Cavendish Hospital

Quality Report

Cavendish Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information we hold about quality, and information given to us from patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Cavendish Hospital (Fenton Ward) is an 18 bedded facility comprising of three side rooms and five three bedded bays. This inpatient service provides rehabilitation and end of life care for adults.

Most patients we spoke with told us they had positive experiences of care. We observed staff providing compassionate care and asking patients for their permission before they started to provide any care or treatment. However, staff did not explain or ask for the patient's consent to display information about them on the whiteboards above their beds.

There were systems for identifying, investigating and learning from patient safety incidents, with an emphasis in the organisation on reducing harm. However, we were concerned about the security of the hospital and the safe storage and disposal of medicines. We saw assessments demonstrating many patients were at risk of falling, however we also saw that equipment was left in the corridors obscuring the grab rails patients used for support.

Inpatient services at Cavendish Hospital were effective and focussed on the needs of patients. Care provided was evidence based and followed approved national guidance and nationally recognised assessment tools. We saw examples of effective collaboration between members of the multi-disciplinary team. Staffing levels had been reviewed to support safe practice. However, not all staff had received regular clinical supervision.

There was effective multidisciplinary team working between the ward and community teams which ensured patients were provided with care that met their needs. Staff working at Cavendish Hospital were responsive to the needs of patients; however the physical environment of the hospital did not always meet the needs of patients with dementia. Discharge planning was well managed and effective.

There were organisational, governance and risk management structures in place. Staff told us there was two way communications between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

As a result of our concerns about storage and disposal of medicines, we judged the provider was not meeting Regulation 13, Medicines management. We have asked the provider to send us a report that says what action they are going to take to meet this essential standard.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

There were systems for identifying, investigating and learning from patient safety incidents, with an emphasis in the organisation on reducing harm. However, we were concerned about the security of the hospital and the safe storage and disposal of medicines. We saw assessments demonstrating many patients were at risk of falling, however we also saw that equipment was left in the corridors obscuring the grab rails patients used for support.

Are services effective?

Inpatient services at Cavendish Hospital were effective and focussed on the needs of patients. Care provided was evidence based and followed approved national guidance and nationally recognised assessment tools. We saw examples of effective collaboration between members of the multi-disciplinary team. Staffing levels had been reviewed to support safe practice. However, not all staff had received regular clinical supervision.

Are services caring?

Most patients we spoke with told us they had positive experiences of care and we observed care being provided in a compassionate way. We saw staff asking patients for their permission before they started to provide any care or treatment. However, staff did not explain or ask for the patient's consent to display information about them on the whiteboards above their beds.

Are services responsive to people's needs?

There was effective multidisciplinary team working between the ward and community teams which ensured patients were provided with care that met their needs. Staff working at Cavendish Hospital were responsive to the needs of patients but the physical environment of the hospital did not always meet the needs of patients with dementia. Discharge planning was well managed and effective.

Are services well-led?

There were organisational, governance and risk management structures in place. Staff told us there was two way communications between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

There were systems for identifying, investigating and learning from patient safety incidents with an emphasis in the organisation to reduce harm. However, we were concerned about the security of the hospital and the safe storage of medicines. We saw risk assessments demonstrating many patients were at risk of falling. However we saw that equipment was left in the corridors obscuring the grab rails patients used for support.

Inpatient services at Cavendish Hospital were effective and evidence based. There was effective collaboration between members of the multi-disciplinary team. Staffing levels had been reviewed to support safe practice. However, not all staff had received regular clinical supervision.

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There was effective multidisciplinary team working between the ward and community teams which ensured patients were provided with care that met their needs. Staff working at Cavendish Hospital were responsive to the needs of patients but the physical environment of the hospital did not always meet the needs of patients with dementia. There were organisational, governance and risk management structures in place. Staff felt included in the organisation's vision and supported to raise concerns.

Summary of findings

What people who use the community health services say

The Friends and Family Test seeks to find out whether patients would recommend their care to friends and family. Derbyshire Community Health Services NHS Trust completed the test in April 2013. The most recent figures (October 2013) placed the Trust in the top 25% of the whole of England for inpatient scores. The overall performance was relatively stable with high performance scores. The Friends and Family Test score for Cavendish Hospital was a maximum possible score of 100.

Patient Opinion is an independent feedback for health services, which aims to facilitate honest and meaningful conversations between patients and providers. A comment posted on their website in February 2013 described Cavendish Hospital as "Very caring".

The majority of patients we spoke with were complimentary about the care they received.

A customer survey was conducted at Cavendish Hospital and the results were positive. Positive findings included, "Very pleased with the care. Lovely ward and staff" and, "Staff explain treatment".

Areas for improvement

Action the community health service MUST take to improve

- Ensure appropriate arrangements are in place for the safe keeping and disposal of medicines

Action the community health service SHOULD take to improve

- Ensure appropriate measures are put in place in relation to the secure access to the Hospital
- Ensure grab rails designed to support patients from the risk of falling are not obscured by equipment
- Ensure staff are given the opportunity to receive clinical supervision
- Ensure patient's consent is obtained to display personal information above their beds

Action the community health service COULD take to improve

- Review the ward environment to ensure that it meets the needs of patients with dementia

Good practice

Our inspection team highlighted the following areas of good practice:

- There was effective collaborative working practices between members of the multidisciplinary team
- Staffing levels had been reviewed to support safe practice
- The discharge and transfer of patients was very well managed and responsive to patients' needs.

Cavendish Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance Berkshire Healthcare Foundation Trust.

Head of Inspections: Ros Johnson, Care Quality Commission

The team included a CQC inspector, a nurse specialist and an expert by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we inspected.

Background to Cavendish Hospital

Cavendish Hospital is managed by Derbyshire Community Health services NHS Trust which delivers a variety of services across Derbyshire and in parts of Leicestershire. It was registered with CQC as a location of Derbyshire Community Health Services NHS Trust in May 2011. Cavendish Hospital is registered to provide the regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and screening procedures, Surgical procedures, and Treatment of disease, disorder or injury

Shortly before our inspection, Spencer ward, which provides older people's mental health services, was temporarily closed and patients were moved to another hospital. We inspected Fenton ward, which provides rehabilitation and end of life care for up to 18 adults.

Cavendish Hospital has not previously been inspected by CQC.

Why we carried out this inspection

This provider and location were inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

How we carried out this inspection

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

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

Detailed findings

The inspection team always looks at the following core service area at each inspection:

- Community inpatient services

Before inspecting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the location.

We carried out an announced inspection on 26 February 2014. During our visit we held two focus groups, one with health care support workers and another with the intermediate team including nurses, physiotherapists and occupational therapists. We observed how six patients were cared for and talked to them. We reviewed personal care and treatment records of three patients.

Community inpatient services

Information about the service

Cavendish Hospital registered with the CQC in May 2011. Cavendish Hospital (Fenton Ward) is an 18 bedded facility, comprising three side rooms and five three bedded bays. This inpatient service provides rehabilitation and end of life care for adults. During our inspection, we spoke with six patients and five members of staff. We looked at the care records of three patients and spoke with these patients. This helped us to understand the outcomes and experiences of selected patients.

Summary of findings

Most patients we spoke with told us they had positive experiences of care. We observed staff providing compassionate care and asking patients for their permission before they started to provide any care or treatment. However, staff did not explain or ask for the patient's consent to display information about them on the whiteboards above their beds.

There were systems for identifying, investigating and learning from patient safety incidents, with an emphasis in the organisation on reducing harm. However, we were concerned about the security of the hospital and the safe storage and disposal of medicines. We saw assessments demonstrating many patients were at risk of falling, however we also saw that equipment was left in the corridors obscuring the grab rails patients used for support.

Inpatient services at Cavendish Hospital were effective and focussed on the needs of patients. Care provided was evidence based and followed approved national guidance and nationally recognised assessment tools. We saw examples of effective collaboration between members of the multi-disciplinary team. Staffing levels had been reviewed to support safe practice. However, not all staff had received regular clinical supervision.

There was effective multidisciplinary team working between the ward and community teams which ensured patients were provided with care that met their needs. Staff working at Cavendish Hospital were responsive to the needs of patients; however the physical environment of the hospital did not always meet the needs of patients with dementia. Discharge planning was well managed and effective.

There were organisational, governance and risk management structures in place. Staff told us there was two way communications between staff and managers. Staff felt included in the organisation's vision and supported to raise concerns.

Community inpatient services

As a result of our concerns about storage and disposal of medicines, we judged the provider was not meeting Regulation 13, Medicines management. We have asked the provider to send us a report that says what action they are going to take to meet this essential standard.

Are community inpatient services safe?

Safety in the past

Community inpatients were protected from abuse and avoidable harm. Staff demonstrated a good knowledge about reporting serious incidents and providing information to the ward manager or nurse in charge if they suspected poor practice which could harm a patient. There was a whiteboard at the entrance of the ward that displayed safe care information. This was used to inform patients, relatives and staff about the incidents that had occurred and any actions taken to prevent them occurring again. The number of preventable harms such as pressure areas and falls had been assessed and the results were displayed in the ward area.

Staff we spoke with told us they had received training in safeguarding vulnerable adults, the Mental Capacity Act 2005 and the four harms (this included falls prevention, pressure area care, prevention of venous thromboembolism and catheter care). Staff told us that the training helped them to keep patients safe. They were able to describe to us what they would do and who they would report their concerns to if they suspected abuse. Staff we spoke with were aware of the safeguarding policy and where to locate it for reference and support. We saw the ward manager maintained a training matrix that identified when staff had received safeguarding training and when they required an update.

We looked at the arrangements for ensuring emergency drugs and equipment were fit for purpose in the event of a medical emergency. There were systems in place for the daily checking of the emergency drugs, airway management equipment and the defibrillator. We saw they were in date and stored securely. Staff told us they received annual cardiopulmonary resuscitation training and demonstrated a good knowledge of what they would do in a medical emergency.

Learning and improvement

Staff were familiar with the reporting systems for incidents via an electronic system and told us they received feedback. Incidents were discussed at team meetings and we saw evidence of this in the team meeting minutes. One member of staff told us, “It’s like reflective practice”.

A monthly clinical quality and patient safety report is completed by Derbyshire Community Health Services NHS

Trust. Within this report insulin administration had been identified as an area of concern across inpatient services. Since April 2013 there have been seven inpatient incidents regarding the administration of insulin. A root cause analysis has been conducted by the Insulin review group and changes put in place to prevent incidents occurring to other patients. Staff told us that all insulin is now checked by two members of staff before it is administered and they had been provided with e-learning training on the administration of insulin. A record of who had and had not completed this training was held by the ward manager to ensure that staff completed the training within the identified time frame.

An in-house domestic hotel services and cleaning audit had been completed in January 2014. The audit had identified health and safety issues regarding one of the chairs on the ward and action had been taken to remove the risk to patients.

Systems, processes and practices

Staff reported that their managers were supportive and they could raise issues without fear of negative consequences. There was an infection control champion who was clearly identified on the staff notice board. Staff told us they could go to the champion for support. One member of staff told us, "We use the champion as a resource". Staff were aware of current infection prevention and control guidelines and we observed good infection prevention and control practices, such as:

- hand washing facilities and alcohol hand gel available throughout the ward area
- staff following hand hygiene and 'bare below the elbow' guidance
- staff wearing personal protective equipment, such as gloves and aprons, whilst delivering care
- suitable arrangements for the handling, storage and disposal of clinical waste, including sharps
- clearly defined roles and responsibilities for cleaning the environment

Patient records were kept securely in trolleys or at the end of the patient's bed if they had requested this. We were able to follow and track the patient care and treatment easily as the records we reviewed were mostly well kept, up to date, and accurately completed. In addition staff were able to easily locate and obtain any additional notes we required when conducting our patient record review.

We looked at the arrangements in place for the safe storage of controlled drugs. We made a random check of some of the controlled drugs and found actual stock levels coincided with the hospital's records. Temperature sensitive medicines were stored securely in a locked fridge. There were systems in place that ensured medicines requiring refrigeration were stored within the manufacturer's guidelines. We saw schedules that confirmed the fridge temperature was checked daily to ensure the effectiveness of the medicines was not affected.

We were concerned about the safe storage and timely manner of the disposal of some medicines. We found 19 different medicines and one dosage pack left unsecured on the work surface of the clinical room. The ward manager told us they should have been disposed of two days ago. The door to the clinical room had a key pad, preventing patient entry, but the room was used by non-clinical staff. In addition, there was an external door to the room which had a bolt on the inside but this was not in place to secure the door when we visited. This meant that an unauthorised person could enter the room and pick up the medicines.

The Trust's medication policy for the destruction of expired or unwanted medicines states: 'Expired stocks of solid dosage forms and unwanted or discontinued patient's own drugs (PODs) must be destroyed on the ward, unit, or clinic. They should NOT be returned to the Trust pharmacy for destruction. The method is to put them into a yellow-lidded sharps bin, which will ensure that they are incinerated'. This had not been adhered to. The sharps box that was to be used for the disposal of medicines was stored unsecured on the top of the work surface.

Adequate arrangements were not in place in relation to the security of the hospital or the safe storage of medicines.

Monitoring safety and responding to risk

We saw evidence that risk assessments had been completed and staff understood the importance of this. Staff we spoke with were aware of the recent risks around the administration of insulin within the trust and were able to describe to us the changes in practice that were required. A training matrix on the ward enabled the ward manager to monitor who had completed and was yet to complete the training on the safe administration of insulin.

All new patient admissions to the hospital underwent screening for Methicillin-resistant Staphylococcus aureus (MRSA). This screening is used to identify those patients

who were at 'high risk' of acquiring MRSA so these risks could be minimised. Results were recorded in the patient admission and discharge booklet. Weekly audits were completed to identify any patients that may have missed this screening. The ward manger told us that the audits had not identified any omissions in the last six months.

Information relating to patient safety was displayed on notice boards in the areas we inspected. This provided up-to-date information on performance in areas such as hand hygiene which was 100%, environment and equipment cleanliness which was 93%, falls, pressure ulcers and other incidents.

A range of risk assessments were undertaken to ensure staff and patient safety, of which all the staff we spoke with were aware. We saw risk assessments were completed in patient records such as for the risk of developing pressure sores or falling. We saw that the three patients we looked at were at risk of falling but equipment was left in the corridors obscuring the grab rails for patients to use for support. We returned the next day to see if this equipment had been moved but it had not. This meant that staff had not responded to our concerns to keep patients safe from the risk of falls.

Anticipation and planning

All the staff we spoke with reported that they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The mandatory training matrix displayed on the ward confirmed that nearly all staff on the ward had attended required mandatory training.

Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included: venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks. Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care.

Are community inpatient services effective?

(for example, treatment is effective)

Evidence-based guidance

We observed care provided was evidence based and followed recognised and approved national guidance such as the National Institute for Health and Care Excellence (NICE) and nationally recognised assessment tools. For example, staff used tools such as the Waterlow pressure ulcer risk assessment and the Malnutrition Universal Screening Tool (MUST) to determine patients' nutritional needs. All risks identified such as visual or hearing impairment, risk of falls, the need for special diets and support with toileting were transposed to a whiteboard above the patient's bed. This provided staff with a visual prompt to highlight the specific level of risk to the patient. We saw that what was recorded on the board accurately reflected what was recorded in their care records.

Integrated pathways for multi-disciplinary teams were in place and there was evidence of a multi-disciplinary approach to care and planning. New care plans had been introduced which were person centred setting goals for patients to achieve and aid their recovery. Staff told us they had been uncertain how to use the new care plans but the trust had responded by providing training for all staff. Training was being delivered on the day of our inspection The trainer told us, "It's about what patients want and what they feel is their need".

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. For example, in the records of one patient we saw that consideration had been made regarding the need to assess their mental capacity due to their confusion on admission. It was clearly documented that their care plan had been completed with regard to their best interests and family members had been involved. Following the appropriate treatment their confusion resolved. The patient told us, "The staff are very good. They always ask and explain things".

Monitoring and improvement of outcomes

We saw that the performance and delivery of this service was included within the quality and safety board report for senior leaders of Derbyshire Community Health Services NHS Trust. Quality indicators such as grade three and four pressure ulcers, falls resulting in severe injury and death and single sex accommodation breaches were in place to monitor the effectiveness of the care patients received. The trust was following the national trend of decreases in pressure ulcers. Staff we spoke with were aware of the current outcomes and the results of some of these quality

indicators which were clearly displayed on the safe care information whiteboard within Cavendish Hospital, Fenton ward. On the day of our inspection patients were cared for in single sex bays.

Overall, complaints to the trust decreased between 2011/2012 and 2012/2013. The majority of complaints were in relation to all aspects of clinical treatment. At Cavendish Hospital there was a system in place for patients to complain and the number of complaints were clearly displayed on the safe care information whiteboard. Some patients at Cavendish Hospital had complained there were insufficient activities on the ward. A 'You said, we did' board displayed on the ward informed patients of the actions that would be taken to address this issue. This included the purchasing of additional radios and a programme of activities that is to be delivered by the occupational therapists in May 2014. The trust used these complaints to improve the service for other patients at Cavendish Hospital.

Staffing arrangements

Staffing levels and skill mix supported safe practice. We noted that the Trust's Risk Register Report from December 2013 identified staff shortages as a key risk but staff at Cavendish Hospital told us staffing levels had improved over the last six months. Shortly before our inspection, one ward was closed as a result of inadequate staffing levels and patients were transferred to another hospital.

We saw that bank staff were employed to cover sickness and annual leave but staff told us the same bank staff were usually used to ensure continuity of care for patients. Optimum and actual staffing levels were displayed on a whiteboard on the ward and on the day of our inspection the optimum staffing levels were achieved. The ward manager confirmed that they had been supported to recruit additional staff and to employ bank staff if a patient's nursing needs increased. Patients told us that calls were answered quickly and they did not have to wait for treatments or medication. One patient told us, "There is ample staff".

Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff told us there was access to mandatory training study days. They told us that the content was appropriate and enabled them to care for patients effectively. A training matrix on the ward was used to record when staff had received training and when an update was required. This meant the provider ensured staff had the right skills, experience and support to deliver safe and efficient care.

At the end of November 2013, 80% of staff had received an appraisal in the previous year. The Trust had set a target of 100% of staff receiving an appraisal. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager. At Cavendish Hospital we saw that all the staff, except a new member of staff to the ward, had received an appraisal within the last year.

There were inconsistencies amongst staff regarding access to clinical supervision. The Trust's policy states staff should receive three clinical supervision sessions a year. The ward manager had maintained records of when staff had received clinical supervision within the six months she had been in post. She told us nine staff members out of 27 had not received clinical supervision within the last six months. One member of staff told us they had not received clinical supervision in the six months they had worked there but they had received one to one sessions with their manager on a weekly basis which they found supportive.

Multidisciplinary working and support

The delivery of care was predominantly nurse led but there was effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of person centred care. Medical staff cover was provided by an advanced nurse practitioner (ANP) Monday to Friday with additional GP cover four of these five days. Out of hours and weekend cover was provided by an external agency. Weekly multidisciplinary meetings, involving a consultant geriatrician, ANP, nursing staff, physiotherapists and occupational therapists ensured patients' needs were fully explored. A MDT meeting was being held on the day of our inspection and we saw evidence of the outcomes of these meetings in patient records. A MDT meeting was held on a separate day with the social work team to ensure that patients' social needs were also met.

We observed staff working well together and that healthcare professionals valued and respected each other's contributions in the planning and delivery of patient care. Patients we spoke with told us they were clear about the goals set for them by each member of the multi-disciplinary team. Community staff told us that they

had developed good links with the inpatient staff and go onto the ward to meet with some patients before they are discharged. This showed that care with other services was well co-ordinated.

Patient records detailing current care needs were available for all patients ensuring staff were fully informed of the patient's diagnosis and current physical and emotional needs. Patients were given the choice to keep their records at the end of their bed or in the ward record trolley. This provided the patient with the choice of how informed and involved they were in their care and treatment.

Are community inpatient services caring?

Compassion, dignity and empathy

We spoke with six patients during our inspection and the majority of these patients told us staff provided compassionate and empathetic care and maintained their dignity. One patient told us, "The staff are most obliging, cheerful, pleasant and can't do enough for you". We observed staff providing compassionate care to patients ensuring they were comfortable, holding patients' hands to reassure them and spending time listening to what patients said. On two separate occasions we observed staff asking patients for their permission before they started to provide their care or treatment.

We spoke with a member of staff who was a dignity champion for patients on the ward. A dignity champion is someone who promotes being treated with dignity as a basic human right. Compliance with same-sex accommodation guidelines was ensured through the designation of single sex bay areas and the provision of toilet and bathing facilities in each bay and side room. We observed curtains being drawn around each bed prior to delivery of care and discussions with patients in regards to their care. One patient told us, "There's beautiful care at Cavendish, can't fault it".

Involvement in care

Patients and their families were involved in and central to making decisions about their care and the support needed. By looking at care plans and talking to patients and staff we found that care was planned in accordance with best practice as set down by national guidelines. One patient told us, "My son and daughter are kept in the loop throughout". Another patient told us, "My daughter is very involved in all matters because I am almost blind". We looked in the care plan for this patient and observed it was documented that information had been provided for family members to read regarding how to prevent pressure ulcers occurring. This showed that staff involved families to ensure specific care needs were met.

We found that relatives and /or the patient's representative were involved in discussions around the discharge planning process. We observed in patients' records that discharge planning started from admission and most patients we spoke with were aware of this and signed to give the consent where able. All the records we looked at demonstrated how families and patient representatives were involved in patient's inpatient care and discharge planning.

Generally staff had a good understanding of consent and applied their knowledge when delivering care to patients. We observed positive interactions between staff and patients when seeking verbal consent and the patients we spoke with confirmed their consent had been sought prior to care being delivered. One patient told us, "They tell you what they're going to do and ask permission". We looked at the risk white boards displayed above patients' beds. They displayed the level of risk each patient was prone to and a description of their night time function assessment which included details about toileting arrangements. Patients told us they had not been made aware of these whiteboards or asked for their consent to display this information. Staff we spoke with told us they did not ask for the patient's consent to display this sensitive information.

The hospital had a protected meal time's policy which meant that all non-urgent clinical tasks stopped for a period of time so that patients ate their meals without rushing. Meal times were displayed within the ward to inform staff, patients and visitors when these times were. There was a toolkit on the ward with pictures of food that staff used to involve patients with dementia related conditions in choosing what food they ate.

Trust and respect

We observed staff treating patients respectfully and developing trusting relationships when care needs were being met. A patient told us how they needed to take pain killers for their pain and that staff members always came quickly when they pressed the call bell. All patients were asked what name they would like to be called whilst in hospital and this was clearly written on the whiteboard above their bed to ensure that staff respected their wishes.

Community inpatient services

Staff told us that effective communication and collaboration between all members of the multidisciplinary team ensured trust and respect in those delivering prescribed treatment and care. Different members of the multidisciplinary team told us they received joint training which standardised what they did and helped them to understand each other's roles and break down barriers.

Patient-Led Assessments of the Care Environment (PLACE) is an annual assessment of inpatient healthcare. Inpatient services provided by Derbyshire Community Health Services NHS Trust were assessed between April and June 2013. The trust scored 92.81% in privacy, dignity and wellbeing. This was supported by a rating of 'good' in the Patient Environment Action Team (PEAT) which is an annual assessment focusing on the caring environment and the quality of non-clinical services.

Emotional support

Staff were clear on the importance of emotional support needed when delivering care. We observed positive interactions between staff and patients, where staff knew the patients well and built up a good rapport. We saw staff providing reassurance and comfort to patients. For example, we observed a member of staff taking extra time with a patient when they became distressed. They spent time reassuring the patient and making them comfortable. They contacted a relative of the patient to ask them to come on to the ward to provide additional emotional support. We observed another member of staff providing emotional support to a patient by holding their hand and listening patiently whilst kneeling by their bed.

We saw that patients had supportive discharge plans in place. One patient told us that this reduced their anxiety knowing that support would be in place when they went home. Another patient told us, "I'm the happiest here of any hospital I've ever been in".

Are community inpatient services responsive to people's needs?
(for example, to feedback?)

Meeting people's needs

There was some evidence that staff met the needs of patients admitted to Cavendish Hospital. There were systems in place for information sharing between inpatient and community teams and a willingness to engage with other service providers, such as the acute trusts, to ensure that all care needs were met. For example, one patient told us that a consultant from the acute trust was coming to see them on the day of our inspection. We observed that staff met the needs of patients in a timely manner. However, the physical environment did not always meet the needs of patients with dementia. The signage on patients' risk boards above their beds was for the use of staff but patients we spoke with were unaware what the symbols on the board meant. This meant that they were not fully informed about the information displayed about them. There was a lack of object signage to provide visual prompts for patients with dementia. The blue contrasting grab rail fitted to the wall of the corridor to provide a sense of direction for patients was obscured by trolleys and equipment.

Patients were complimentary about the meals. Specific patient dietary requirements were recorded in their care plans and displayed on the patient boards above their beds. Staff were knowledgeable about meeting the religious and cultural needs of their patients. For example, one member of staff told us how they had arranged for a patient's minister to visit them in hospital to provide spiritual support.

Access to services

People were able to go to Cavendish Hospital for rehabilitation following illness or injury, such as a fall at home or suffering a stroke. They were referred from an acute hospital or by their GP for assessment. This meant that people did not have prolonged stays at an acute hospital and were able to stay closer to home.

Spencer ward at Cavendish Hospital was closed termporarily shortly before our inspection. The decision was taken very suddenly and was unsettling for some patients and staff.

Care and treatment was provided to patients with regard to their disability. Access to Cavendish Hospital was by an electronic push button door and the ward was on the ground floor. The ward bays and corridors were spacious and light. There were disabled parking places available for patients with mobility difficulties. We observed that patient toilets were fitted with grab rails to provide additional support.

Community inpatient services

Vulnerable patients and capacity

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. All staff received mandatory training in safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). In addition to the mandatory training, staff working within Fenton ward had received training for caring for patients with dementia. Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients.

Where patients lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals. For example, in the care records of one patient we observed that consideration had been made regarding the need to assess their mental capacity due to their confusion on admission. It was clearly documented that their care plan had been completed with regard to their best interests and family members had been involved.

Leaving hospital

The discharge and transfer of patients was well managed and responsive to patients' needs. Systems were in place that ensured discharge arrangements met the needs of patients. For example, staff told us that the occupational therapists performed a kitchen assessment with patients prior to discharge and also carried out home visits. One patient told us about a home visit that was arranged for them to assess what aids they needed for when they were discharged back home. Discharge planning commenced at admission when a provisional date of six weeks was assigned and patients told us they were made aware of this. If appropriate, patients signed to consent to their discharge plan. There was evidence of collaborative working with the social work team through MDT meetings and documented telephone referrals.

Multidisciplinary team meetings (MDT) were held every Wednesday which included a consultant geriatrician, an advanced nurse practitioner, nursing staff, physiotherapists and occupational therapists. MDT meetings were also held every Tuesday with the social work team. Patients discharges were discussed at both of the MDT meetings and all the staff worked towards the provisional agreed discharge date. We saw evidence of discussions around discharge during our review of patient care records.

We saw evidence in patient care records that patients and their relatives were provided with information relating to their discharge from the ward.

Learning from experiences, concerns and complaints

Overall, complaints to the trust decreased between 2011/2012 and 2012/2013. The majority of complaints were in relation to all aspects of clinical treatment. At Cavendish Hospital there was a system in place for patients to complain and the number of complaints were clearly displayed on the safe care information whiteboard. Some patients at Cavendish Hospital had complained there were insufficient activities on the ward. A 'You said, we did' board displayed on the ward informed patients of the actions that would be taken to address this issue. This included the purchasing of additional radios and a programme of activities to be delivered by the occupational therapists in May 2014. The trust used these complaints to improve the service for other patients at Cavendish Hospital.

Are community inpatient services well-led?

Vision, strategy and risks

Staff were clear about the organisation's vision, 'To be the best provider of local healthcare and to be a great place to work' and the organisations' values. Staff referred to this as 'working the DCHS way'. The corporate induction for new staff included the provider's core values and objectives for the organisation. Staff told us that the board and senior managers were visible and approachable and that they received a weekly e-mail from the Chief Executive informing them of developments within the trust and the celebration of staff achievements. There was also a trust newsletter called 'The Voice' that kept staff up to date with relevant trust information.

The NHS Litigation Authority (NHSLA) contributes to incentives to reduce the number of negligent or preventable incidents by a risk management programme.

Community inpatient services

In February 2012 the trust was found to be compliant with the NHSLA's risk management standards at level 1, meaning that the process for managing risks has been described and documented.

The trust's Risk Register Report from December 2013 identified staff shortages as a key risk however staff at Cavendish Hospital told us that staffing levels had improved over the last six months.

Quality, performance and problems

We saw that the Board used a variety of methods to monitor the quality and safety of in-patient care. These included audits and an Information Governance toolkit which rated the trust as 'satisfactory' in 2012/2013. The trust also participates in the Friends and Family Test which asks patients at or after discharge if they would recommend the hospital where they were treated. We observed the whiteboard on the ward at Cavendish Hospital and saw that 100% of patients said they would.

The NHS Safety Thermometer is a local improvement tool used to measure, monitor and analyse patient harms and harm free care. We noted that the trust is following the England trend of decreases in pressure ulcers, below the England average for new venous thromboembolisms, a decrease in the overall number of falls with harm and a below the England average for new urinary tract infections. Staff we spoke with were aware of the importance of preventing these harms and informed us they received annual training to manage these risks.

Leadership and culture

Most staff said there was visible leadership across the organisation and expressed confidence that any concerns raised with managers would be acted on. A new member of staff told us they had one to one meetings on a weekly basis with their direct line manager. Staff were aware of who the Board members were and spoke positively of changes that had taken place within the organisation since the appointment of the current Board.

Staff told us that their managers were visible, accessible and approachable and that opportunities to lead in key areas were available. For example, we spoke with one nurse who was a champion for promoting the importance of maintaining patient's dignity on the ward. Whilst care delivery was predominantly nurse led, we saw effective collaboration and communication amongst all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. The staff roles and responsibilities were clearly defined. A sufficient skill mix of staff across all staff grades would be achieved once the newly appointment night staff nurse started to work on the ward. We observed staff commitment in ensuring patients were looked after in a caring manner.

Patient experiences and staff involvement and engagement

Staff told us they were communicated with in a variety of ways, for example a newsletter called The Voice, weekly emails from the Chief Executive and briefing documents. Staff told us there was two way communications between themselves and managers and they received responses via e-mails or telephone calls. Staff told us they were made aware when new policies were issued and that they definitely felt included in the organisation's vision.

As of November 2013 staff turnover was 9.2%, which is within their target of 14%. The trust's Risk Register Report from December 2013 identified staff shortages as a key risk. We saw that this risk was being proactively managed at Cavendish Hospital. The results of the NHS staff survey for 2012 showed that in 19 out of the 28 indicators the trust scored better than average, scored average in six of the indicators and worse than average against three demonstrating a significant fall in staff receiving health and safety training across the trust. We saw that health and safety training was monitored by the ward manager at Cavendish Hospital ensuring that staff had received this training or were booked to attend.

Learning, improvement, innovation and sustainability

Staff new to the trust told us they received an induction when they started. One member of staff told us, "My induction to the ward was difficult at first as there were less staff then but the staffing levels are much better now so I feel more supported".

Staff told us they were supported to access and attend mandatory training to ensure they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner. We saw that staff training was monitored at ward level to ensure staff accessed training. Training that was in date was highlighted green on the training matrix and planned or booked training was highlighted yellow. This meant that there was an effective system in place to ensure staff received training in a timely manner. Some staff told us it was not always

easy to access the on-line e-learning due to shift patterns. E-learning is a computer generated way of learning. Staff watch a video or briefing and have to answer questions on a specific subject.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the Regulation was not being met: Medicines were not always kept safely or disposed of properly and in a timely manner. Regulation 13

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the Regulation was not being met: Medicines were not always kept safely or disposed of properly and in a timely manner. Regulation 13

Regulated activity	Regulation
Surgical procedures	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. How the Regulation was not being met: Medicines were not always kept safely or disposed of properly and in a timely manner. Regulation 13

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Compliance actions

How the Regulation was not being met:

Medicines were not always kept safely or disposed of properly and in a timely manner.

Regulation 13