GP and the consultant to ensure joint decision making. The consultant said that this was "a good arrangement as the nurse acted as the advocate for the patient allowing the team to make the right decisions for the patient, not just for a medical basis".
- Some patients were engaged in activities on a regular basis. We found that the day rooms in all three of the community hospitals were constantly in use by patients and their relatives. The day room at Paulton Memorial Hospital and Thornbury Hospital had reminiscence 'pods' to encourage and stimulate reminiscence. These 'pods' were walls and furniture decorated in the style of a 1950's room and a picnic scene to improve wellbeing for those living with dementia. At St. Martin's Hospital, reminiscence was encouraged through a memory group. Other activities included a balance group, painting group, gardening group, and a knitting group. They also encouraged patients to participate in a summer and winter bazaar. Paulton Memorial Hospital employed a porter who regularly played the piano located in the day room. The hospital had also put out to advert a job role for an activity coordinator who would host group and 1:1 sessions for the patients and their relatives.

Equality and diversity

- Staff could give multiple examples of where services had been tailored to take into account the needs of people of different ages, disability, and gender to ensure that the service was equal to all. There were multiple posters around the wards advertising the friends and family test in different languages. This encouraged people with different languages to English to participate. Staff said, "it didn't matter who the patient was, they would all be treated like individuals" and when asked about equality and diversity discussed the organisations values of 'making it personal'.
- There were no mixed sex breaches in the last 12 months. Two thirds of bays and side rooms were for female

patients to meet the demand. We were told by staff of the processes involved with ensuring that the standard was met and had continuity plans in place to move patients into side rooms if there was a risk of breaching.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability. At all three hospitals there were strong links with the organisation's learning disability service to ensure that reasonable adjustments were made where appropriate. Staff also worked with the local acute trust, and the local authority to maintain a consistent level of support between providers. People living with dementia all had a 'This Is Me' passport. A 'This Is Me' passport is a written discussion between a nurse and a patient to allow them to tell staff about their needs, preferences, likes, dislikes and interests.
- We saw that reasonable adjustments had been made for patients living with dementia. We found that at Paulton Memorial Hospital there were specific rooms to ensure safety and to reduce confusion of patients. For example, one bay and two side rooms had a cushioned floor to reduce the risk of harm during a fall, as well as daylight bulbs to maintain a consistent level of light during the day. Outside organisations, which specialise in dementia care, were invited into the hospital every few weeks to facilitate activities and a specially trained care dog came into the hospital to visit patients regularly.
- Paulton Memorial Hospital and St. Martin's Hospital had specific equipment to care and manage the treatment for bariatric patients.
- Patient led assessment of the care environment (PLACE) allow organisations to see how well they are meeting the needs of the patient and to identify where services can improve. We found that for food and hydration St. Martin's Hospital scored 82.68%, Paulton Memorial Hospital scored 91.12% and Thornbury Hospital scored 71.34%. Paulton Memorial Hospital exceeded the national average of 88.49%. St. Martin's Hospital fell below the national average and Thornbury Hospital scored significantly below the national average. Work had been done to ascertain the issues of food at Thornbury Hospital and this had been made a quality priority for the organisation. Work was ongoing to use an external food contractor rather than food from the local acute trust, which required personal preference for meals to be made two days in advance.
- Thornbury Hospital was not meeting the needs of patients living with dementia and this was reflected in the PLACE assessments. Thornbury Hospital scored 55.3%, which was significantly lower than the national average of 74.5%. This was because of the cluttered and cramped conditions on the ward. Although, there was a reminiscence pod in the day room. We did not receive scores for Paulton Memorial Hospital or St. Martin's Hospital.
- At Paulton Memorial Hospital one member of staff described to inspectors that a patient who was deaf was given a picture book to explain processes and procedures and was also given a white board to communicate with staff.

Access to the right care at the right time

- People who used the service had timely access to care and treatment. Each hospital had a consultant ward round on a weekly basis. St. Martin's Hospital had an additional ward round to accommodate for patients admitted on the stroke part of the ward. Paulton Memorial Hospital and St. Martin's Hospital had in house doctors who managed the day-to-day medical needs of the patients. Thornbury Hospital had access to a GP on a daily basis to perform the same function. Out of hours, support was provided by on call doctors from other organisations. Staff told us that this ensured that there was always appropriate medical cover to manage care and to ask for advice any time of day.
- Although the therapies staffing was at full establishment some staff said that they could not always perform therapy on the patients they needed to in a day due to the complexity and acuity of the patients. For example at Paulton Memorial Hospital two days before the inspection, six patients went without therapy, and the day before the inspection three patients went without therapy due to staffing issues. We were told at Paulton Memorial Hospital that Saturday sessions had to be stopped due to staffing issues but plans were in place to reintroduce them again. This meant that although patients were not receiving unsafe care, they were not receiving the optimum level of therapy possible.
- All patients had access to speech and language therapists who attended the hospitals once a week as

well as access to the mental health team if necessary. Staff told us that these services were easy to access on an ad hoc basis as well as regularly to meet the needs of the patients.

- Paulton Memorial Hospital had plain X-ray facilities on site, which allowed patients to have simple scans conducted there. All three community hospitals had good links with transport companies and the acute trusts to ensure scans could be completed during the day in a smooth way reducing the anxiety of the patient. Staff from all of the community hospitals said that where possible, they would ensure that all scanning had been completed before being admitted to the ward, unless they were direct access from home.

Learning from complaints and concerns

- People who used the service knew how to make a complaint. We spoke with several patients who said they felt able to raise concerns with nurses. Relatives we spoke with pointed us towards complaints leaflets, which were located around the community hospitals. We spoke with a patient who had raised a complaint about the service. They said that they were supported by staff during this and found the process un-judgemental and positive. Another patient said they "felt empowered by staff to make suggestions and raise concerns when necessary".
- Complaints were handled effectively and confidently. Every complaint was investigated, with staff describing seeing opportunities for improvement and learning through complaints. We saw evidence in meeting minutes where learning from complaints was shared between all three community hospitals.
- There had been a total of seven complaints managed by the complaints team between July 2015 and June 2016. Four were attributed to Paulton Memorial Hospital and three were attributed to St. Martin's Hospital. Three complaints in total were upheld. The main themes from complaints throughout the year were communication, delays in access to services, and quality of care.
- Staff discussed openness and transparency when managing complaints, regardless of the outcome of the investigation, and if the service user has been disappointed with the service, staff would always say sorry.

Good

Are services well-led?

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

Summary

We rated well led to be good:

- We found that the statement of vision and values for the organisation were driven by quality and safety. This had been translated into a credible strategy and well-defined objectives. The vision and strategy were well known by the staff who were able to describe the impact it had on how they worked.
- Strategic objectives were supported in the community hospitals by quantifiable and measurable outcomes.
- Governance within the hospitals worked effectively and structures, processes and systems of accountability (including the governance and management of partnerships, joint working arrangements, and shared services) were clearly set out and were effective.
- There was an effective and comprehensive process in place to identify, understand and reduce risks in the community hospitals and performance was monitored on a regular basis. Where performance had declined, rigorous processes were put in place to improve it.
- Leaders in the community hospitals were knowledgeable about quality issues and proprieties, understood what the challenges were and proactively took action to address them.

Service vision and strategy

- There was a clear organisational vision and a set of values with quality and safety the top priorities, which was effectively cascaded to all staff. Staff we spoke with were able to describe the vision and values of the organisation and unanimously discussed the impact "taking it personally" had on patient care and what it meant to them.
- There were robust and realistic quality measures to ensure that organisation's strategy was achieved. This was based on up to date information and we saw impact of this in the hospitals. For example, we saw that food provision at Thornbury Hospital had been made a quality priority in years 2016/2017 and staff could confidently describe progress with this project.
- Staff discussed the positive rapport they had with the patients and how it fitted in with the organisation's values. One member of staff said, "we know the patients as people with a condition, rather than just a patient".

Governance, risk management and quality measurement

- Locally there was an effective governance framework to support the delivery of the organisation's strategy and good quality care. In each hospital, on a monthly basis, there was a whole team meeting (which included therapists and doctors), and a senior nurse meeting. Meeting minutes differed in style in each of the community hospitals. Paulton Memorial Hospital had their meeting minutes set out in the five CQC domains to relate it to the legal requirements of the Health and Social Care Act 2008.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. We saw multiple examples of audits and action plans that demonstrated improvements to practice on a continual basis. Example included the action plan from the PLACE food assessment at Thornbury Hospital.
- Locally there were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. As of October 2016, there were four risks relating to community inpatients on the organisation's (or organisational) risk register. All of these items had appropriate mitigating action, timely updates, and nominated responsible individuals to manage them. There was one risk, which was rated at 12, which was high levels of staff vacancies at Paulton Hospital. This was discussed at an organisation board meeting and actioned through this forum. All local ward managers had a good understanding of their risks and what was on the risk register and why.
- However, governance systems and processes failed to manage and mitigate the risks around staff receiving safeguarding training.
- At each community hospital there was a folder which contained all risk assessments completed on site. These

assessments were concise, informative and contained all information related to the risks and mitigating actions. Examples of local risks included the use of a hearing dog at Thornbury Hospital.

- There was a vast quantity of safety measures available to determine the performance of the hospitals and this was being monitored on a monthly basis with the hospitals matron and with the local CCGs. For example, a score card of performance for Thornbury Hospital had 46 indicators, all of which were being robustly monitored and actioned.
- At St. Martin's Hospital, all staff were expected to read and sign meeting minutes when they were released to ensure that information was appropriately distributed and listened too.

Leadership of this service

- Leaders (at a local level and at an executive level) were visible and approachable. All staff we spoke with were consistently positive about the ward managers and the matron. At St. Martin's Hospital one member of staff said that the ward manager was "fab, on the ball, knows what's what, and has been very good to me". Ward managers led by example and acted as positive role models for the other staff encouraging supportive relationships among staff.
- Leaders we spoke with had the skills, knowledge, experience and integrity that they needed to lead effectively. All ward managers and the matron had a clear understanding of the challenges to good quality care and could confidently identify actions to address them.

Culture within this service

- All staff we spoke with felt confident to raise concerns with their line managers and more senior managers if necessary and felt that their concerns would be listened to and actioned.
- Ward managers could give examples of action taken when staff demonstrated behaviour and performance that was inconsistent with the vision and values of the organisation. Staff we spoke with felt confident to challenge their peers and go to their managers if they felt something was not being done right.
- The organisation conducted a yearly staff survey to assess the culture and wellbeing of staff rating them in a percentage from 0% being low and 100% being good. Although results of this was not broken down to individual wards response rates from the hospitals was good. The average score across the organisation was 69% with the highest scoring question with a score of 78% being 'I feel my role makes a difference to service users' and the lowest scoring question with a score of 61% being 'How would you currently rate your wellbeing at work'. Thornbury hospital was one of the highest scoring areas throughout the entire organisation with a score of 86% however; this was only based on six responses.
- One member of staff at Paulton Memorial Hospital said, "everyone genuinely cares for the patients and each other".
- At Thornbury Hospital, security at night was a priority based on concerns raised by staff. All staff were given a security alarm, which directly called the police who could attend within 10 minutes. Although they were not lone workers, they were secluded in the ward building. This was adequately risk assessed, on the risk register, and reviewed on a monthly basis.
- Staff said that they "worked as a team" and were "there for each other". They told us that the culture of multidisciplinary teamwork between all levels of staff had a positive impact on the care and wellbeing of patients.

Public and staff engagement

- Paulton Memorial Hospital and St. Martin's Hospital had been working with a university on a project around the impact the local population had on a community hospital and the impact a community hospital had on a local population. They interviewed 37 staff, patients, carers, volunteers and members of the community and conducted five focus groups. Staff told inspectors about the positive comments they received about the impact they had. There were also lessons to be learnt from the findings, which needed to be discussed further with the assessors, patients and staff once the report had been published.
- Paulton Memorial Hospital had a very active 'League of Friends' who consistently funded hospital projects. These included the refurbishment of the occupational therapy gym and kitchen, the dementia friendly rooms, and the day room.
- There were monthly staff meetings held in each hospital to disseminate information from higher in the organisation and to act as forum for listening to

concerns and worries from the staff. We saw evidence in minutes that actions had come from staff raising concerns. Staff we spoke with were positive about the meeting structure and said there was a good balance "between having meetings and being allowed to get on with the job".

- Staff at St. Martin's Hospital were all complimentary about the culture of the ward compared to where it was 12 months ago. Staff said that the learning and development team had spent time on the ward to develop a forum for listening and engaging with staff. Actions to come from this forum was the decoration of the ward, which had a positive impact on the wellbeing of both staff and patients. One member of staff said "they didn't feel listened too but they do now" and attributed this positive change due to a new manager. Another member of staff said "responsibility is now shared between staff and we feel more engaged and part of the ward". One comment card from a member of staff said there is "a more positive mood on the ward and staff feel listened too, appreciated, and thanked for their work and care".

Innovation, improvement and sustainability

- When developments to the service were introduced the impact on quality and sustainability were rigorously assessed and monitored. We saw that when new equipment or techniques based on best practice, were introduced, the impact on care was audited and actions put in place to ensure continual learning and improvement.
- We were given examples where staff were encouraged to be innovative and improve. A ward sister at Paulton Memorial Hospital was working with the local acute trust to introduce a 'catheter passport' This informs the nurses in the community hospitals and onwards in the community teams the reasons a patient had a catheter, when it was inserted, and the instructions around its care. There were leaflets for patients, which were tailored specifically to their needs. For example, the female leaflet had instruction and guidance on maintaining sexual activity.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13. – (2) Systems and processes must be established and operated effectively to prevent abuse of service users. At St. Martin's Hospital and Thornbury Hospital Staff did not have appropriate levels of safeguarding training. This increased the risk of safeguarding concerns being missed.

This section is primarily information for the provider

Enforcement actions

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.