Medway Community Healthcare C.I.C

Quality Report

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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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

Summary of findings

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We found the following areas of good practice:

There was a strong person-centred culture. We observed staff showing kindness to patients and always preserved their dignity when performing personal care.

We found services were planned which took into account the needs of the patients and the units provided an alternative to acute care. Group therapy sessions took place which covered both mental and physical activities.

People had comprehensive holistic assessments completed of their needs; these included physical health and wellbeing, social, nutritional, and hydration needs. A multi-disciplinary team of staff were qualified and had the skills they needed to carry out their roles effectively and ensured patients received individualised care to meet their complex needs.

The head of services of both units and senior managers had the skills, knowledge, and experience to deliver good quality care. Staff we spoke to felt supported by the senior managers on both units. Research projects were being actively undertaken across Medway Community Healthcare.

However, we also found the following issues that the service provider needs to improve:

Community adult inpatient services were short staffed and relied on agency and bank nursing and therapy staff to address the shortfall.

The environment was not conducive to nursing rehabilitation patients as staff were unable to monitor and observe patients easily due to all patients being nursed in single rooms.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Good 	• People had comprehensive holistic assessments completed of their needs; these included physical health wellbeing, social, nutritional, and hydration needs. A multi-disciplinary team of staff were qualified and had the skills they needed to carry out their roles effectively and ensured patients received individual care to meet their complex needs. Care was delivered in a coordinated way and referrals were made to specialist services to meet patients' individual needs. • There was a strong person-centred culture. We observed staff showing kindness to patients and always preserved their dignity when performing personal care. 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 could and to maintain independence. • We found services were planned which took into account the needs of the patients and the units provided an alternative to acute care. Group therapy sessions took place which covered both mental and physical activities. A communication group was available to support patients whose speech was impaired; aids, prompts, picture boards and charts were used to encourage patients to talk again. • The head of services of both units and senior managers had the skills, knowledge, and experience to deliver good quality care. Staff we spoke with felt supported by the senior managers on both units. A stroke survivor's support group was available which allowed patients, family, and carers to meet and share their experiences. A member of the Medway Community Healthcare stroke team was on hand to provide advice and support. Research projects were being actively undertaken across Medway Community Healthcare.

Summary of findings

However:

- Community adult inpatient services were short staffed and relied on agency and bank nursing and therapy staff to address the shortfall.
- The environment was not conducive to nursing patients as staff were unable to monitor and observe patients easily due to all patients being nursed in single rooms.

Summary of findings

Contents

Overall rating:

Good

Amherst Court

Services we looked at

Community health inpatient services.

Summary of this inspection

Background to Amherst Court

Amherst Court is part of Medway Community Healthcare (MCH), which is an independent Community Interest Company, co-owned and has1,359 staff. As a social enterprise they are a for-better-profit organisation and reinvest any surplus back into health and care services and the local community. MCH provides community services and social care services in Medway and the surrounding areas for a population of around 280,000 people.

The unit opened in September 2016 after the closure of the local community hospital. The service has 40 single rooms with en suite shower room across 2 units, Britannia Suite and Endeavour Suite.

The top floor of the building provides inpatient services and the bottom level is a residential care home. The residential care home did not form part of this inspection.

Amherst Court is registered for the following regulatory activities:

Treatment of disease, disorder or injury

There is a registered manager.

We also inspected MCH community health services for adults and community health services for children, young people and families based in MCH House the registered location. This inspection report is a separate location report. Primary care services and adult care services are provided from various other registered locations and these have been inspected within these directorates.

This was the first inspection

Our inspection team

Team leaders: Elaine Biddle and Sheona Keeler

The team that inspected the service comprised four CQC inspectors and a variety of specialists: community nurse, board level director and a community matron.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

Before our inspection, we reviewed a range of information we hold about the organisation and asked other organisations to share what they knew.

- We reviewed 38 patient comment cards collected from CQC feedback boxes placed at reception desks prior to and during our inspection.
- During the visit, we held focus groups with a range of staff who worked within the service. We spoke with 56 staff across the service including administrators, health visitors, speech and language therapists, technical assistants, physiotherapists and occupational therapists and nurses. We interviewed the executive and non-executive leads
- We talked with people and carers who use services. We observed how people were being cared for and reviewed care or treatment records of people who use services.

Summary of this inspection

- We reviewed information received from members of the public who contacted us separately to tell us about their experiences. We evaluated results of patient surveys and other performance information about the organisation.

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

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

We carried out an announced visit on 6 and 7 March and an unannounced inspection on 15 March 2017.

What people who use the service say

All patients we spoke with were overwhelmingly positive about the care they received.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated this service as requires improvement for safe because:

- Two dashboards were in use to monitor the safety of the care delivered. On the preventing harm oversight group (PHOG) dashboard, we saw that there were areas of poor compliance around the completion of body maps for pressure ulcers, the infection control status documented, falls assessments and patient's baseline observations over the period April 2016 to March 2017.
- Data received from the organisation confirmed that there were three serious incidents (SI's) on Britannia between September 2016 and February 2017. The three incidents were in relation to environment which meant patients were not easily visible to nursing staff. They resulted in three falls at night three patients fracturing their hips.
- Both Britannia and Endeavour were made up of 20 ensuite bedrooms. On Endeavour the unit was constructed in a row and Britannia was constructed in a T-shape. The unit's layout was not conducive to nursing patients as staff were unable to monitor and observe patients easily.
- On Endeavour the resuscitation equipment was stored in an accessible location. The records of safety checks had only been completed since January 2017. We found the resuscitation trolley did not contain a tamper proof tab and there was easy access to the emergency drugs box which could be easily removed.
- Information technology (IT) problems (lack of capacity) existed at Amherst Court. Electronic patient records were available on Endeavour and paper patient records were available on Britannia. Agency staff had no access to the electronic patient records which resulted in a two tier system. By having two different systems in place there was a risk that documentation could be lost along with no chronological evidence of continuous patient care.
- There were no dedicated hand washing basins in patient bedrooms. Staff, patients, and visitors used the basin in the ensuite bathroom or the handwashing facilities in the sluice and kitchenette. This is not in accordance with the Department of Health's (DoH) Health Building Note (HBN) 00-09: infection control in the built environment.

Summary of this inspection

- Both units were short staffed. To cover the shortfall, NHS professional and agency staff were employed to bridge the gap in the staff rotas.

However:

- Staff knew how to report incidents using the electronic reporting database. Lessons learnt from incidents were cascaded to staff through handovers and staff meetings. Safety was discussed at the senior team meeting where pressure ulcers and falls were discussed along with workforce safety. The head of service reviewed the data on a monthly basis.
- Care records were stored securely and contained appropriate risk assessments and management plans.

Are services effective?

Good

We rated this service as Good for effective because:

- People had comprehensive holistic assessments completed of their needs; these included physical health, and wellbeing, social, nutritional, and hydration needs. These were recorded in comprehensive care plans which were reviewed weekly by a multi-disciplinary team.
- A multi-disciplinary team of staff were qualified and had the skills they needed to carry out their roles effectively and ensured patients received individual care to meet their complex needs. Care was delivered in a coordinated way and referrals were made to specialist services to meet patients' individual needs.
- Pain was well managed on the units. Patients we spoke with told us pain was regularly monitored and no patients complained they were left in pain. A therapist told us there was good communication between therapists, nursing staff and GPs in terms of pain management to ensure patients had pain free therapy sessions.
- A variety of audits were regularly performed by the link nurses across both units. The audits included commodes, mattresses, infection prevention control and intravenous therapy audits. Any audits that were not compliant were followed up with an action plan.
- A variety of family meetings took place for staff to learn about the patients and for the patients and families to discuss their relatives' care. These meetings set out the priorities for the patient and established plans for their care. The patient and their relative's preferences and expectations were discussed and contributed to the care plans.

However

Summary of this inspection

- Staff on Endeavour were unable to comply with the National Institute for Health and Care Excellence (NICE) clinical guidance CG162: stroke rehabilitation in adults due to commissioning requirements. The guidelines suggest each patient should receive 45 minutes of therapy per day. With staffing levels at the time of inspection, this was not possible. The head of service was developing a business plan to try to address this non-compliance.
- MCH operated a 'trusted' referral system from the local NHS acute trust. No referral guidelines were available. Referral was based on individual need however, nursing staff told us patients arrived with inadequate handovers, missing medication and missing drug charts. We reviewed the incident logs for both units and found ten incidents had been reported since the units opened. Twenty one patients were transferred back to the acute trust due to not being medically fit for rehabilitation.

Are services caring?

Good

We rated caring as good because:

- There was a strong person-centred culture. We observed staff showing kindness to patients and always preserved their dignity when performing personal care. Relationships between people who use the service, those close to them and the staff were always caring and supportive.
- 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.
- On Endeavour we heard staff singing a song popular in the 1940's to a patient. Staff told us the patient was not very responsive but family had told them they liked music and their favourite songs, so staff sang to them regularly.
- A key worker was allocated to each patient; the team were thoughtful and would allocate a staff member dependent on the needs of the patient.

Are services responsive?

Good

We rated responsive as Good because:

- We found that services were planned which took into account the needs of the patients and the units provided an alternative to acute care.
- Staff received training in equality and diversity and training levels sat at 97% compliance.

Summary of this inspection

- All patients were risk assessed prior to admission to ensure the organisation provided a safe environment. To support patients living with dementia a number of tools were available. The unit environment was conducive for dementia patients.
- Group therapy sessions took place which covered both mental and physical activities. Sessions undertaken included chair based exercises, group bingo and memory games. A rehabilitation assistant in their room offered any patient who was unable to attend a group session one to one exercises.
- On Endeavour, a communication group was available to support patients whose speech was impaired; aids, prompts, picture boards and charts were used to encourage patients to talk again.
- People were generally getting access to the right care at the right time including from nursing staff, GPs, and therapists.

However

- Due to the demands on the units not all patients received therapy as often as would be optimum for good rehabilitation care. This was particular at the weekends.

Are services well-led?

Good

We rated well led services as good because:

- Governance within MCH 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. The heads of services within both units at Amherst Court were actively involved in the governance process within MCH.
- There was an effective and comprehensive process in place to identify, understand, and reduce risks in both units and performance was monitored on a regular basis. Where performance had declined, processes were put in place to improve it.
- The head of services of both units and senior managers had the skills, knowledge, and experience to deliver good quality care. Staff we spoke with felt supported by the senior managers on both units.
- On a quarterly basis the head of service on Endeavour fedback to all staff through the 'manager's moment'. This was the forum used to give frontline staff positive and negative feedback regarding the care delivered.

Summary of this inspection

- A stroke survivors' support group was available which allowed patients, family, and carers to meet and share their experiences. A member of the MCH stroke team was on hand to provide advice and support.
- Research projects were being actively undertaken across MCH.

However

- On Britannia staff felt there was a distance between the nursing and therapy staff and both teams were not working together as they should or could .Communication between the two groups was poor.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

Good

Community health inpatient services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are community health inpatient services safe?

Requires improvement

Safety performance

- The unit manager on Endeavour told us all patients were risk assessed on admission and throughout their stay at regular intervals. Patients were risk assessed for pressure ulcers, urinary tract infection and venous thromboembolism (VTE). The unit monitored the above through the electronic reporting system.
- Managers monitored safety outcomes at the Preventing Harm Oversight Group (PHOG) meetings which took place monthly. The unit managers of Britannia and Endeavour told us the NHS Safety thermometer was no longer used and the PHOG was the forum where they had an overview of risks to patients using more meaningful data. We reviewed the minutes from the PHOG meetings and saw that there was good attendance from key staff and safety areas discussed included falls prevention, tissue viability and the Braden score (special scoring system to evaluate a patient's risk of developing a pressure ulcer),the dementia assessment tool, hydration and malnutrition universal screening tool (MUST).
- Two dashboards were in use to monitor the safety of the care delivered. The PHOG dashboard included falls assessments, MUST assessments, completion of drug charts, patient baseline observations and allergies/ sensitivities. The second dashboard related to personalised care planning and included the completion of individualised care plans and consent.
- We reviewed the completed dashboards for the period April 2016 to March 2017.On the PHOG dashboard we saw there were areas of poor compliance around the completion of body maps for pressure ulcers, the infection control status documented, falls assessments and patient baseline observations. Areas of good compliance included completion of the Braden score (special scoring system to evaluate a patient's risk of developing a pressure ulcer), patient clinical needs assessed and the completion of drug charts.
- Senior staff told us safety outcomes were discussed and analysed for learning. The head of service on Endeavour told us safety was discussed at the senior team meeting where pressure ulcers, falls were discussed along with workforce safety. Mandatory training and competency profiles were discussed to ensure staff were trained and safe to deliver care. The head of service reviews the data and gains assurance on a monthly basis.

Incidents

- Patients were protected from the risk of inappropriate or unsafe care because there were systems to ensure incidents were identified, reported, investigated, and learned from, to prevent recurrence. Amherst Court staff had a good understanding of the processes to report incidents. However, the unit manager on Endeavour told us they did not report near misses and how this needed to be improved. Incidents were reviewed by the unit manager and investigations and outcomes were placed in a report and presented at the Governance Assurance Information Network (GAIN) meeting.
- Medway Community Healthcare (MCH) had reported no never events in the patient services at Amherst Court in the period September 2016 to February 2017 (Never

events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.)

- When Britannia and Endeavour units were opened in September 2016 at Amherst Court, three serious incidents (SIs) were reported on Britannia, which were related to the change of the nursing environment. The units had moved from a ward based environment to a single room facility with each patient being nursed in a single room. Data received from the organisation confirmed there were three serious incidents on Britannia between September 2016 and February 2017. The three incidents were in relation to falls at night, all of which resulted in a hip fracture with one shoulder dislocation. Information received from MCH confirmed that each incident was logged electronically by staff and actions and learning from incidents was reviewed and monitored by managers.
- We discussed the SIs with the unit manager and reviewed the root cause analysis (RCA) and saw comprehensive investigations took place following the SIs and recommendations in practice were made. An action plan was put in place to implement the recommendations into clinical practice. The recommendations included the introduction of a falls risk assessment for every patient which was repeated at regular intervals throughout their stay. The falls safety cross was introduced at night, the introduction of a falls board on the unit highlighting who was at risk of falls, placing high risk patients close to the nurses station and encouraged patients to sit in the communal area. This gave assurance that Britannia unit was actively monitoring its own safety performance over time in order to improve patient experience.
- Lessons learnt from incidents were regularly communicated through handovers and staff meetings. We reviewed the band six nursing meeting minutes for February 2017 and the unit meeting minutes for February 2017 and saw the SIs were discussed with actions to be taken to prevent similar incidents happening in the future. Staff confirmed they received feedback following incidents; they said they routinely had access to an overview of incidents for their services. This was confirmed by records we reviewed.
- The unit manager on Endeavour told us agency staff had no access to the electronic incident reporting systems. Any incidents were written up and a substantive member of staff entered on to the electronic reporting system.
- On Endeavour the unit manager told us deaths were not discussed within the multi-disciplinary team to ensure the care delivered had been appropriate. This meant mortality reviews were not being carried routinely following the death of a patient.

Duty of Candour

- Staff we spoke with had a good understanding of the duty of candour requirement and were able to explain how it applied to their specific roles. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training. Duty of candour training was part of the mandatory training programme.
- The unit manager on Britannia told us duty of candour had been discussed at the last staff meeting. We reviewed the minutes of the meeting which confirmed this.
- We reviewed investigations into incidents such as falls and found a duty of candour letter was sent to the patients following the incidents and patient meetings took place. On the electronic incident reporting system a window was available that had to be completed about the duty of candour. We saw this was completed appropriately by staff.

Safeguarding

- MCH had adult and children's safeguarding systems in place to keep patients safe. Staff were aware of the systems and how to report concerns. MCH's policy was accessible to all staff via their intranet and staff knew where they could find this.
- The Care Quality Commission (CQC) received no safeguarding notifications relating to Amherst Court in the last 12 months, as at 19 December 2016.
- Staff we spoke with were able to demonstrate a clear understanding a how to identify a safeguarding concern.

They felt team leaders would support them to make a safeguarding alert to the appropriate local authority. Staff knew who the organisation's safeguarding leads were.

- Staff received training in adult safeguarding at level one and two as part of their mandatory training. Across both units, level one adult training was 98% compliant and level 2 training was 94% compliant. Safeguarding training formed part of the yearly one day statutory training day.

Medicines

- Staff stored medications securely on both Endeavour and Britannia. The units Controlled Drugs (CDs) were locked behind two doors and medication trolleys were kept locked when not in use. Two staff nurses were required to sign for CDs. All stock on the unit was safely stored in line with legal requirements.
- The General Practitioner visited the units daily and would prescribe any medications required.
- We saw a staff nurse completing the drug round on Endeavour; the trolley was not left unlocked at any time.
- The pharmacist attended the unit to review the patient administration charts. We reviewed five medication administration charts and saw they were fully completed, including details of any missed doses and the reason for this. Allergies were clearly documented on each chart and all charts were signed and dated.
- The pharmacist proactively identified patients due for discharge and ensured all take home medications (TTO's) were available.
- Blue sharps boxes were available in the medicine room for the disposal of medicines, along with the register staff completed when disposing of medication.
- The unit manager on Britannia told us that no recent medication audits had taken place.

Environment and equipment

- Endeavour was made up of 20 ensuite bedrooms constructed in a row with the dining room, gym, and nurses' station in the middle of the unit. Staff told us the unit layout was not conducive to nursing stroke patients as staff were unable to monitor and observe patients easily.
- Britannia unit had 20 en-suite bedrooms. The unit was constructed in a T shape with the dining room, gym and nurses' station at the centre of the ward. Staff told us the layout of the unit made it difficult to nurse patients effectively and observe patients who maybe at a high risk of falling.
- All the bedrooms on both units had call bells however; no call bells were available in the shower rooms which meant patients had no means of alerting staff in an emergency. We saw the call bells were regularly checked. One patient on Britannia confirmed staff came promptly when the bell was pressed.
- In each room there was an electric bed (patient could move with push pad), locker, wardrobe and lockable medicines cupboard for the patient's own medicine. Bedroom doors had no window recesses which meant staff could not see into the room if the door was closed.
- We saw bedroom windows had the appropriate window restraints in place.
- On Endeavour, one bath with a hoist was available.
- Resuscitation trolleys were available on the units. On Endeavour the resuscitation equipment was stored in an accessible location. We looked at the records of safety checks and saw the records had been completed since January 2017. We found the resuscitation trolley did not contain a tamper proof tab and there was easy access to the emergency drugs box. This meant drugs could be easily removed from the trolley.
- On both units we saw equipment and furniture was in good order with evidence that clinical equipment had been regularly serviced. Portable electrical tests (the examination of electrical appliances and equipment to ensure they are safe to use) had been undertaken. We saw records during the inspection to confirm this.
- The gym was well equipped with equipment that looked new and well maintained. Bariatric treatment beds were available. All equipment was made of wipe clean fabric. Staff told us they had no problem accessing equipment for patients (frames/crutches etc.) The Medway Integrated Community Equipment Services (MICES) team provided equipment for patients to return home with including installation of rails if required.
- Staff told us there was no room for storage. We saw a bariatric chair, standing hoist, hoist, two rota stands, and four wheelchairs in a corridor.
- Equipment in the kitchen area had an electrical safety test done within the last year. The (food) fridge

temperatures were checked regularly (min and max) however on Britannia ward there had been six days in the previous two weeks where the fridge temperatures had not been checked.

- Both units were on the third floor of the building. Two small lifts were available for the transfer of patients. We saw the lifts were small and staff told us there were issues with the transfer of bariatric patients due to the small size of the lift. A risk assessment had been carried out.
- We saw a fire point was located in the corridor on Endeavour. This contained fire extinguishers, (checked 2016), break glass point to raise the alarm and a fire poster with instructions.

Quality of records

- Due to information technology (IT) problems (lack of capacity) at Amherst Court, electronic patient records were available on Endeavour and paper patient records were available on Britannia. Staff told us the Community Health System (CHS) was available 95% of the time. On Endeavour we saw paper records were kept when agency staff saw patients as they could not access the electronic patient records. Patient care records were stored securely in locked cabinets in the staff office. They were then scanned onto the electronic record by the ward clerk. However, by having two different systems in place there was a risk that documentation could be lost along with no chronological evidence of continuous patient care.
- We reviewed five paper medical records on Britannia. They all included evidence of MRSA screening on admission. We saw evidence of body maps being completed on initial assessment and two records contained 'my urinary catheter passport' which had been completed.
- On Britannia, we reviewed two patients care plans. Both contained 'my plan' which detailed individual objectives for each patient, which included Deprivation of Liberty Safeguards (DoLS) application, catheter care, referral to therapy, review of medication (variety of individual objectives). Both had falls risk assessments, an assessment rated as 'medium risk' would be reviewed daily and we saw that it had been reviewed daily. The second risk assessment rated as low risk, only needed to be reviewed weekly, but was also reviewed daily.
- We saw patient health questionnaires completed, patient depression questionnaire and a Berg balance scale completed (a variety of patient outcome measures).
- Following admission and the completion of risk assessments the patient's nursing notes were placed in coloured folders to highlight to staff the risk rating of the patient. For patients at high risk, for example falls, the nursing information would be placed in a red folder. If there was a medium risk nursing notes would be placed in an amber folder and low risk in a green folder. Staff would be aware straight away by the colour if patients required extra support and daily risk assessments or if weekly assessment were sufficient.

Cleanliness, infection control and hygiene

- There were no dedicated hand washing basins in the patient bedrooms. Staff, patients, and visitors used the basin in the ensuite bathroom or the hand washing facilities in the sluice and kitchenette. This was not in line with MCH Infection Prevention & Control Policy (Strategy)' (dated June 2014), which stated 'Provision of an adequate number of hand wash sinks e.g. 1 per 4 bedded bay, 1 per clinical room, 1 per bathroom or toilet, 1 per sluice and 1 per food preparation area, 1 per single room and 1 per laundry area. Which indicated there should be one hand washing sink in the bedroom and one in the bathroom or toilet.
  - This did not comply with NICE Quality statement (QS) 61. The standard recommends hands can be cleaned using the alcohol-based hand sanitising gel except in the following situations, when soap and water must be used. When hands are visibly soiled or potentially contaminated with body fluids, or when caring for patients with vomiting or diarrhoeal illness, regardless if gloves have been worn. We saw the lack of hand washing facilities on the ward was included on the risk register along with a range of control measures intended to mitigate this risk. This meant the hospital, did recognise this non-compliance, as a risk, and took action to control it. However, there was still a potential of cross infection.
- All clinical areas we visited were visibly clean. We saw staff completing hand hygiene before and after contact with patients. This was in line with National Institute for

Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

- Data showed both Britannia and Endeavour hand hygiene compliance rates were 100 % for February 2017 .Where there were episodes of non-compliance we saw members of staff were spoken with immediately and audits were performed weekly until compliance rates met the 100% target. This meant the organisation could be confident staff were cleaning their hands in line with policy.
- We reviewed the environmental audit which took place on both Britannia and Endeavour units in January 2017 by the infection control lead. On Britannia ward the overall compliance rate sat at 78%. Areas of concern included dust on bed frames and vents, no clinical hand wash sinks in the patients' rooms, toilet brush holders dirty and bath and shower heads not in regular use need temperature checks to monitor compliance. An action plan was in place with all actions due to be completed by the end of February 2017. We saw an updated action plan, which indicated actions had been completed.
- Clinical staff were bare below the elbows and wore uniforms in line with MCH policy.
- On the units we observed equipment cleaning assurance labels, which indicated re-useable patient equipment was clean and ready for use. Commodes we inspected were clean, labelled, and ready for use.
- All cleaning products were stored appropriately, in line with the Control of Substances Hazardous to Health guidelines 2003.
- Housekeeping staff had received appropriate training from the infection prevention control (IPC) lead at MCH and were supplied with nationally recognised colour-coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination.
- Personal protective equipment (PPE) such as disposable aprons and gloves were easily accessible for staff. We saw gloves and aprons were available in all the patient rooms. We observed staff wearing them when delivering personal care and we saw the housekeeping staff were wearing the appropriate PPE when undertaking full cleans in the bedrooms.
- We observed alcohol hand gels were available in the corridors outside the patient rooms. However, we saw no posters around the gel to highlight to staff, patients, and the public to use the gel when entering and exiting an area.
- On Britannia we saw green 'I am clean' sticker on the door of a patient room. This indicated this room had been deep cleaned and all the equipment in it had been cleaned following a patient's discharge. One patient on Britannia confirmed the cleaners cleaned their rooms and bathrooms daily.
- In the shower room, five moments of hand hygiene posters were next to the hand washing basin. We saw a toilet cleaning schedule (completed by staff), completed every day when the room was in use. PPE was available. We saw that staff had their own hand sanitiser clipped to their uniform.
- We observed sharps containers were properly maintained, and were in accordance with the current guidelines.
- The segregation and storage of clinical waste was in line with current guidelines set by the Department of Health, Management and disposal of healthcare waste (07-01) 2013.
- Every three months a mattress audit was undertaken on Endeavour, to check the quality of the mattresses. We spoke to a Registered Nurse (RN) who was able to describe the mattress tests undertaken. If a mattress failed the test, it was removed from the unit and a new mattress was bought.
- As all patients were nursed in single rooms any patients with an infection were isolated. We spoke with a RN who was able to describe the infection control procedures in place for any patients with a MRSA infection. This included the taking of swabs from the recommended sites which were repeated on day one, day seven, and day fourteen. Three clear swabs had to be taken before screening could be stopped.
- Curtains were cleaned every six months or immediately after an infectious patient had been discharged. We saw records that confirmed the regular changing of the curtains.
- The sluice room on Britannia was small. A small metal sink which was the only hand washing sink available. There was limited space for putting equipment whilst washing your hands.

Mandatory training

Good

Community health inpatient services

- Staff across the two units completed mandatory training, which included basic life support, fire safety, health, and safety, moving and handling and infection control. Compliance with mandatory training for manual handling was 84% on Britannia and 89% on Endeavour in January 2017. Overall mandatory compliance rates were 76% for Britannia and 84% for Endeavour. Mandatory training rates did not reach the MCH target of 85%.
- Infection control training was monitored quarterly. Between October and December 2016 the compliance rate across the two units was 85%, this was in line with the organisations target. Training compliance was monitored by the IPC team on a monthly basis and reminders were issued to managers to alert them to staff who were non-compliant. Extra face to face training sessions were also offered to services that had a low compliance.
- Across both units conflict resolution training was 87% compliant. This was above the 85% target set by MCH.
- We asked two members of staff about mandatory training and both said that they had completed mandatory training in the last 12 months. Staff told us that they would get time during the working day to complete training.

Assessing and responding to patient risk

- Patients were assessed for risk upon admission through risk assessments, tests and examination and transfer records from the local acute NHS trust. Past medical history and lifestyle issues were captured appropriately and care plans were established to deal with any highlighted needs.
- Risk assessments were completed in areas such as manual handling, mobility, falls, skin integrity, venous thromboembolism (VTE) and wound care.
- On both units the physiotherapists (PT) and occupational therapists (OT) undertook frontline assessments and full functional assessment of patients within 24 hours of admission to establish if patients needed any aids or assistance with their movement and activities.
- Functional assessments by the OT included reviewing patients at breakfast time. Toast would be given and patients were encouraged to spread butter and pour their own tea from small teapots in order that lost skills were learnt again. Washing and clothing assessments would allow rehabilitation assistants to support the patient to wash and dress themselves again.
- On Endeavour they used the Community Healthcare Early Warning Score (CHEWS) to identify and escalate care of any deteriorating patients. When a patient was identified as deteriorating by nursing staff their concerns were immediately escalated to the unit manager. If concerns remained, an ambulance would be called and the patient would be transferred to the local NHS acute trust. We were given an example of a patient who after admission became unresponsive and had to be transferred back to the local acute NHS Trust. MCH policy was adhered to when transferring the patient.
- Patients were under the care of a local general practitioner (GP) who would visit the units once a day to provide medical input. There was no other medical staff employed on the units. Out of hours and weekend cover was from Medway On Call Care (MedOCC) who treated patients when the GP surgeries were closed.
- The unit manager on Britannia told us not all patients were reviewed by the GP on admission however all drug charts were reviewed. A doctor's book on the unit documented what needs to be done and covers areas such as tests and medicine management.
- Staff told us in an emergency they would call 999 and the patient would be transferred to the local NHS acute hospital via an ambulance. Senior staff could give us examples of when this had occurred and how the situation had been managed.
- All patients were cared for in individual rooms. This meant that nursing staff had limited sight of patients who were at risk of falls. Nursing staff had put in place measures to reduce risk which included 'intentional rounding' to check on patients.
- On Endeavour we reviewed five sets of patient records, when opening the electronic record, if there was a special alert i.e. allergy it flagged up on opening the record. Staff were unable to read further until they acknowledge they have read the alert. This meant patient safety was being considered at all times.

Staffing levels and caseload

- A pharmacist was available on the units daily (Monday to Friday) from the local NHS trust to review reconciliation medication, check prescription charts, and liaise with staff and the GP regarding medications.

Good

Community health inpatient services

- A GP would attend Amherst Court for approximately three hours each day Monday to Friday. Out of hours and at the weekend, both units were supported by MedOCC. There were no nurse prescribers based on the inpatient units.
- Physiotherapists (PT's) and Occupational Therapists(OT's) worked five days a week from 7- 6pm. Staff were available for home visits and did these combined (PT and OT). On Britannia staff told us the therapists were agency staff and therefore found the engagement with the therapist disjointed as different therapists attended the ward.
- On Britannia, the unit manager told us there was no staffing tool in use, staff numbers were based on patients and their level of care. Data submitted showed between December 2016 and February 2017, Britannia had 29.7 whole time equivalent (WTE) staff which consisted of registered nurses (RN's), junior sisters, therapists, and rehabilitation assistants. The planned number of staff was 30.3 WTE. The unit manger told us with an extra five beds open one extra RN and HCA were scheduled for the day shift and one extra RN was scheduled on the night shift. Three RN vacancies existed of which interviews were planned.
- During the night shift on Britannia, the manager told us, five staff were on duty, these being one RN and four rehabilitation assistants. The manager regularly met with the night staff. One RN was a permanent member of night staff (who visited the unit or communicated with the manager by phone) whilst the other staff rotated with the day shifts.
- On Endeavour, the unit manager told us there was no staffing tool in use, staff numbers were based on patients and their level of care. Data submitted showed that between December 2016 and February 2017, Endeavour had 22.3 WTE staff which consisted of RN's, junior sisters, therapists, and rehabilitation assistants. The planned number of staff was 25.4 WTE, which meant the unit was below establishment. At the time of inspection 20 beds were occupied and although managers told us these five beds were a contingency, staff told us the occupation of these beds was a regular occurrence.
- We spoke with one patient on Endeavour who told us they felt there were not enough staff on the unit with another patient telling us Britannia was short staffed which meant they had to ring their bell and just wait until a staff member was available.

Managing anticipated risks

- Potential risks were taken into account in the MCH major incident plan. We did not see any evidence of staff training on the units around the plan however all staff received information regarding the major incident plan at induction.
- A comprehensive intermediate care business continuity plan was in place and covered areas such as IT issues, staffing and emergency evacuations. The plan detailed possible situations, the risks as a result, and the mitigation actions in a clear and concise way for any member of staff to follow. During the inspection the business continuity plan was in place with regard to IT issues. The IT system was unable to support both units. A solution was expected by July 2017.
- We saw evidence of appropriate risk assessment and mitigation when an anticipated risk was identified. We were given an example at Amherst Court where the lift to transfer bariatric patients to the units was small. This was appropriately risk assessed and mitigating actions put in place to reduce risk to patients.

Are community health inpatient services effective?

(for example, treatment is effective)

Good

Evidence based care and treatment

- Staff knew how to access policies via the staff intranet. Policies were based on national guidance. For example, the guidance for pressure ulcers, staff used the grading scores recommended by National Institute for Health and Care Excellence (NICE). However the stroke team was unable to comply with the NICE Stroke rehabilitation in adults clinical guideline [CG162] due to understaffing. The guidelines suggest each patient should receive 45 minutes of therapy per day. With staffing levels at the time of inspection, this was not possible on Endeavour. The head of service was developing a business plan to ask for more staff in order that the unit could deliver the NICE guidance.
- The stroke team at Medway Community Healthcare (MCH) managed the whole stroke pathway from hospital to home and contributed to the Sentinel Stroke

National Audit Programme (SSNAP) which aims to improve the quality of stroke care by measuring both the structure and processes of stroke care against evidence based standards. However, this audit looks at acute care and not community inpatient care so no data was available.

- The ward managers on both wards told us there were regular links with specialist teams which included the dementia team, diabetic, intravenous access team, cardiology, and respiratory teams. This ensured that evidence based care and treatment was being delivered and patient's individual needs were being met.
- Staff on Britannia told us that no mental health pathway was in place which meant staff found it challenging when patients demonstrated abnormal mental health behaviour. It was difficult to get the appropriate support if a crisis developed. For patients with depression no arrangements were in place for continuing care. Staff told us they escalated crisis situations to the head of patient safety.
- On Endeavour, the unit manager told us a variety of audits were regularly performed by the link nurses. The audits included a commode, mattress, IPC and IV therapy audits. Any audits that were not compliant were followed up with an action plan. The recent commode audit found that the commodes were not 100% clean. This resulted in spot checks of the audits throughout the day by staff. No results of the spot checks were available at the time of the inspection as the checks had only started.
- To access the quality of patient records, a 10 pull patient records audit was recently re introduced at Amherst Court following the move. This covered information governance and clinical information. We saw the results of the audit were discussed at the business unit meeting and any actions are addressed and rectified as soon as possible.
- As part of the audit and NICE guidance report, the clinical quality team would delegate NICE guidance up for review to the appropriate head of service. We reviewed the February 2017 report and saw a large number were up for review with actions taken by the heads of departments. A robust system was in place to review national guidance.

Pain relief

- Patients told us their pain was well managed. We asked two patients on Britannia about pain management and both of them said staff regularly offered them pain relief and had their pain score assessed during the medicine round.
- Staff used 'intentional rounding' to check on patients' well-being and comfort. This meant nursing staff proactively checked on patients' pain a minimum of every four hours.
- In the five patient records we reviewed on Britannia each contained a pain assessment and documentation of actions taken to manage patients' pain.
- We asked one therapist about management of patient's pain in relation to their progression with rehabilitation. The therapist told us that there was good communication between therapists, nursing staff and GPs in terms of pain management.
- We reviewed five prescription charts. Medicines records showed pain relief was given according to prescription in a timely way on both in patient units.

Nutrition and hydration

- In five sets of patient records we reviewed on Britannia, we saw records contained nutritional assessments, for example the Malnutrition Universal Screening Tool (MUST). This is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. These were completed with MUST scores, weight documented, and actions taken in response to the scores.
- Any staff member worried about a patient's weight following the MUST assessment could make a referral to the Speech and Language Therapist (SALT) or dietician who would prescribe supplements or soft or puree foods. The SALT was on site so assessment could be made on the day or the next morning following admission.
- The registered nurse (RN) on Endeavour told us if a patient has any food allergies this would be on the handover documentation from the acute trust, written on the drug chart and on the patient's profile. On Endeavour we reviewed five sets of patient records and saw allergies were documented.

- Any patients identified as being at risk of getting dehydrated would have all fluid intake and output recorded on a fluid balance chart. A 24 hour balance would be reviewed and appropriate action taken to address any concerns.
- The nutritional requirements of individual patients were highlighted during handovers and multidisciplinary meetings to ensure a holistic approach to care. Those who were on fluid or food charts and those who needed assistance or encouragement with eating and drinking were highlighted.
- Patients were encouraged and assisted to attend the dining rooms for their meals. This was believed to be a more favourable environment for eating, and had been shown to improve appetite and encourage better food intake than eating in bed. However, two patients told us that it took too long to be taken to the communal area so they ate in their rooms.
- One patient on Britannia told us 'the food was fine; they had no complaints'. Regular hot and cold drinks were offered throughout the day.

Patient outcomes

- On Britannia we reviewed data and saw acceptable improvements in outcomes had occurred in 63.3% of patients for the last quarter of 2016/17.This was slightly above the target of 60%.
- The unit manager on Endeavour told us that they worked closely with the SALT around conversation training for patients whose speech was impaired. Patients were reviewed by the SALT and an overview was given to the staff regarding the best way to manage the patient's speech to get the maximum improvement possible. One patient showed us the speech exercises given by the SALT.
- The therapy lead on Endeavour told us patient outcomes were measured through goal setting which included the Bartel and Modified Rankin Scale. The modified Rankin Scale(mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke or other causes of neurological disability. Other team members use outcome measures specific to their therapy including the Berg balance. However, we were unable to review this data during the inspection.

Competent staff

- Staff told us they received good support and supervision from their line managers. In addition to their annual appraisal, they could request meetings with managers, and there was always someone to go to for advice and extra tuition. Staff told us there was supportive and inclusive teamwork and collaborative team spirit.
- There were good opportunities for development and training for nursing, rehabilitation support assistants and allied professional staff. They were encouraged and supported to develop their expertise and competencies and extend their skills. On Britannia, a senior rehabilitation assistant told us they were undertaking a foundation degree course at university which would allow them on completion to apply for a band 4 associate practitioner post. MCH funded the course.
- Annual appraisals gave an opportunity for staff and managers to meet, review performance and development opportunities which promoted competence, well-being, and capability. Data provided by MCH showed 79% of staff on Britannia and endeavour had received an appraisal in the last twelve months. Re-validation was 100%. Britannia was a newly commissioned service from 1 October 2016. Some MCH staff transferred into this service following the closure of the local community hospital. Plans were in place to ensure all staff transferred have their appraisals completed and new objectives set.
- Therapy staff demonstrated they were experienced, competent, skilled, and knowledgeable and demonstrated a good understanding of the needs of their patients. However, one rehabilitation support assistant on Britannia told us no formal training had been given around patient exercise classes and therefore it was unclear if staff were competent to undertake these classes.
- The ward manager on Britannia told us the tissue viability team had visited the unit and delivered training around compression bandages and Lymphoedema.
- On Endeavour the unit manager told us clinical supervision groups took place three to four times a year to support staff and provide guidance.
- The head of service on Endeavour was sending staff on cognitive behavioural training and counselling skills courses to bridge the gap in the service where neuropsychological services were not available.

Multi-disciplinary working and coordinated care pathways

Good

Community health inpatient services

- There was very good multidisciplinary team working, all staff disciplines had input into the planning, assessing and delivering of patients' care and treatment. The patients' holistic needs were assessed and acted upon.
- Care was coordinated and organised well. Staff attended a multidisciplinary team (MDT) meeting every Tuesday on Endeavour. This meeting was attended by therapists, nurses, a speech and language therapist and a care manager (social worker). We attended a Tuesday MDT and saw there was good communication between different professionals at this meeting. Each staff member was aware of each patient's management plan and their roles within that plan. Each patient's management plan was completed during the meeting which meant all information was relevant and up to date. No current inpatients have been on the unit for longer than five weeks.
- Staff carried out a handover meeting each morning at 7am on Britannia. The handover was attended by the nurses however, members of the therapies team were not always present at these handover meetings. The handover discussed important information, for example discharge plans for patients and updates on patients' medical conditions. At the end of the day, the therapists would hand over to the RN's and this information was updated overnight.
- We saw documentation of MDT meetings in patient records. This documentation included discharge plans and referrals that were needed.
- On Endeavour the unit manager told us a 'Joint therapies' MDT took place every two weeks between the team on Endeavour and community Rehabilitation team where discharges and handovers were discussed.
- Nursing staff on the unit had monthly meetings. Staff told us the meetings on Britannia were open and all staff were encouraged to add to the agenda. All minutes were placed in the off duty folder for staff who were unable to attend the meeting. We viewed the meeting minutes from December 2016. These showed meetings were attended by nursing staff of all levels and included discussions on fire safety, handovers, off duties and the doctor's book.

Referral, transfer, discharge and transition

- Referrals into intermediate care on Britannia came from the local NHS acute trust, GPs, and community care teams. We reviewed Britannia's key performance indicators (KPI) and saw once the referral was accepted, the service would be in place within 24 hours of first contact and a risk assessment was in place in 92.1% of cases, in the last quarter of 2016. This was above the 90% target set.
- At the time of the inspection, four patients were awaiting admission from the acute trust. Delays in discharge from Britannia often happened if a patient required a placement to a nursing home. Other delays occurred if funding was required for small and large home adaptions. The care workers would liaise with colleagues in social care teams to ensure the appropriate support was in place for patients on discharge.
- Upon discharge patients were referred appropriately to community care services, for example district nursing, community intermediate and reablement teams to ensure their ongoing needs were met following discharge. The length of stay predicted on admission to Britannia was six weeks. Reviewing the data for the last quarter of 2016, we saw 86.5% of patients were discharged at six weeks. This was below the target set of 100%.
- Referrals to clinical nurse specialists such as tissue viability nurses, speech and language therapists, falls specialists, diabetic specialists, and dieticians were available. Staff said the referral process was easy to use and effective and patients did not experience long delays in receiving attention.
- For younger patients with cognitive impairment, referrals were made to the adult social care team to organise discharges to the Shared Lives programme. This would provide step down care in self-contained flats with 24 hour support before they were able to make the final step down to caring for themselves at home.
- The care manager attended the family meetings and home visits and ensured that if a care package was required this would be in place for the patient's discharge. Any advice on benefits was available to support patient needs.
- MCH operated a 'trusted' referral system from the local NHS acute trust. No referral guidelines were available. Referral was based on individual need. If patients were inappropriately referred with regard to the level of care

they needed they were sent back to the referring hospital. We reviewed the incident data and saw 21 patients had been referred back to the acute trust since the unit opened.

- The unit liaised with OT, PT, podiatry, diabetic team, Parkinson's team, MS nurse, dementia support, dietician, and SALT to ensure individual needs were met.
- For patients where their discharge was not going to plan, any complex issues would be raised with the appropriate social and mental health agencies to provide support to patients on their discharge. We were given examples by the therapy lead on Endeavour who had involved the housing team for a patient who had complex home conditions and the mental health team who were involved to support a grieving patient and a patient who was self-neglecting.

Access to information

- There were systems in place to ensure staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner. This included test results, risk assessments and medical and nursing records**.**
- Staff showed us how to access key policies and standard operating procedures on the organisation's intranet. Communication from senior management was cascaded to staff via team meeting, emails or through MCH newsletters. Staff confirmed this during the inspection.
- We found the organisation provided information, which supported patients and their relatives to make decisions about their care and treatment. On Endeavour a variety of patient information leaflets were on display including 'stroke and alcohol' and 'stroke and nutrition'.
- On Britannia we were told by the unit manager that on several occasions' insufficient information was available to update staff on patients arriving from the local acute hospital. Patients arrived from the acute trust with inadequate handovers, missing medication and missing drug charts. We reviewed the incident logs for both units and found across the reporting period ten incidents had been reported. These incidents were placed in a weekly 'transfer of care concerns report' and were raised with the head of patient safety.
- On Britannia and Endeavour the discharge summaries were comprehensive and complete, a copy was sent to the patient's GP and a copy to the patient. Discharge discussions were detailed and covered rehabilitation goals, details of medications and support service. We reviewed three discharge summaries during the inspection.
- On Endeavour we saw a nursing handover sheet which was updated by the nurse in charge overnight. If the member of staff was from an agency, they would write on it then a permanent member of staff would update it electronically. The handover sheet had actions from the MDT. The resuscitation status of the patient was recorded in red. Handover sheets also recorded patient's mobility and transfer information, falls risk, diet and food.
- Board meetings took place daily on Britannia. Areas discussed included progress of patients and any referrals made, new admissions and any home assessments completed or due to be undertaken. The board meeting ensured staff were up to date on the position of each patient on the unit.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had undertaken Mental Capacity Act (2005) training which included the Deprivation of Liberty Safeguards (DoLS). They appeared to be knowledgeable on the subject and knew the procedure to follow.
- Staff undertook and documented patients' informal consent to undertake personal care and therapy treatment in the patient's notes. We observed staff seeking consent to interventions during our inspection.
- We reviewed five electronic paper records on Endeavour. Consent was documented in all, along with comprehensive documentation of nursing assessments and interventions.
- On admission, Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) forms were reviewed by the GP's. We reviewed three DNACPR forms on Endeavour with treatment escalation plans on the reverse. All were completed and had review dates (they were within the review date).

Good

Community health inpatient services

Are community health inpatient services caring?

Good

Compassionate care

- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) QS15.
- During our inspection we saw staff within both units were very person-centred in caring for their patients. We saw staff put patients at the centre of everything they did and strived to make patients as comfortable and happy as possible. We observed a therapist kneeling down to talk to a patient whilst another held their patient's hand while they spoke to them. On Britannia, one patient told us the staff were 'lovely on the ward' and they had no complaints with another patient telling us they felt safe in the unit and in the nurses' hands.
- We saw staff anticipated and responded to patients' needs promptly and effectively and did so in a patient and kind manner .We saw staff introduced themselves by name and explained what their role was. We saw staff knocked and waited to enter patient bedrooms on Endeavour.
- The clinical quality team audited patient satisfaction surveys. During the period April 2016 to March 2017, some of the comments received by the stroke team included 'very friendly team, brilliant service, treatment delivered respectfully and sensitively and exceptional care.'
- Staff took steps to provide genuine holistic care including their mental, emotional, and physical needs. They took time to assess patients' mental health needs. We observed a member of staff meeting the needs of the patient on Britannia.
- During the inspection, on Endeavour we heard staff singing a song popular in the 1940's to a patient. We asked if this was regular occurrence. They told us that particular patient was not very responsive but family had told them they liked music and their favourite songs, so staff sang them to him regularly. They also told us at Christmas they sang with all the residents and one who had lost speech became very emotional.
- Patients were allocated a keyworker. Any health professional could be a key worker however, the team would allocate a staff member dependent on the needs of the patient. i.e. if they had largely speech problems their key worker would be a SALT.

Understanding and involvement of patients and those close to them

- The patients and relatives we spoke with told us they found all members of staff respectful, responsive and approachable. They reported staff of all levels listened to what they had to say, acted upon their concerns, and addressed any issues. Patients said they felt they had sufficient time to ask their questions and had all their questions answered.
- Family meetings took place on Endeavour. The unit manager told us the first family meeting allowed families and staff to ask questions about the patient before the event. Families were able to ask questions and unload any emotions. Another meeting two to three weeks later which was led by the band 7 and one member of staff followed this up from each professional group. This meeting set out the priorities for the patient and established plans for their care. The patient and their relative's preferences and expectations were discussed. The lead therapists told us that these meetings were important as they would learn about what the patient wanted and would help the therapist to develop a reablement plan around individual needs.
- In the five patient records we reviewed it confirmed patient and carer involvement; there was evidence of joint discussions involving goal setting, expectations, and aspirations.
- Patients were encouraged to be as independent as possible, they were encouraged with activities of daily living and mobility however, support was also provided as required. Rehabilitation support assistants on Britannia told us at weekends they would support patients' dressing and washing assessments with the aim of getting patients to do as much as they can for themselves and promote independence.
- Families had a variety of support available to them during their relative's stay. This included the key worker who was the point of contact, family meetings, family training sessions (patient transfers) and attending patient access visits. Families were also closely involved in selecting placements for their relatives on discharge.

Good

Community health inpatient services

- Families were encouraged to take part in therapy sessions and were invited to afternoon tea sessions with their relative.

Emotional support

- Staff within the two units were on hand to offer emotional support to patients and were very happy to offer a listening ear. The unit manager and care manager on Endeavour were able to provide counselling support for patients during their time on the unit.
- The unit manager on Endeavour told us mental health assessments were undertaken which covered mood, capacity, and insight. One of the stroke rehabilitation assistants supported patients with anxiety during the inpatient six week stay. Support would be given to reduce anxiety which included trips out.
- The SALT was able to provide support to staff and patients if communication issues were holding patients back. This included an assessment which would highlight the issues and recommend devices such as pen and paper to aid communications.
- No psychologist or religious or spiritual support was available on Endeavour. The unit manager told us if a patient required support, they would contact the senior management team for guidance with the aim to support the patient's needs.

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

(for example, to feedback?)

Good

Planning and delivering services which meet people's needs

- The services were planned and delivered to meet the needs of local people by providing a step down/ intermediate care service for patients who no longer required an acute bed.
- Staff understood the different needs of the people they cared for and acted on these to plan and deliver appropriate individual care and treatment. At the weekends, fewer therapies were delivered. The head of service on Endeavour told us a business case was being developed to get therapy funding so more therapies could be delivered at the weekend. This would mean patients would receive rehabilitation 24/7.
- The Medway Community Healthcare (MCH) stroke team managed the whole stroke pathway from hospital to home. Referral forms were received from the local acute trust. The unit manager and therapy lead would review all referral forms to ensure the appropriate support was available for the patient's admission to Endeavour. For example if it was highlighted that the patient was at a high risk of falls, a room would be made available near to the nurse's station on admission.
- Intermediate care patients on Britannia continue to receive therapy for six weeks following discharge by the team. Patients were then referred onto community therapists for further treatment, if required.
- The services worked well with local commissioners, social care, community organisations, acute, and other healthcare organisations to meet the holistic needs of patients and overcame potential barriers to implement effective individualised care.
- One patient on Endeavour told us the unit was quiet at night so they were able to sleep.
- To prepare patients for intermediate care, the integrated discharge team undertook assessments in the acute trust. A step down service was available for respite care. At the time of the inspection, two patients were due to be discharged for respite care.

Equality and diversity

- We found staff were adept at identifying potential cultural or individual needs and these were recognised and recorded as part of the assessment of care and treatment plan, such needs were catered for accordingly and appropriately.
- Staff received training in equality and diversity on induction and every three years as part of corporate mandatory training. Data provided by the trust showed 97% of staff in inpatient services had completed this training up to the end of December 2016.

Meeting the needs of people in vulnerable circumstances

- The unit manager on Endeavour told us staff allowed three days for patients to settle in to the unit. When the initial assessment was carried out, the unit tried to

include families at the assessment stage to establish the patient's goals (my plan). One patient on Britannia told us their daughter always got updates from the unit manager regarding her relative's care but at this point they were both unaware when they were due to be discharged.

- We saw evidence across all services staff considered the individual needs of patients particularly those in vulnerable circumstances such as those living with dementia, learning difficulties and mental health problems. The services were able to make reasonable adjustments to accommodate their needs and were flexible in their approach.
- All patients were risk assessed prior to admission to ensure the unit provided a safe environment. For a patient living with dementia this included a mental capacity assessment and a discussion around a Deprivation of Liberty Safeguards (DoLS) application with the unit manager. Dementia tools on Endeavour included deep rim crockery with support when eating and the use of a blue toilet seat. A sign would be placed on the door to the shower room saying 'toilet' to support the patient around their room.
- Care pathways were designed to be flexible to make sure different services worked together to meet the patient's changing needs.
- On Britannia, group therapy sessions took place which covered both mental and physical activities. Sessions undertaken included chair based exercises, group bingo and memory games. A rehabilitation assistant in their room offered any patient who was unable to attend a group session one to one exercises. Sessions lasted 20-40 minutes and were led by the rehabilitation assistants. One patient told us they received daily exercises and they felt their foot was improving.
- On Endeavour, the rehabilitation assistants had recently introduced baking as a therapy session for patients.
- On Britannia, we observed a rehabilitation assistant undertaking a falls awareness session with seven patients. The aim of the session was to raise awareness around falls and medication, footwear, hearing issues and the importance of hydration.
- Due to the units being made up of single rooms, staff took longer to get patients ready in the morning as they spent all their time in the room with the patient. This meant it was difficult to run therapy sessions in the morning as staff were occupied with getting patients washed and dressed.
- We saw that on both units, during handover individual patient issues such as those on DNACPR orders, those at high risk of falls, those on a special diet etc. were highlighted.
- One patient on Britannia told us they found the single rooms lonely so they would keep the room door open so they could see people walking past as they were unable to get around without help.
- We found speaking to staff the teams were realistic about the needs of patients and provided the necessary support on their discharge. One example we were given was liaising with the housing team for a patient with complex home issues. A package of care was put in place to support the patient's discharge.

Access to the right care at the right time

- The unit managers told us the waiting time for admissions was approximately one week. We saw a chart in the nurse's office on Britannia with a list of patients waiting for admission. Four patients were waiting for admission at the time of the inspection.
- No mental health nurse was allocated to the units at Amherst Court .The mental health service was contracted from the local Mental Health NHS trust. On Britannia we saw a referral for a mental health assessment. Staff told us the mental health team was very responsive in assessing and providing on-going treatment for patients. However, on Endeavour staff felt the mental health team were not so responsive, as they would not assess a patient until the patient was six months post stroke.
- On Britannia staff told us at weekends less staff were on duty and therefore less time was available to perform other activities such as group therapy sessions. Extended visiting times meant patients were not always ready when their relatives arrived and staff spent more time talking and supporting relatives.
- On Endeavour, a communication group was available to support patients whose speech was impaired, aids, prompts, picture boards and charts were used to encourage patients to talk again.

Learning from complaints and concerns

- MCH had a complaints policy, dated December 2015. Staff told us about MCH's complaints policy and procedures and how they would advise people using the service to make a complaint.

Good

Community health inpatient services

- MCH house and Amherst Court reported 60 complaints over the reporting period. We were unable to review any inpatient complaints for Amherst Court.

Are community health inpatient services well-led?

Good

Leadership of this service

- Leaders we spoke with had the skills; knowledge, experience, and integrity that they needed to lead effectively. The unit managers and therapy leads had a clear understanding of the challenges to good quality care and could confidently identify actions to address them.
- Staff we spoke with on Endeavour felt they were appreciated by the managers who were visible on the unit. Staff felt supported and listened to.
- On Endeavour, the unit manager told us they felt supported by the GP's who attended the unit, Monday to Friday**.** Monthly GP meetings were due to commence following the move to Amherst Court. Agenda items discussed would include medicine management and nursing and medical issues.

Service vision and strategy

- Medway Community Healthcare (MCH) is a social enterprise and community interest company (CIC) established in 2011.The vision of MCH was to be successful, vibrant CIC that benefited the communities they served with a commitment to lead the way in excellent healthcare.
- MCH had a set of values which included working in partnership, delivering quality and value and being caring and compassionate. The vision and values were displayed on Endeavour with a pledge from staff to deliver the values.
- MCH had a five year strategic plan to develop services in Medway in order to ensure people they provided services to experienced safe, effective, and responsive care. MCH aimed to do this by delivering a range of services for local people, support clinical teams to innovate and develop their services and supporting out of hospital services in order to reduce the demand for hospital services.
- MCH also aimed to develop services outside of Medway by establishing themselves as providers of accessible, high quality integrated care across Kent.

Governance, risk management and quality measurement

- The heads of services on Britannia and Endeavour were part of the membership of a variety of committees including the Quality Assurance Group (QAG), the information governance group and the infection prevention and control subcommittee. Information from these committees was cascaded down to frontline staff at staff meetings. Minutes from recent meetings were kept in the meetings folder in the learning lounge.
- Endeavour and Britannia units had an effective clinical and corporate governance structure; they had a system for measuring their key performance indicators to measure quality and determine ways to improve the quality and service provided.
- The head of service and unit manager on Endeavour attended the Governance Assurance Information Network (GAIN) meeting which was a forum for clinical staff where incidents, lessons learnt and policies were discussed and ratified. We reviewed the minutes of the February GAIN meeting and saw areas discussed included a health and safety update, medicine management, and the policies that had been ratified including resuscitation guidelines, controlled drugs policy, and consent for care.
- There was evidence of effective clinical governance procedures and quality measurement processes, these enabled risks to be captured, identified, and escalated to the senior management team. This supported the dissemination of shared learning and service improvements and an avenue for escalation to the MCH board.
- MCH had developed a quality framework, which was in line with the five key questions of safe, effective, caring, responsive, and well-led. Each key question had three commitments which were aligned with the organisational values.
- The GAIN, medicines management subcommittee, infection prevention and control subcommittee, fed into the QAC. The QAC, performance overview group and audit and risk committee reported to the board.

Good

Community health inpatient services

- The QAC met every month and discussed policy updates, involvement in research and reports from the sub groups. Reports reviewed included clinical and medicines incidents. Clinical risks raised by each service were discussed at the business meeting every month.
- Locally there were robust arrangements for identifying, recording, and managing risks, issues, and mitigating actions. The risks relating to Amherst Court were placed on the risk register by the heads of service. All of these items had appropriate mitigating action, timely updates, and nominated responsible individuals to manage them. Both unit managers had a good understanding of their risks and what was on the risk register and why.

Culture within this service

- All staff we spoke with felt confident to raise concerns with their line managers and more senior managers if necessary, they felt their concerns would be listened to and actioned. Recent issues raised with the senior management team included IT issues and pensions. There was a culture of candour, openness, and honesty. Staff told us they were encouraged to report incidents
- Staff told us managers had an open door policy and maintained one to ones with staff where issues need to be resolved.
- Staff on Endeavour said that they "worked as a team" and were "there for each other." They told us the culture of multidisciplinary teamwork between all levels of staff had a positive impact on the care and wellbeing of patients**.** Staff felt the teamwork on the unit was effective. However, on Britannia staff felt there was a distance between the nursing and therapy staff and both teams were not working together as they should or could. Communication between the two groups was poor.
- Staff on Britannia told us emotional support was available through the occupational health department. Staff also felt emotional support was given by the managers on the units.

Public engagement

- Within the stroke pathway, 12 friends and families surveys were completed monthly. We saw data confirmed that in November and December 2016, 100% of patients surveyed would recommend the service. On Endeavour when a patient was due to be discharged the patients would be asked to complete a survey with support from a rehabilitation assistant.
- Online surveys are undertaken and reviewed by the clinical quality team. Staff demonstrated the survey software that was used. Any areas of concern would be flagged up by the head of service, so the appropriate actions could be taken.
- A stroke survivors' support group was available which allowed patients, family, and carers to meet and share their experiences. A member of the MCH stroke team was on hand to provide advice and support.

Staff engagement

- There were monthly staff meetings held on the units to disseminate information from higher up in the organisation and to act as a forum for listening to concerns and worries from the staff. On a quarterly basis the head of service on Endeavour fed back to all staff through the 'manager's moment'. This was the forum used to give frontline staff positive and negative feedback regarding the care delivered.
- To keep the lines of communication open across the service on Endeavour a variety of meetings took place. A senior staff meeting with registered nurses and therapists took place once a month on a Wednesday. This was followed by a staff meeting the following Tuesday to pass information onto staff. A band 6 workshop took place on the Thursday where safety issues, training, management plans, and local procedures were discussed. An action plan was in place to implement new work practices discussed at the band 6 workshops.
- On a monthly basis all staff covering the whole stroke pathway attended a meeting. This allowed staff from the local acute trust and the community to meet with the Endeavour team to engage, so joined up care would be delivered through good team work.
- Schwartz Center Rounds ® were a forum where staff discussed emotional and social dilemmas that arise for caring for patients. Staff told us they attended these when they could and found them helpful.

Innovation, improvement and sustainability

- The head of service on Endeavour was able to describe the research projects being undertaken across MCH,

with support from the local research network. One research project was for stroke patients called KEMIST which was a medicine support study. The number of patients due to be recruited in 2016/17 was 111. This target had been met by the team and the research was on-going.

- The head of service for the stroke team was involved with the stroke network where good practice was discussed and shared across a variety of providers. The work undertaken included quality standards updates, consultations on Transient Ischaemic Attack's (TIA's) and guidance for commissioning. The head of service was engaged and was actively involved in the new work streams to ensure MCH patients received nationally recommended pathways of care.
- The SALT on Endeavour had secured funding for an electronic device to support a language programme. This was part of the next year's service improvement project.
- Work was ongoing across the units regarding the integration between the therapy and the nursing staff. A business plan was being developed to support weekend therapies.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Patient risks were not consistently assessed and monitored to ensure they received appropriate intervention and support therefore the provider should ensure that staff complete all the necessary body maps for pressure ulcers, the documentation of infection control status, falls assessments and patient's baseline observations.
- An active recruitment programme should be maintained to fill vacant posts and reduce the reliance on agency staff.
- The electronic patient records system should be made available to all staff on both units as soon as possible to ensure all staff can access patient information and show evidence of continuous patient care records.
- A robust referral system should be introduced to prevent the inappropriate transfer of patients to the units who are not medically fit for rehabilitation or step down care.
- The resuscitation trolley should be secure to prevent the removal of emergency drugs.
- Adequate numbers of staff should be available to comply with national guidance to ensure evidence based care is delivered to all patients in the stroke rehabilitation programme.
- Mental health support should be improved on Endeavour to support patients and staff in delivering individualised care needs of the patients.