Birmingham Community Healthcare NHS Trust

RYW

Community health inpatient services

Quality Report

3 Priestley Wharf,
Holt Street,
Birmingham,
B7 4BN
Tel: 0121 466 6000
Website: bhamcommunity.nhs.uk

Date of inspection visit: 23-27 June 2014
Date of publication: 30/09/2014

This report describes our judgement of the quality of care provided within this core service by Community health inpatient services. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Community health inpatient services and these are brought together to inform our overall judgement of Community health inpatient services

Summary of findings

Ratings

Overall rating for Community health inpatient services	Good
Are Community health inpatient services safe?	Good
Are Community health inpatient services effective?	Requires Improvement
Are Community health inpatient services caring?	Good
Are Community health inpatient services responsive?	Good
Are Community health inpatient services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Community inpatient services had systems and processes in place to keep patients safe, and the majority of staff were aware of the systems. Feedback was variable amongst staff and across units. Risk and safety information was displayed on wards, and the majority of staff indicated that this was discussed at team meetings.

Wards were in a good state of repair, were visibly clean and the majority of staff followed appropriate infection prevention practices. Some concerns were identified with out of date stock and unsecured environments and storage facilities.

The quality of records varied, there were concerns particularly on the intermediate care units regarding the completeness of assessment and planning records. Staffing levels met the needs of the patients at the time of our inspection.

There was variation in the use of evidence based practice, and effective assessment and delivery of care across a number of wards and hospitals.

Pain relief and nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measure of patient outcomes, and one ward was involved in a national study to measure effectiveness of care and patient outcomes.

Staff uptake of mandatory training was below the trust's target in the month of April 2014. We found that most staff had received little or no training in stroke care and national guidance in stroke rehabilitation was not always followed. The majority of staff received supervision but this was not the case for all staff. Multidisciplinary team working was good.

Staff were committed and hardworking. All of the patients we spoke with had a positive experience, felt their privacy and dignity was maintained and most patients said things were explained to them in terms they could understand. The interaction we observed between staff and patients varied though was mostly positive in nature. However in some areas, staff were task oriented and did not always provide a person centred care approach. Some patients told us that they had not been fully involved in drawing up their care plans.

Some community inpatient services were responsive to patient needs. Discharge planning had been reinforced using the Project Jonah (a trust initiative to hold daily multi-disciplinary meetings to facilitate effective discharge planning) approach, but we found not all areas had formally adopted this approach.

Staff felt supported and valued, and were clearly passionate about delivering good care. Staff views on the trust's leadership and vision varied but services were well led at a local level in most areas. Not all staff had a clear understanding of the vision of the trust. In some areas, staff felt they were not engaged in decision making about their service and there was not effective two way communication streams.

Summary of findings

Background to the service

Birmingham Community Healthcare NHS Trust was first registered on 30th March 2011 and delivers community-based healthcare to people of all ages across Birmingham, Sandwell, Dudley and Walsall. It also delivers specialist rehabilitation services.

The 12 inpatient services are provided from seven locations across Birmingham and provide a total of 302 inpatient beds. There are three intermediate care units at the Norman Power, Anne Marie Howes and Perry Tree Care Centres. Good Hope Hospital and Heartlands Hospital both have a community unit (Wards CU27 and CU29 respectively). West Heath Hospital has three wards (Wards 11, 12 and 14) providing sub-acute care and rehabilitation for older people. Moseley Hall Hospital has three wards (Wards 5, 6 and 7) providing sub-acute care and rehabilitation for older people and a specialist inpatient neuro-rehabilitation ward (INRU: Ward 9). Care is delivered by GPs, nurses, support staff and allied health professionals. Some of these services have access to consultant cover.

We attended all 12 locations over four days. During an unannounced visit we revisited one location. We spoke with 89 patients, 75 staff and 15 visitors. We looked at individual plans of care and associated records for 55 patients, including risk assessments and a variety of team specific and service based documents and plans. We also sought feedback from external partner organisations.

Background to the provider

Birmingham Community Healthcare NHS Trust delivers community-based healthcare to people of all ages across Birmingham, covering a population of approximately one million people and a geographical area of 103 square miles across Birmingham, Sandwell, Dudley and Walsall. It also delivers Specialist Rehabilitation services and services at Birmingham Dental Hospital for the people of the wider West Midlands region, including Warwickshire, Staffordshire, Worcestershire, Shropshire and Herefordshire. The Birmingham Community Healthcare NHS Trust learning disability service works across Birmingham, in which 23,800 (2.3 per cent of the 1.1 million population) have a learning disability.

The trust delivers services in people's homes, primary care premises and as well as from the following main sites, of which some are community inpatient facilities:

- In Northfield: Edgewood Road Children's Centre, West Heath Hospital and Sheldon Nursing Home.
- In Selly Oak: Sayer House, Elliott Lodge, Kingswood Drive.
- In Ladywood: Birmingham Community Healthcare NHS Trust Headquarters, HMP Prison Winson Green, Birmingham Dental Hospital and Norman Power.
- In Hodge Hill: The Bungalow, Community and Unit 29.
- In Moseley: Moseley Hall Hospital
- In Erdington : Perry Tree Centre
- In Yardley: Ann Marie Howes Centre
- In Sutton Coldfield: Community Unit 27

The trust provides community and specialist NHS services across Birmingham and the West Midlands and employs 4,845 staff (established posts at March 2014).

Our inspection team

Our inspection team was led by:

Chair: Dr Cheryl Crocker, Director of Quality and Patient Safety, Nottingham North and East Clinical Commissioning Group

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Dentist, Nurses, Therapists, Senior Managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Summary of findings

Why we carried out this inspection

Birmingham Community Healthcare NHS Trust was inspected as part of the second 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?

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

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Birmingham Community Healthcare NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 23 and 27 June 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 46 locations which included 13 community inpatient facilities and the dental hospital. The remaining locations included various community facilities. We carried out an unannounced visit on 27 June to one of the inpatient units.

What people who use the provider say

We spoke with 89 patients during our inspection. All of the patients we spoke with were very positive about the quality of the care and treatment they were receiving. They told us staff attitudes were good and that they felt involved in decisions about their care.

We also received 29 comment cards from people that had used services and the majority were very complimentary about the care provided and about the staff. Four comments were negative and included concerns about perceived low staffing levels and poor communication.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should take steps to ensure that all staff are included in lessons learnt from incidents and near misses.
- Improvements to systems should be made to ensure that checks are made regularly and out of date stock is removed from service.
- Action should be taken to ensure that any chemicals are stored appropriately, and 'out of bounds' areas are appropriately secured.

Summary of findings

- The trust should ensure that the quality of record keeping is improved and that audits accurately reflect practice. This should include staff compliance with the deteriorating patient policy to ensure staff are recognising and managing patient deterioration confidently and competently. Records need to provide adequate evidence for the whole staff team to provide care.
- The trust should ensure that all staff who provide care in the rehabilitation of stroke patients have received appropriate training.
- Care should be delivered using best practice and guidance across all inpatient services, and should involve the patient and their family.
- The trust should ensure staff attendance at mandatory training and ensure all staff received appropriate supervision.
- The trust should review its 24 hour working practices across inpatient units to assure itself that patient flow is as effective as possible.
- The trust should review the national clinical guidance for stroke care to provide assurance that care delivery meets the ongoing needs of the patient and their family or carer.

Put in place benchmarking against other wards within the service, to increase opportunities for learning across inpatient services.

Birmingham Community Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

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

Good

Are Community health inpatient services safe?

By safe, we mean that people are protected from abuse

Summary

Community inpatient services had systems and processes in place to keep patients safe, and the majority of staff were aware of the systems. Staff received feedback regarding incidents and near misses, though this was more variable on the intermediate care units. Risk and safety information was displayed on wards, and the majority of staff indicated that this was discussed at team meetings. All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance.

Wards were in a good state of repair, were visibly clean and the majority of staff followed appropriate infection prevention practices. Some concerns were identified with out of date stock and unsecured environments and storage facilities on the intermediate care units. Medicine management was robust in the majority of cases, but we did identify concerns regarding some administration practices, and temperature checks of some storage rooms and fridges.

The quality of records varied, there were concerns particularly on the intermediate care units regarding the completeness of assessment and planning records. Staffing levels met the needs of the patients at the time of our inspection but not all areas were using a patient dependency tool to link the dependency of the patient population to the staff rota.

Incidents, reporting and learning

The provider had a good track record on safety over time and across services and care settings. Where concerns had arisen they had been addressed in a timely way.

There were effective and embedded arrangements for reporting safety incidents and allegations of or actual abuse, which were in line with national and statutory guidance. Staff told us they reported incidents using Datix

Good

Are Community health inpatient services safe?

(the trust's computer incident reporting system). However, some junior staff told us that they would report incidents to nursing staff to log on Datix, as they could not access the trust's computers.

The provider encouraged openness and transparency. There were clear accountabilities for incident reporting in most wards. The majority of staff could describe their role in the reporting process, were encouraged to report and were treated fairly when they did. Systems were easy to use and but there was an inconsistent approach to reporting across the wards.

There were clear safety-related goals at trust and service level against which the wards could demonstrate continuous improvement. The trust used a series of performance indicators, called Essential Care Indicators (ECIs) and how each ward performed was displayed on notice boards in the units. These indicators showed performance regarding falls, medicines management, and pressure ulcer prevention. Each ward also used a reporting dashboard, the Safety Thermometer, which showed how the ward performed on key risk areas.

The majority of staff were aware of how to report incidents and near misses and received feedback from reported incidents, though staff on the intermediate care units were less likely to receive feedback. The trust had reported no never events for inpatient services for the previous year. As regards reported serious incidents, inpatient areas had 87 incidents, out of a trust total of 443 between December 2012 and March 2014, with the majority attributed to pressure ulcers.

The trust shared learning from safety incidents and safeguarding reviews internally and externally. On most wards, action was taken to improve systems, operating procedures and staff practice as a result of the investigations or reviews.

Norman Power Intermediate Care Unit

Staff were aware of how to report incidents and were recorded in patient notes. Most staff said they did not get feedback from incidents; but when they had staff meetings they discussed learning from Datix incidents. Senior staff said weekly team briefs had been held and that safety issues were discussed. We found that these meetings were not always held on a weekly basis. The unit did not yet have an action plan from learning from incidents; we were told that one would be drawn up after the team away day that was planned for the near future. We did see how the unit had responded to an incident regarding photographs of patients being taken on mobile phones and that appropriate notices were now on display to stop this practice. Some staff told us there was a weekly staff information bulletin sent by the trust that contained patient safety information. Therapists said that when a patient fell, they would receive a full therapy reassessment and the risk assessment in place prior to fall was reviewed to inform learning was shared via team meetings. The ward ECIs were on display and showed that the ward achieved 98.6% compliance with recording of patient observations and 100% compliance with recording of falls risk assessments.

Perry Tree Intermediate Care Unit

Some staff said that there was a lack of feedback after an incident was reported, though others stated that they discussed learning from reported incidents at staff meetings. Senior staff told us that if an incident resulted in serious harm, an investigation was completed and lessons learned were shared within teams at weekly team brief meetings or monthly unit meetings, but this did not usually happened for falls.

Anne Marie Howes Intermediate Care Unit

Staff were aware of what types of incident to report and how this should be done. Some staff felt they received feedback about incidents and that they usually shared learning at team meetings, when they were held. All staff could access the ECIs information on the trust computer system but senior staff said not many staff did. The unit achieved 97.4% compliance in the previous month, which was above the trust target of 95% compliance.

Good Hope Hospital Community Unit 27

All patient falls were investigated fully and any supportive measures were put in place. Staff were able to request additional staff resources if required. If a patient had two falls then additional specialist nurse expertise was requested to review the safety for that patient. Staff told us that patient falls were investigated fully and supportive measures were put in place. Data indicated there was a low level of incidents such as falls or accidents. Staff told us they knew how to report incidents through the Datix computer system. Health care assistants told us they would report to nursing staff any incidents that required reporting. Incidents such as falls were investigated fully and lessons

learnt were shared with all staff to improve safety. Details of incidents in other wards were also shared to ensure that lessons learnt across the trust were shared with the team for their learning.

Heartlands Hospital Community Unit 29

There was a low level of incidents such as falls or accidents. Staff told us they knew how to report incidents through the Datix computer system. Health care assistants told us they would report to nursing staff any incidents that required reporting. We saw that incidents such as falls were investigated fully and lessons learnt were shared with all staff to improve safety. We saw that details of incidents in other wards were also shared to learn lessons across teams in the trust.

Moseley Hall Hospital

Staff had good awareness of incident reporting procedures and feedback on incidents was discussed at weekly team meetings. Staff on some wards gave examples of how practice had changed following lessons learnt from incidents, for example, to reduce the incidents of falls following an analysis of the trends from incidents, patient checks were carried out before medication rounds started. Staff said they always received feedback from incidents. The ward matron viewed all incident reports on Datix and reviewed the incident with staff involved when required to assist with learning from the incident. Safety Thermometer and "Free From Harm" information was clearly displayed at entry to the wards. There were effective arrangements in place to ensure staff were encouraged to report incidents. Incidents were investigated and practice changed, if necessary, to ensure patients were protected from unsafe care. Ward 9 staff had developed their own care "rounding" tool to monitor patients' well-being effectively.

West Heath Hospital

Staff were aware of incident reporting and the use of Datix and received feedback from ward leaders about incidents. The performance indicators, ECIs, and the levels of "Free From Harm" information were displayed at entry to the wards providing a snap shot of the performance for the ward. Most staff said they had access to system for reporting incidents. Incident reporting was encouraged by the matron. Not all of the staff stated they received feedback from incidents they reported.

Cleanliness, infection control and hygiene

Ward areas were visibly clean and tidy and sanitising hand gel was available throughout the units. Posters about effective hand hygiene were also on display. However, some hand gel dispensers and sanitising chemicals in a body fluid spill kits were out of date. Equipment had 'I am clean' stickers on them which were easily visible and documented the last date and time they had been cleaned. We reviewed the cleaning schedules, which identified the frequencies for when equipment was required to be cleaned.

The assisted kitchen areas had posters regarding food hygiene controls and colour coded chopping boards were being used for different food types. Patients told us that they thought the ward areas were clean and saw the cleaner regularly. The majority of staff worked in accordance with best practice for infection control, this included good hand hygiene, wearing personal protective equipment (PPE) when appropriate and being bare below the elbows. Infection control audits were carried out monthly, including checks on bed mattresses.

Norman Power Intermediate Care Unit

The rooms we saw were visibly clean and tidy. Sanitising hand gel dispensers were available for staff and visitor's use through the unit. Posters about effective hand hygiene were also on display. However, we found that two hand gel dispensers were out of date. The assisted kitchen areas had clear posters regarding food hygiene controls and colour coded chopping boards were being used for different food types. Food products in fridges were in date. Temperature probes were used to record the temperature of hot food from the hot trolley at mealtimes and we saw that these checks were recorded. We saw that the unit had body fluid spillage kits available for to use, but that the sanitising chemicals within them had gone past their expiry date. We found that whilst the unit had a system for the storage and disposal of clinical waste, the gate to the outside locked area for clinical waste was open and one of the clinical waste bins was wide open, posing a risk to the public. Staff said that occasional infection control audits were completed but that hand washing audits were not carried out.

Perry Tree Intermediate Care Unit

The rooms we saw were visibly clean and tidy. Sanitising hand gel dispensers were available for staff and visitor's use through the unit. Posters about effective hand hygiene were also on display. Infection control audits, including checks on mattresses and staff hand hygiene, were carried

out monthly. However, we did observe some staff who did not adhere to hand hygiene guidance at times during our visit. There were systems in place for the disposal of clinical waste.

Anne Marie Howes Intermediate Care Unit
The rooms we saw were visibly clean and tidy. Sanitising hand gel dispensers were available for staff and visitor's use through the unit. Posters about effective hand hygiene were also on display. Infection control audits, including checks on mattresses and staff hand hygiene, were carried out monthly. There were systems in place for the disposal of clinical waste.

Good Hope Hospital Community Unit 27
A kitchen area was used by patients in Unit 27 for assessment of manual skills and abilities to prepare for going home. The area was also used as a staff kitchen, the fridge and work surfaces were not maintained in a hygienic condition suitable for patient use. We discussed this with the manager and therapy staff who said they would stop using the facility in this way for patients.

Heartlands Hospital Community Unit 29
Cleanliness was supported by the staff from the main hospital contracted domestic service. We saw that the ward area was visibly clean and tidy.

Moseley Hall Hospital
Staff had systems in place to protect patients from the risk of a hospital acquired infection. All staff we saw were bare below elbow and seen hand washing and using sanitising gel. Cleaning audits had been undertaken. The environment was visibly clean and equipment was labelled when it had been cleaned.

West Heath Hospital
All staff we saw were bare below elbow and were observed hand washing and using sanitising gel. The wards were visibly clean. Senior staff were not able to locate the infection control audits on Ward 12, and although the environment appeared clean, we could not be assured that the cleanliness was regularly monitored to ensure patients were prevented from the risk of a hospital acquired infection.

Maintenance of environment and equipment

Equipment was well maintained and tested for safety appropriately. Some areas were not secured appropriately, which could pose a danger to patients or the public, some trip hazards were identified and some gels and dressings were out of date.

Emergency equipment, including equipment used for resuscitation was checked every day by the night staff. However, in one of the intermediate care units, we noted gaps in recorded checks during June 2014. Pressure relieving equipment was available on site and was available for patients. We checked a random sample of equipment and noted that all equipment was labelled when it was last seen which indicated if it had been tested, received pre-planned maintenance and if it had been safety tested. Firefighting equipment had been tested regularly. Portable electric equipment had been tested regularly to ensure it was safe for use and had clear dates for the next test date on them. Access to some areas in the intermediate care units was not secure presenting potential risk to people living with a dementia. Checks had been carried out on the emergency kits for oxygen use however we found that the sanitising gel sachets for intubating patients were out of date and had not been picked up by the audits in one of the intermediate care units. We checked a number of first aid kits and generally products and medicines were in date.

Estate management had been inconsistent on some units but the trust was now addressing areas of concern. For example, one unit had had a bathroom ceiling track hoist out of order for months, and this had now been placed on the estates management team's action plan. At mealtimes, food was kept at appropriate temperatures in a hot trolley and staff used food temperature probes to check that food was at correct temperature to be served to patients.

Norman Power Intermediate Care Unit
We found that the firefighting equipment had been tested regularly. Portable electric equipment had been tested regularly to ensure they were safe for use and had clear dates for the next test date on them. The door lock mechanism for one utility room was not working, which meant that visitors could have gained access to a staff only area. The door to the assisted kitchen area was not locked as it should have been which meant that patients and visitors could have accessed this area without staff supervision; a five litre container of detergent had been left

on the top of the sink, and had not been locked away. Checks had been carried out on the emergency kits for oxygen use however we found that three sanitising gel sachets for intubating patients were out of date and had not been picked up by the audits. At mealtimes, food was kept at appropriate temperatures in a hot trolley and that staff used temperature probes to check that food was at correct temperature to be served to patients, to minimise the risks of infection from incorrect storage of heated food.

The temperature of the fridge was checked daily, but we noted that there were four gaps in June's recording chart and six gaps on the record chart for May. Some carpet areas were in need of repair and that some joins had been sealed with tape to prevent potential trip hazards. Staff told us that carpet and flooring replacement in these units was being actioned by the trust's estate management service. We saw an electrical cable lying across a corridor floor, posing a trip hazard. Chemicals that were potentially an irritant to the skin were stored in an unlocked cupboard under the sink in the communal kitchen area. The emergency equipment checklist had not been signed as completed for seven times in June 2014, which meant that there was a risk that the emergency equipment in the unit had not been checked daily, as was the unit's procedure. A handyman was on site at the unit to deal with minor issues: more complex repairs were reported to the trust's estates management team.

Perry Tree Intermediate Care Unit

Firefighting equipment had been tested regularly; portable electric equipment had been tested regularly to ensure they were safe for use and had clear dates for the next test date on them. The assisted kitchen was well equipped and maintained. We found two sterile dressings out of date in the first aid box, and brought this to the attention of senior staff. Patients' call bells were linked to pagers that staff wore and senior staff monitored the call bell response times. The adapted bathroom had equipment that was well maintained and safe to use, apart from the ceiling track hoist which had been out of order for over six months. This had been escalated to senior managers and the estates management team. At mealtimes, food was kept at appropriate temperatures in a hot trolley and staff used food temperature probes to check that food was at correct temperature to be served to patients. The trust was planning to replace the call bell system in this unit, as well as the other two intermediate care units. There were some potential trip hazards in communal corridors and some wheelchairs and stand-aid hoists had been left in communal areas without their brakes on. The door to the unit's laundry was not lockable and chemicals that were a skin irritant were not locked away in cupboards.

Anne Marie Howes Intermediate Care Unit

Firefighting equipment was tested regularly and annual safety checks had been carried out on portable electrical equipment. The unit was well maintained and provided a suitable environment for the patients. The plant room had been left unlocked and a variety of electrical tools were accessible if a patient or visitor was to have entered that room. Two other store rooms left unlocked that should have been locked. We brought this to the attention of senior staff so the risk of patients entering these staff only areas was minimised. At mealtimes, food was kept at appropriate temperatures in a hot trolley and staff used temperature probes to check that food was at correct temperature to be served to patients.

Good Hope Hospital Community Unit 27

Heavy stair equipment used by therapy staff with patients was stored in a side room but had to be moved out when needed by patients. This was a health and safety risk to the therapy staff and meant the equipment was not easily available for patients to practice their mobility.

Heartlands Hospital Community Unit 29

Staff told us that maintenance of equipment was completed promptly by the contracted service. We observed that maintenance staff were checking the safety of hydraulic beds.

Moseley Hall Hospital

The resuscitation trolley was stocked with relevant equipment and drugs, and the daily checklist had been signed and dated as per protocol. Equipment was maintained and available when required.

West Heath Hospital

Resuscitation equipment was appropriately stocked, drugs and fluids were within date and sealed. Daily resuscitation equipment checklist had been signed and dated. Equipment was checked and maintained.

Medicines

Medicines were administered correctly and appropriately, though we did identify some minor concerns. Fridge temperatures were checked and recorded appropriately with some exceptions in the intermediate care units, and pharmacists carried out regular medication checks.

Good

Are Community health inpatient services safe?

Nursing staff wore a red tabard during medicine rounds which indicated that the staff should not be disturbed. However, we did note on one occasion the nurse did not wear such a tabard. Nursing staff were aware of medication policies and relevant assessments, including for self-medication.

At West Heath and Moseley Hall Hospitals, appropriate systems were in place for the storage, administration and recording of medicines. Pharmacists visited daily to review medications and carry out reconciliations. At West Health Hospital one nurse did not wear protective gloves when physically handling medicines, which did not adhere to the trust's policy for handling medicines. Pharmacists visited the units daily, or up to three times a week to review patient's medications. Fridge temperatures were checked and recorded daily.

On the intermediate care units, local general practitioners (GPs) wrote patient prescriptions which resulted in delays on some occasions whilst staff waited for the next GP visit. Reconciliation of medicines was carried out two or three times a week by pharmacy technicians and any areas of concern, such as inconsistent administration details, or gaps on medication administration records were identified and addressed.

Norman Power Intermediate Care Unit
This unit did not carry any stock of medication. Local GPs wrote all patients' prescriptions so there were some delays at times as staff had to wait for next GP visit before a patient's medication record could be reviewed and adjusted. Staff told us reconciliations of medicines were carried out two or three times a week by pharmacy technicians and any areas of concern, such as inconsistent administration details, or gaps on medication administration records were identified and addressed. A concern identified during reconciliation audits was regarding eye drop medicines not having an opened date put on them; this had been raised with nursing staff. Medicines requiring refrigeration were in date and in most cases, fridge temperatures were checked daily and recorded. There 24 gaps in fridge temperature records for the previous three months. We found that a fridge that was used to store patient's blood samples did not have its temperature checked and recorded. In one store room where emergency medicines were kept the ambient room temperature was not being recorded so it was not possible to see if the medicines had been stored at the correct temperature. Staff gave medicines following the trust policy for administration of medicines, but we saw one occasion where eye drops were given to a patient without the nurse wearing gloves.

Perry Tree Intermediate Care Unit
The unit had appropriate systems in place for storage and administration of medicines. We reviewed five drug charts and found that they were accurate and up to date. Local GPs wrote all patients' prescriptions so there were some delays at times as staff had to wait for next GP visit before a patient's medication record could be reviewed and adjusted, particularly for pain relief. Controlled drugs had been audited monthly and the unit had appropriate systems in place for storage, administration and the disposal of these drugs.

Anne Marie Howes Intermediate Care Unit
The unit had appropriate systems in place for storage and administration of medicines. However, we observed one patient had been left with medication next to them. There was no evidence in that patient's records that they were self-medicating and no risk assessment had been completed. The patient was not able to tell us what the medicine was for. Staff confirmed that this patient was not self-medicating and that an incident report would be completed. We also found that the drug record did not record this medicine, although the hospital discharge letter did state the patient was on this medicine. We also found that for another medicine for this patient, the administration details on the box did not correspond to the drug chart.

Good Hope Hospital Community Unit 27
Medications were stored appropriately and there was regular auditing of supplies and use of medications by staff and pharmacy personnel.

Heartlands Hospital Community Unit 29
Medications were stored appropriately and there was regular auditing of supplies and use of medications by staff and pharmacy personnel. We examined four medication charts and saw that one person had not been given a regular drug on two consecutive occasions but the reason for the omission had not been recorded.

Moseley Hall Hospital
Medicine administration and storage at Moseley Hall Hospital was in line with national guidance. Out of hours medication was available on site or from the local hospital.

Good

Are Community health inpatient services safe?

Appropriate systems were in place for the storage, administration and recording of medicines. Pharmacists visited daily to review medications and carry out reconciliations. The controlled drug book was reviewed and had been signed and dated by 2 members of staff in accordance with trust policy.

West Heath Hospital
At West Heath Hospital, appropriate systems were in place for the storage, administration and recording of medicines. Pharmacists visited daily to review medications and carry out reconciliations. However, we saw one nurse did not wear protective gloves when physically handling medicines, which did not adhere to the trust's policy for handling medicines. Fridge temperatures were checked and recorded daily.

Safeguarding

There were effective safeguarding policies and procedures which were understood and implemented by staff. Adherence to safety and safeguarding systems and procedures were monitored and audited on a risk basis, and necessary actions taken as a result of findings. Staff were able to tell us the process for reporting safeguarding concerns and knew where they would access the safeguarding policy and procedures; safeguarding information was displayed on the wards. Staff informed us that they had completed safeguarding training, and were able to tell us of the signs for recognising abuse, how to raise an alert and that the trust had a whistleblowing policy in place. The majority of staff had received safeguarding training, though 33% of staff on one ward at Moseley Hall Hospital required safeguarding training; dates were in place for the training to take place. Trust data for May 2014 indicated that 93.7% of staff had received level 1 safeguarding adults training. However, not all staff were able to tell us how they report a concern outside the organisation if required.

Norman Power Intermediate Care Unit
Staff were aware of how to recognise signs of abuse and report safeguarding concerns, and were able to tell us how they report an area of concern to the trust's safeguarding team. Not all staff had had safeguarding training provided by the trust.

Perry Tree Intermediate Care Unit
Staff were aware of how to recognise signs of abuse and report safeguarding concerns, and were able to tell us how they report an area of concern to the trust's safeguarding team. Support from the trust's safeguarding adult's team was very good and timely advice regarding concerns was always provided.

Anne Marie Howes Intermediate Care Unit
Staff were aware of how to recognise signs of abuse and report safeguarding concerns, and were able to tell us how they report an area of concern to the trust's safeguarding team. Staff we spoke with were aware of the trust's policy on whistleblowing.

Good Hope Hospital Community Unit 27
Staff told us they had attended training about safeguarding of vulnerable adults and knew about different types of abuse.

Heartlands Hospital Community Unit 29
Staff had attended training about safeguarding of vulnerable adults and knew about different types of abuse. We found that training records showing that all staff had attended training about safeguarding of vulnerable adults.

Moseley Hall Hospital
Staff at Mosley Hall Hospital were aware of their responsibilities with regards to safeguarding vulnerable patients. Gaps in training had been identified and plans were in place to address where staff had not received relevant training. For one ward, ten out of 30 staff had had safeguarding training booked as they had not completed it.

West Heath Hospital
Staff had attended training about safeguarding of vulnerable adults and knew about different types of abuse. The matron had identified where staff had not completed the training and a plan was in place to address this. One patient had been referred to the local safeguarding authority for investigation as staff had concerns about their safety at home.

Records

During our inspection we observed that medical records were securely stored in either a locked cabinet or dedicated rooms. In some wards, patient care plan files were kept at the end of the patient's bed so they could be accessible to the patient and their visitors. The trust had systems in place to ensure patient records remained confidential. We identified concerns with the accuracy of some records on the intermediate care units, though at the other hospitals records were of a better standard.

Good

Are Community health inpatient services safe?

During our inspection we looked at the care records of 55 patients across inpatient services. Some records were well organised, information was easy to access and records were complete and up to date and included transfer of care assessments forms, biographical details and contact details for next of kin. We saw evidence that units were using the "This is me" document to support care planning for people with dementia. Screening for dementia assessments were being carried out in the units, but we found two examples where they had not been completed correctly.

Norman Power Intermediate Care Unit
The accuracy of record keeping varied for some patients' essential care records, including assessments, care plans, daily observations, repositioning and food and fluid intake charts. Eight food and fluid charts had significant gaps where staff had not recorded any food or fluid intake, for up to half a day. Staff told us that one patient's family brought their meals in the evening, but these had not been recorded on the charts. Nurses were to review care plans at the weekends and a monthly audit of documentation was carried out as part of the ECI checks. Audits of therapists' notes and documentation had just commenced. The trust was planning to introduce an electronic recording system in October 2014, and senior staff told us that training for staff in using the new system was planned for August and September.

Perry Tree Intermediate Care Unit
Two patients' notes did not have clear recording of the patient's identity on the essential records. Also, in two cases, the doctors prescribed actions on the MEWS charts had not been dated or signed. In two cases, MEWS charts had not been completed in accordance with trust policy. In one patient's record, the manual handling risk assessment had not been fully completed and risk assessments had not been signed as reviewed on a regular basis as was the trust policy.

Anne Marie Howes Intermediate Care Unit
The records we saw reflected the needs of the patients and were accurate and up to date. However, we found the dementia screening assessment was incomplete for one patient and there was no record of a letter being sent to the person's GP as was trust procedure for dementia screening protocols.

One patient had had recorded chest pain, yet this was not reflected on their MEWS chart.

Good Hope Hospital Community Unit 27
Some records of 'intentional rounding' checks on patients were incomplete, we found this was due to lack of recording rather than patient's not being attended to. We found gaps, inaccuracies or inadequate detail in patient records. These were related to completion of risk assessments, therapy assessments, the early warning scores to monitor for deterioration of condition and the daily shift record. Although managers told us they had regular audits of records these omissions and inaccuracies were not being identified.

Heartlands Hospital Community Unit 29
Risk assessments in patient notes were mostly completed but there were some omissions and inaccuracies which had not been noted or corrected in subsequent records by nursing staff. We found gaps in the observational checks on patients, and inadequate details in some risk assessments and therapy assessments. Although managers told us they had regular audits of records these omissions and inaccuracies were not being identified.

Moseley Hall Hospital
Care was regularly assessed and updated to reflect the changing needs of patients to ensure the care they received was appropriate to their needs. Patient records demonstrated that risk assessments had been completed and signed, this included falls risk assessments, pressure area risk assessments, nutrition and hydration risk assessments.

West Heath Hospital
Records were inconsistently completed across the wards we visited. Therapist's notes were detailed and gave clear explanation of care given. Nursing notes were inconsistent and some information had been completed inaccurately, for example, in the pressure area risk assessments. On Ward 14, we found gaps, inaccuracies or inadequate detail in some patient records. These were related to completion of risk assessments, therapy assessments, the early warning scores to monitor for deterioration of condition and the daily shift record. Although managers told us they had regular audits of records, these omissions and inaccuracies were not being identified. We discussed our findings with the managers who said they would review the safety concerns identified.

In one case the Geriatric Depression Score not was completed, although the patient had a diagnosis of dementia. Completion of the Waterlow risk assessment for

risk of pressure damage to skin was inaccurate and variable. Nursing entries lacked structure and consistency in approach. Some daily record entries were very brief and task focused; and it was difficult to identify individualised patient approaches. Other members of the multidisciplinary team recorded all their treatments planning and outcomes in patients' medical records. The therapist's notes had well written entries with a consistent structure, and always recorded verbal consent from patients. They had detailed objectives and action plan for the patient for staff to follow. For another person, the Malnutrition Universal Screening Tool (MUST) showed inconsistency about the height recording and interpretation of the patient's Body mass index (BMI).

Adaptation of safety systems for care in different settings

Ward managers were aware of local risks within their area and reported these through the online reporting system or via the trusts risk register as required. However, we did not always see effective person centred care and treatment planning, particularly for those patients with a cognitive impairment in the intermediate care units.

Some health and safety risks to people with cognitive impairment, or living with dementia, had not been fully considered on one ward at West Heath Hospital and the intermediate care units. For example, some cleaning products were not stored securely in cupboards and as noted above some were kept under a sink in one unit. This presented a risk that a mobile person with a cognitive impairment may ingest these chemicals causing harm. Staff told us they had had control of substances hazardous to health (COSHH) training as part of health and safety training.

Norman Power Intermediate Care Unit

The unit had an emergency oxygen kit and a defibrillator but if a patient was having a heart attack, then the unit would call the emergency services. Staff had been trained to provide cardio pulmonary resuscitation. Mobility equipment had been labelled with colour coded tags to indicate a patient's level of dependency and what type of support they needed when mobilising.

Perry Tree Intermediate Care Unit

The unit had general health and safety risk management procedures in place but these did not reflect the risk of patients living with a dementia in the ward.

Anne Marie Howes Intermediate Care Unit

The unit had general health and safety risk management procedures in place but these did not reflect the risk of patients living with a dementia in the ward.

Good Hope Hospital Community Unit 27

The unit had general health and safety risk management procedures in place.

Heartlands Hospital Community Unit 29

The lack of comprehensive therapy assessments meant that people may not have been provided with sufficient support to promote recovery and safety during admission.

Moseley Hall Hospital

The unit had general health and safety risk management procedures in place.

West Heath Hospital

The unit had general health and safety risk management procedures in place.

Assessing and responding to patient risk

In accordance with the trust's deteriorating patient policy staff used an early warning system, the Modified Early Warning Score (MEWS), to record routine physiological observations such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. This was used as part of a "track-and-trigger" system whereby an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient's observations up to urgent review by a senior nurse or the doctor.

We looked at the nursing notes for 12 patients, in five of these we found a number of examples where trust policy had not been followed; patient observations were such that a specific response had been required and observations had not been repeated in accordance with the policy.

The rates for falls for the 12 months preceding our inspection were below the England average. Within inpatient services the ward sisters we spoke with were proactive in the management of falls. We were told of examples where ward sisters had looked at any themes from patient falls, such as a number of falls occurring in a particular area of the ward. However generally across all inpatient areas, there was not a proactive consideration of using assistive technology, such as movement sensors, that may have helped reduced the risk for some patients.

Good

Are Community health inpatient services safe?

Norman Power Intermediate Care Unit
There were examples where the MEWS observations had been completed daily as required, but the overall score had not been recorded, with the risk that those instances where a higher score requiring a review by a nurse or doctor had not been identified. There were also two instances were patients' MEWS score had not been completed and also for two patients, they had had an elevated MEWS score but it had not been escalated

Perry Tree Intermediate Care Unit
We found risk assessments regarding main areas of patient risk had been completed but care plans were not holistic. The trust did not have dementia care pathways and staff at this unit had now developed their own care plans for managing difficult behaviours with escalation guidance for staff. There were two instances were patients' MEWS score had not been completed and also for two patients, they had had an elevated MEWS score but it had not been escalated for GP review. We found two other instances were GPs had reviewed a patient following escalation due to high MEWS score, but that the GP record had not been signed or dated.

Anne Marie Howes Intermediate Care Unit
Risk assessments regarding main areas of patient risk had been completed but care plans were not holistic. We found two instances where a patient had had an elevated MEWS score, yet there was no record of any escalation so the patients could have seen a GP.

Good Hope Hospital Community Unit 27
Medical support for patients in the enhanced assessment ward was good. The ward was located within an acute hospital site and this meant that medical staff were available through the 24 hour period to support in case of emergency or deterioration of condition. Some patients who had been assessed as at risk of falls had not been considered for assistive technology for example to warn staff that the patient was moving away from the bed.

Heartlands Hospital Community Unit 29
Medical support for patients in the enhanced assessment ward was good. The ward was located within an acute hospital site and this meant that medical staff were available through the 24 hour period to support in case of emergency or deterioration of condition. Staff told us that the consultant staff and their teams attended when required. However, we found for one patient that the risks for their activity had not been adequately assessed to protect their well-being or safety of other people in the ward area as they were leaving the ward late at night, and bringing visitors in during the night for social engagement. We brought this issue to the attention of senior staff on the ward who agreed to address this concern. Three patients had a risk assessment of their susceptibility to pressure sores and had been assessed as needing a special mattress or cushion but none of this equipment had been provided for use by those patients.

Moseley Hall Hospital
At this hospital, the MEWS was used and responded to if condition changes. We witnessed an emergency alarm for a patient and the staff response was swift and appropriate. This area had consultant cover out of hours. Staff aware of their roles and responsibilities in a medical emergency. Risks had been assessed and plans were in place to manage those risks.

West Heath Hospital
Wards had a scoring system for staff to monitor changes of patient's condition. When staff made checks such as on blood pressure and temperature they also collated the information to make a score which if raised could indicate a deteriorating condition; however when one patient's condition had changed no action had been recorded. The patient's warning score was raised due to a low temperature and their breathing rate, but no nursing shift records had been made for that day, and the patient's observations were not repeated until the next day. This meant that the patient could have deteriorated without staff recognising the change quickly enough.

In the notes we reviewed we saw that although some risk assessments had been completed correctly, staff had not responded to changes in patient's conditions and the monitoring of patients with diabetes was inconsistently applied. We were told a protocol for patients with diabetes had recently been removed and that staff were not clear about how to monitor patients with diabetes. There was a risk that if a patient's condition deteriorated this would not be identified or acted upon in a timely manner.

Staffing levels and caseload
The majority of inpatient services had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. Staff rotas demonstrated that where there was reduced staffing levels, plans were in place to address the risk to care delivery. All areas were reporting planned and actual staffing levels using the trust's safe staffing

protocols and the daily shift cover of nurses and health care assistants was on display in each area we visited. However, not all areas were using a patient dependency tool to link the dependency of the patient population to the staffing rota. The service was measuring actual staffing levels against planned staffing levels and, for example, in May 2014, the wards at West Heath Hospital and Moseley Hall Hospital showed a combined total of 67% shifts were staffed according to the planned staff levels; 21% of shifts were 1 staff member short and 12 % of shifts were 2 or more staff members short of the planned staff levels.

Staffing levels on the intermediate care units in the afternoons and evenings were being reviewed. There had been some increases in staffing levels on various shifts. There was no consultant medical cover arrangements in some intermediate care units and staff were reliant on the on call system for doctors during the evenings and weekends. There were no therapy staff working at the weekends. Some staff on the intermediate care units told us of staffing level concerns at the weekends, when there was no catering staff available to prepare breakfasts and also when staff went out to accompany patients for hospital appointments. Staff told us the units could be short staffed at these times. Overall, we observed call bells to be answered quickly. Some ward managers told us that call bell audits were carried out to check the response times to a call bell being activated, but these checks were not consistently recorded.

For the community units, the level of nursing staff in the assessment wards had increased following a review into safe staffing levels. There were planned levels of qualified nursing staff and health care assistants for each shift and reflected the number of beds occupied by patients and the level of need of patients on the ward. Staff told us that the recent changes meant a safer level of staffing on day and night shifts.

For Moseley Hall Hospital, a recent patient acuity review meant they needed more staff but senior staff were not clear about the impact this would have on the wards staffing levels. Staff told us that if agency nurses were used senior nurses assess the skill mix of staff to ensure ward was safe and appropriately staffed.

Norman Power Intermediate Care Unit

A local GP would visit daily for up to two hours during the week to provide medical cover. Physician cover during evenings and weekends was not from dedicated doctors but by accessing an on call rota from local GP practices. The unit did not have any consultant cover available. Senior staff said the provision of medical cover for all the intermediate care units was being reviewed by the trust but were not able to tell us the timescale for this review. In the mornings, the unit had four qualified nurses and eight health care assistants, with three nurses and six health care assistants in the afternoons and evenings. Night cover was three qualified nurses and two health care assistants. At night the qualified nurse to patient ratio was 1:11, which some staff said was not sufficient to meet patient's needs. Staffing in the unit had been increased in the afternoons recently from two nurses to three and senior staff were considering having four qualified nurses. The unit had two occupational therapists and two physiotherapists and one therapy assistant practitioner working during the week. Additionally, there was a senior occupational therapist and physiotherapist that worked across all three intermediate care units. There was no therapist cover available at the weekends. Therapists said there were enough therapists on duty during the week to meet patients' needs. Two social workers from the local authority were also based at the unit. The unit did not have its own porters.

The unit was not using a patient dependency or acuity assessment tool to inform staffing rotas. Senior staff said the staff skill mix was right for the unit and that nurses did consider the overall dependency of the patient group when looking at staff rotas. Not all patients said there was enough staff. One told us "There are not enough nurses. They have so much to do. They are rushed off their feet". Another told us "Staff come quick when I press my bell." We saw that call bells were responded to quickly during our visit.

Perry Tree Intermediate Care Unit

This unit had consultant cover provided from Good Hope Hospital and a consultant would visit up to three times a week; however staff told us that there had not been a consultant visit for four weeks. Two GP surgeries also provided cover with visits twice a week. At evenings and weekends, physician cover was provided by the on call GP service. In the mornings, the unit had four qualified nurses and eight multi skilled assistants, with three nurses and six multi skilled assistants in the afternoons and evenings. Night cover was three qualified nurses and two multi skilled assistants. The unit also had a housekeeper on duty during the week and at alternate weekends. The unit did not have any nursing vacancies and only two vacancies for

multi skilled assistants, which were being recruited to. The patient to qualified nurse ratio was 1:16 in the afternoons and evenings as the unit had 3 nurses on duty, but one would act as the shift leader and floater, whilst the other two nurses would support up to 16 patients each. The unit had used a patient dependency assessment tool and this was linked to the staffing rota, but the main factor impacting on staffing levels was the occupancy of the unit, staff told us. Staff were able to tell us about the escalation procedure if there were staffing level concerns.

Anne Marie Howes Intermediate Care Unit
This unit had consultant cover provided from another trust and a consultant would visit up to three times a week. The unit had systems in place to ensure minimum staffing levels were maintained and staff knew the escalation procedure of they were short staffed on a shift. Staff said there was some flexibility across the three intermediate care units so that staff could work in another unit if there was an urgent situation. Patients said staffing levels had improved but that sometimes staff were busy so at times had to wait for their call bells to be answered.

Good Hope Hospital Community Unit 27
The level of nursing staff in the assessment wards had increased following a review into safe staffing levels. There were stated expected levels of qualified nursing staff and health care assistants. This was also dependent on the number of beds occupied by patients and the level of need of patients on the ward. Staff told us that the recent changes meant a safer level of staffing on day and night shifts.

Heartlands Hospital Community Unit 29
The level of nursing staff in the assessment wards had increased following a review into safe staffing levels. There were stated expected levels of qualified nursing staff and health care assistants. This was also dependent on the number of beds occupied by patients and the level of need of patients on the ward. Staff told us that the recent changes meant a safer level of staffing on day and night shifts.

Moseley Hall Hospital
For Moseley Hall Hospital, a recent patient acuity review meant they needed more staff but senior staff were not clear about the impact this would have on the wards staffing levels. Staff told us that if agency nurses are used senior nurses assess the skill mix of staff to ensure ward was safe and appropriately staffed.

West Heath Hospital
At West Heath Hospital, staff told us that they were seeing patients with higher dependencies being admitted but there had been recent changes to staffing, with more staff available. Safer staffing levels were on display in the wards. Staff told us that the junior doctor cover and rota worked well and out of hours cover was provided by an on-call consultant. Junior doctors covered both West Heath and Moseley Hall Hospitals at night but doctors did not feel that there was a concern about night time cover, and they had good support from the on-call consultant. There was good support from the night staff in charge of the wards and in the event of an emergency, ward staff prioritised effectively and called emergency services on 999 as required. Safer staffing levels had been introduced which meant that staffing levels were assessed by the needs of the patient.

Deprivation of Liberty safeguards

Staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. Therapists told us that a patient's verbal consent was always obtained before carrying out treatment plans but we found that these discussions were not recorded in the patient's care and treatment plans apart from "consent obtained". We did not see robust evidence of meaningful mental capacity assessments being carried out and recorded on the trust's own capacity assessment documentation in most areas.

Norman Power Intermediate Care Unit
Senior staff had had DoLs awareness training and were aware of the implications of the legislation. Some junior staff were able to tell us about the mental capacity act, but not all staff had had specific training in this area.

Perry Tree Intermediate Care Unit
The unit did not have any patients requiring a DoLs application but staff were aware of the trust's procedures for DoLs. The consultant providing cover at the unit would complete mental capacity assessments as required.

Anne Marie Howes Intermediate Care Unit
Senior staff had had DoLs awareness training and were aware of the implications of the legislation. Some junior staff were able to tell us about the mental capacity act, but not all staff had had specific training in this area.

Good

Are Community health inpatient services safe?

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29
Staff were aware of their responsibilities and knew about the trust's procedures for assessing capacity and whether a DoLs concern needed to be assessed.

Moseley Hall Hospital
On ward 9, we found that two Deprivation of Liberty safeguards (DoLs) applications had been completed correctly. Staff were aware of DoLs procedures and had had MCA and safeguarding training. Staff said the trust's board were supportive regarding safeguarding concerns.

On ward 5, we looked at three patient records for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions and found two had the appropriate documentation to support this decision. However, for one patient who lacked capacity, there was no evidence of a discussion with their family regarding the DNACPR decision.

West Heath Hospital
Staff were aware of DoLs procedures and had had MCA and safeguarding training.

Managing anticipated risks

The board's assurance framework enabled the trust to have an overview of risks which may affect the safe running of inpatient services. All staff were aware of the electronic reporting system and some staff were able to see where actions had been put in place to prevent a reoccurrence of incidents. Individual areas did not maintain their own risk register we were told, but significant risks would be escalated via their line managers to be included on the corporate risk register. The lack of person centred care planning for people with cognitive impairment or dementia was identified on the trusts board assurance framework as a quality priority for 2014-2015. The intermediate care units had defibrillators for staff to use but in the event of patients needing cardio pulmonary resuscitation, then staff would call the emergency paramedic service.

Norman Power Intermediate Care Unit
The unit had daily handover arrangements in place so that any new concerns or potential risks were discussed and actions in place to address them.

Perry Tree Intermediate Care Unit
The unit had daily handover arrangements in place so that any new concerns or potential risks were discussed and actions in place to address them.

Anne Marie Howes Intermediate Care Unit
The unit had daily handover arrangements in place so that any new concerns or potential risks were discussed and actions in place to address them.

Good Hope Hospital Community Unit 27
Planning for discharge and monitoring of progress was undertaken at daily handover and multidisciplinary team meetings to ensure each team member were aware of their duties towards discharge and patient risks. The trust was implementing a new system using computers to keep track of these decisions and prompt daily discussion and record of progress. Staff completed intentional rounding checks which meant that patients were checked and positions changed to prevent pressure sores and ensure they were not in pain.

Heartlands Hospital Community Unit 29
Planning for discharge and monitoring of progress was undertaken at daily handover and multidisciplinary team meetings to ensure each team member were aware of their duties towards discharge and patient risks. Staff completed intentional rounding checks which meant that patients were checked and positions changed to prevent pressure sores and ensure they were not in pain.

Moseley Hall Hospital
The unit had daily handover arrangements in place so that any new concerns or potential risks were discussed and actions in place to address them.

West Heath Hospital
The unit had daily handover arrangements in place so that any new concerns or potential risks were discussed and actions in place to address them.

Major incident awareness and training

The trust had plans in place to manage and mitigate anticipated safety risks, including changes in demand, disruptions to staffing or facilities, or periodic incidents such as bad weather or illness. The trust had appropriate plans in place to respond to emergencies and major incidents. Plans were practiced and reviewed on a regular basis. However, staff at all levels were not fully aware of these plans.

All the ward sisters we spoke with were aware of the trust's major incident plan and business continuity plans to ensure minimal disruption to essential services. The major incident plan was available on the trust's intranet and accessible for all staff. Staff we spoke with were aware of

Good

Are Community health inpatient services safe?

the trust's fire safety policy and their individual responsibilities. Ward sisters told us of fire drill discussions with staff on an ad hoc basis. Fire training amongst staff within inpatient services was 79%, below the trust target of 85%, however health and safety training for staff was above the trust target at 89%. Some areas had site specific training planned for fire safety and some senior staff had had major incident training. Not all junior staff were aware of major incident planning and protocols and had not had training on this area.

Norman Power Intermediate Care Unit
Senior staff were aware of the trust's serious incident policy but not all were able to tell us the contents of this policy.

Perry Tree Intermediate Care Unit
Staff were aware of fire safety protocols and had had mandatory fire safety training within the past year. The local fire officer also provided emergency evacuation training regularly. Staff told us they practised fire evacuations with patients' being supported to exit the unit to test the effectiveness of the fire drill procedures.

Anne Marie Howes Intermediate Care Unit
Senior staff were aware of the trust incident policy and said other staff were aware of how to access it.

Good Hope Hospital Community Unit 27
Senior staff were aware of the trust incident policy and said other staff were aware of how to access it.

Heartlands Hospital Community Unit 29
Senior staff were aware of the trust incident policy and said other staff were aware of how to access it.

Moseley Hall Hospital
There was site specific training planned for fire safety. Senior staff had had major incident training. Senior staff were unsure whether all staff had received major incident training. The lack of training may impact on staff being able to respond appropriately should a major incident occur.

West Heath Hospital
Senior staff had previously had major incident training and were aware of the trust policy.

Requires Improvement

Are Community health inpatient services effective?

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

Summary

There was variation in the use of evidence based practice, and effective assessment and deliver of care across a number of wards and hospitals.

Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measurement of patient outcomes, and one ward was involved in a national study to measure effectiveness of care and patient outcomes.

Staff uptake of mandatory training was below the trust's target. We found that most staff had received little or no training in stroke care and national guidance in stroke rehabilitation was not always followed. The majority of staff received supervision but this was not the case for all staff. Multidisciplinary team working was good.

Evidence based care and treatment

There was not systematic use of relevant legislation, current and new best practice and evidence based guidelines and standards throughout each service.

Assessments and care plans for patients were not always comprehensive and did not cover all health (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Not all care plans were regularly reviewed and updated. People's care and treatment was not always being planned and delivered in line with evidence based guidelines. Care plans were not consistently personalised or holistic to enable people to maximise their health and well-being. Not all patients were able to describe what their care was and how it was being delivered to meet their needs.

The intermediate care units did not have clearly defined care pathways, other than to support people to return home or to improve their mobility. Therapy assessments were not comprehensive enough to enable staff to share judgements about patient's mobility and ability and for plans of rehabilitation to be developed.

Apart from Moseley Hall Hospital, patients that had had a stroke had not received treatment as per the National Institute for Health and Care Excellence (NICE) guidelines for stroke rehabilitation. Ward sisters told us some patients were admitted following a stroke. During our inspection we did not identify where additional or specialist therapy sessions were in use for stroke patients. Not all areas were recording the daily level of therapy interventions with patients so it was not possible to measure whether therapy treatment plans were being followed or not, and we were unable to determine if each intervention was at a level recommended for stroke patients. We were told that the rehabilitation measures used across inpatient services were not specific to stroke patients. Regular multidisciplinary team meetings occurred daily in some area and individual goals for patients were set. However, none of the staff we spoke with could tell us if stroke patients were receiving the recommended level of therapy or treatment and most of the staff we spoke with had received little or no training in caring for this group of patients.

Recognised rehabilitation measures were not being used by the physiotherapists, such as the 10 Meter Walking Test and the Timed Up and Go test to assess the patient's mobility and, the Tinetti Performance Oriented Mobility Assessment designed to measure balance (including fall risk) and gait function. Nursing care records demonstrated where staff had included an assessment of the risks presented by the patient's conditions by using recognised risk assessment tools. For example the risk of developing pressure damage was assessed using the Waterlow scale, a nationally recognised practice tool. Where pressure damage was identified as a risk there was a management plan in place for prevention. Where patients had been admitted with pressure damage there were wound assessment notes and body maps to monitor progression of healing. Care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment. We found that risk assessments in patient notes had inaccuracies which meant to care not being provided according to expected standards

Norman Power Intermediate Care Unit

Following a patient's admission, the unit would carry out a joint therapy assessment with an occupational therapist and physiotherapist and a therapy plan would be discussed with the patient. Each person's room had a white

board that showed the basic therapy plan for staff and visitors, and included a patient's mobility and nutritional needs. The unit was not using clear outcome measures and did not have clear care pathways in place for staff to follow. Staff said they used to use the Barthel scoring index to assess patient's overall dependency and to monitor progress but were not now using this assessment tool. There was a lack of clearly defined care pathways for staff to follow. Therapists said they used the Elderly Mobility Score on assessment and reviewed again two weeks later. Other assessment tools were available but not used.

The therapy plans we reviewed were not detailed and only gave broad care plan goals for staff to follow. For example, one said "increase range of movement in shoulder joint" but did not give clear guidance or recommend therapy techniques for all staff to follow to meet this outcome. One patients care plan did not include any guidance for staff as how to support the person with their personal care needs, yet they were not self-caring. A recent fall had not been referred to on the therapy evaluation sheets or the patient's moving and handling plan.

Patients that had had a stroke had not received treatment as per the National Institute for Health and Care Excellence (NICE) guidelines for stroke rehabilitation. Ward sisters told us some patients were admitted following a stroke. Support could be provided by the community stroke team nurses, but these were employed by a different Trust.

Perry Tree Intermediate Care Unit

Therapists assessed new patients within 24 hours and set goals, for example for mobility, with the aim of promoting patient's independence to be able to return home within a four week timescale. Nursing staff said therapists set goals for care pathways based on the rehabilitation needs of patients but were not able to tell us how these linked to national guidance. Patients did not sign these therapy goal plans.

At this unit, records for one patient, who staff told us had displayed aggressive behaviours, did not contain an effective care plan in place for this behaviour and staff did not have clear guidance as to how to keep the person safe, and to minimise the risk of disturbance to other patients. The ward had not effectively followed up a referral to the mental health team for a reassessment for over two months. Six out of eight aggressive incidents had not been reported using the trust's online reporting system so that senior staff were not fully aware of the risks that this person presented to themselves or others. There were three separate manual handling care plans on this file giving conflicting guidance to staff. The patient also had had a significant history of falls, which had been documented, but the falls risk assessment had not been reviewed after each fall, as was trust procedure. The ward took immediate action on the day of inspection to address these issues and also were now planning to incorporate the NICE guidelines for dementia care into their care planning process.

Anne Marie Howes Intermediate Care Unit

Therapists assessed new patients within 24 hours and set goals, for example for mobility, with the aim of promoting patient's independence to be able to return home within a four week timescale. Therapy plans were not detailed and gave patient goals but not always clear guidance for staff how to achieve the goal, for example, one said "improve mobility". Patients that had had a stroke had not received treatment as per the National Institute for Health and Care Excellence (NICE) guidelines for stroke rehabilitation.

Good Hope Hospital Community Unit 27

Assessments made by therapy staff were not always taken into account by nursing staff. We saw in one patient's notes that the risk of damage to skin and mobility arrangements suggested by therapy staff were not then transferred into the nursing care plan. This meant that teams had not always effectively shared useful information about patients. We found that records of the assessment of rehabilitation needs were not always completed accurately or fully.

Heartlands Hospital Community Unit 29

Staff mostly recorded details of assessments and of care accurately. There were completed notes about the regular, sometimes two hourly, checks on patient's condition and care needs. We saw good records of dietary intake, weekly recalculation of falls or skin integrity risk, and daily shift records including support to maintain personal hygiene. We found that some parts of the records of assessment on admission were not completed. Records of patient's mental acuity score, and assessments of depression or mood on admission, were not documented in many of the patient records we examined. We found that some therapy assessments had not been completed in sufficient detail to plan rehabilitation and monitor progress. Therapy assessments were not comprehensive enough to enable staff to share clear judgements about patient's mobility

Requires Improvement

Are Community health inpatient services effective?

and ability, and for plans of rehabilitation to be developed. The progress of each patient's ability could not be effectively monitored due to incomplete assessment of therapy needs. Three patients had a risk assessment of their susceptibility to pressure sores and had been assessed as needing a special mattress or chair cushion but none of this equipment had been provided for use by those patients.

Moseley Hall Hospital

At Moseley Hall Hospital, we found that NICE guidance was used to inform evidenced based practice. The standards for stroke treatment and care had 80% compliance. A programme for upper limb recovery was being used by teams. Senior staff told us that there was a "lot of information on the intranet about NICE" but not all were able to tell us about which specific areas had been followed. We found that MUST scores had been completed regularly and referrals to dietician made when required. However, fluid intake charts had been completed inconsistently. In ward 9, we found that patients received care based on current best practice and evidence based guidelines.

West Heath Hospital

At West Heath Hospital, we found that risk assessments in patient notes had inaccuracies which meant that care was not being provided according to expected standards. In one case we found risk assessments for skin integrity had been completed incorrectly as the patient's medical conditions were not fully included in the scoring. The assessment was then not rechecked for ten days. It was then also incorrectly completed as the patient's poor circulation in the legs was not considered. Preventive measures such as protection for the patient's heels had not been implemented despite the identified risk. The patient in this case had not developed pressure ulcers. Care plans were in place and were current and reviewed and changed regularly to meet patient's changing needs. Patients had been referred to dietician when required and were weighed daily or weekly depending on need.

We saw inconsistency in recording in the notes we reviewed. We saw some evidence that DNACPR forms had been completed correctly and evidence of discussion with people close to the patient. However we saw three records that did not contain evidence of discussion with family members for patients that did not have capacity. This meant people close to the patient may not be aware of decisions made about their care.

For one patient living with dementia, we found their care plan was not person centred and had no information as to how staff could support them with episodes of confusion. The care plan had been reviewed monthly but the review remained the same each month. A senior nurse stated "I don't like these care plans" and agreed the monthly review did not acknowledge any changes of care to meet person's needs.

Pain relief

Patients indicated that they received pain relief medication when they required it. Some wards used an assessment tool to determine if people were in pain. For people who were not able to communicate staff told us the assessment of pain depended on the experience of nurse. At Moseley Hall Hospital, we found that patients' pain levels were assessed appropriately.

Norman Power Intermediate Care Unit

Staff monitored the condition of all patients throughout the day and night and nurses were able to offer pain relief if requested if the patient had been prescribed appropriate pain relief by the GP.

Perry Tree Intermediate Care Unit

Staff monitored the condition of all patients throughout the day and night and nurses were able to offer pain relief if requested if the patient had been prescribed appropriate pain relief by the GP.

Anne Marie Howes Intermediate Care Unit

Staff monitored the condition of all patients throughout the day and night and nurses were able to offer pain relief if requested if the patient had been prescribed appropriate pain relief by the GP.

Good Hope Hospital Community Unit 27

Consultant staff reviewed patients' progress, including medication, weekly as needed. Medical staff were available in the ward area regularly. Each day a GP visited and supported nursing staff for example by prescribing or reviewing any medication such as pain control.

Requires Improvement

Are Community health inpatient services effective?

Heartlands Hospital Community Unit 29
One patient had been prescribed medication for nausea on the day prior to our inspection visit. The medication had not been ordered from pharmacy until the time of our visit, and so the patient had waited 24 hours from the time the doctor had decided the drug would be beneficial.

Moseley Hall Hospital
Staff assessed the patients' pain levels appropriately and used a 'tick list' to assess if someone who could not communicate displayed behaviour that may have meant they are in pain. One patient told us "I get pain relief when I need it; they answer my bell very quickly".

West Heath Hospital
In ward 12, there was no clear assessment tool for recording of pain. Patients reported they receive pain relief if required. There was no clear guidance for assessing pain for a patient with communication difficulties. This meant patients who had difficulty with communication may not get appropriate pain relief. Patients told us: "If I want painkillers I always get them" and "They (the nurses) always ask me what I would like to do"

Nutrition and hydration

Across all of inpatient services we saw patients were screened for malnutrition and the risk of malnutrition on admission to hospital using a recognised assessment tool. Generally, care plans were in place to minimise risks from poor dietary intake as appropriate. We saw evidence that most care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment. Most areas had protected meal times and patients generally had a choice where to eat their meals. Some wards used volunteers to support some patients with eating their meals. With the exception of Moseley Hall and West Health Hospitals dieticians provided support mainly through telephone or other remote communication. Staff completed nutrition assessments and they told us that dietetic support on the wards could be arranged if required.

In one of the community units, risk assessments in patient notes were mostly completed but there were some omissions and inaccuracies which had not been noted or corrected by subsequent records by nursing staff. We found one patient had the wrong height recorded which meant that the risk assessment for nutrition indicated the need for increased calorific intake and was having food supplements. The inaccuracy was not noted for a number of weeks until a dietician checked the records.

Norman Power Intermediate Care Unit
We saw that for two patients, their food and fluid intake charts had not always been completed accurately and that their care plans had not been updated weekly as was trust procedure. Staff told us that sometimes they did not get what patients had ordered from the kitchen so had to make requests again.

Perry Tree Intermediate Care Unit
We found that food and fluid intake charts were completed accurately. Most patients' said they liked the food and usually had a choice.

Anne Marie Howes Intermediate Care Unit
Five patients told us the food was good and they usually had a choice. Staff told us sometimes they did not get what patients had ordered from the kitchen so had to make requests again.

Good Hope Hospital Community Unit 27
The unit had protocols in place to ensure that patients' were assessed for the risk of malnutrition and dehydration.

Heartlands Hospital Community Unit 29
In this unit, risk assessments in patient notes were mostly completed but there were some omissions and inaccuracies which had not been noted or corrected by subsequent records by nursing staff. We found one patient had the wrong height recorded which meant that the risk assessment for nutrition indicated the need for increased calorific intake and was having food supplements. The inaccuracy was not noted for a number of weeks until a dietician checked the records. A correct record would have meant the patient did not need additional nutritional intake. In this case due to the patient's reluctance to eat there was minimal impact due to this error in the assessment and recording. Dieticians provided support mainly through telephone discussions and we saw that staff completed nutrition assessments and they told us that dietetic support on the ward could be arranged if required.

Moseley Hall Hospital
Patients encouraged to eat together in the dining room, mealtimes are protected (with no visitors allowed). Recently the ward had started to have volunteers who come in to assist patients with their meals.

Patients were sensitively supported to eat and drink if required.

Requires Improvement

Are Community health inpatient services effective?

West Heath Hospital
The unit had protocols in place to ensure that patients' were assessed for the risk of malnutrition and dehydration.

Patient outcomes

Patients' performance in activities of daily living was not being measured consistently across the service so there was not a reliable measure of the patient's ability to perform daily self-care activities. Some patients were involved in reviewing their progress throughout their inpatient stay. The trust was not using national tools, such as the EQ-5D tool, a standardised instrument for use as a measure of health outcomes, which meant patients were not rating their performance in activities of daily living at the beginning and end of their inpatient stay allowing staff to evaluate patient progress.

Some areas were using the Elderly Mobility Score to measure outcome of therapy intervention, but this did not give an overall measure of the effectiveness of the rehabilitation treatment and the patient's views during the process. Generally, only mobility goals were set in terms of rehabilitation pathways and treatment. Staff at the intermediate care units said staff said they used to use the Barthel scoring index to assess patient's overall dependency and to monitor progress but were not now using this assessment tool.

At Moseley Hall Hospital, one ward was taking part in data collection for the UK Specialist Rehabilitation Outcomes Collaborative (UKROC) database. In this ward patient outcomes were being compared nationally to comparable units around the country. Staff told us that ECI's were being used to compare services and there was benchmarking at meetings for clinical effectiveness.

Norman Power Intermediate Care Unit
The average length of stay for patients in this unit was 31 days. Staff told us this had reduced since the introduction of the Project Jonah MDT meetings. Therapists told us that new patients were to be assessed within 24 hours of admission during the week and within 48 hours of admission at the weekends and that this was being monitored. Therapists were using the Canadian Occupational Performance Measure (COPM) to measure the effectiveness of occupational therapy intervention, but this was stopped 6 months prior to the inspection and staff said no alternative tool was being used. Physiotherapists were using the Elderly Mobility Scale (EMS) tool. Senior staff told us there was no overall monitoring of patient outcomes and it was work in progress. Therapists said their activity with patients was not recorded so there was no overall measure of how much therapist time each patient had received.

Perry Tree Intermediate Care Unit
Since the introduction of the Project Jonah meetings, the average length of stay had reduced from six weeks to four weeks. Outcomes that the unit measured were for Harm Free Care, for example, the number days since the last pressure ulcer on the unit, which was 24 days on the day of our visit. The unit used a safety thermometer and also regular audits of records were carried out. Senior staff told us that the unit's compliance with audits had improved from 83% six months ago to currently 98% compliance. Senior staff said the EMS tool was used to measure outcomes of therapist interventions but outcome measures focused on the process rather than the outcome for patients.

Anne Marie Howes Intermediate Care Unit
The only outcome measure for patients' goals being used was the elderly disability index. This did not give a holistic overview of the outcome of the rehabilitation process for individual patients. The ward also used the ECIs and safety thermometer to report on harm Free Care for the ward.

Good Hope Hospital Community Unit 27
Assessments and continuing records of therapy support for patients was not comprehensive. There was no use of outcome measures recorded for therapy services. This meant that individual patient outcomes could not be accurately monitored, and there was minimal data by which to appraise the overall therapy service performance.

Heartlands Hospital Community Unit 29
Assessments and continuing records of therapy support for patients was not comprehensive. There was no use of outcome measures recorded for therapy services. This meant that individual patient outcomes could not be accurately monitored, and there was minimal data by which to appraise the overall therapy service performance.

Moseley Hall Hospital
Ward 9 was taking part in data collection for the UK ROC database so this ward was comparing its patient outcomes to comparable units around the country.

Requires Improvement

Are Community health inpatient services effective?

West Heath Hospital
Monthly meetings were held to assess if there were any emerging risks to patients and to ensure these identified risks were addressed.

Performance information

Complete, accurate and timely performance information, including outcomes for people using the service, was readily available and shared internally and externally. Most Staff understood the performance information they received.

Most wards we visited had a performance information dashboard on display in the clinical area. We saw evidence where this was updated on a regular basis. Ward sisters told us they shared performance information at monthly operational team meetings and relevant governance meetings. Not all staff were able to tell us what these measures were and how learning from these measures was shared across teams.

Staff told us the trust measured harm free care for patients using a series of measures, the ECIs. Some of the outcome measures used were a monthly documentation audit, call bell audit, infection prevention and control audits and the ECIs. In May 2014, the inpatients' service recorded harm free care of 93.69%, against a trust wide total of 96.60% and the INRU ward showed a harm free care total of 100% for this month. The trust target for harm free care in all services was 95%. Ward sisters were not always able to tell us how they monitored clinical outcomes for patients. The intermediate care units did measure the average length of stay for patients and patient satisfaction with the service provided.

The essential care indicators were based on an audit of at least 10 patient records and looked at falls assessments, patient observations, tissue viability and nutrition. Senior staff told us the ECIs were not comprehensive and did not assess holistically the quality of nursing assessments. For the community units, there were no outcome measures recorded for therapy services apart from average length of stay.

Norman Power Intermediate Care Unit
The unit had displayed a range of indicators such as numbers of falls and infection rates. Some of the data was detailed and managers told us the information had been used to discuss performance with staff and improve their service. Performance information had been discussed at team meetings.

Perry Tree Intermediate Care Unit
The unit had displayed a range of indicators such as numbers of falls and infection rates. Some of the data was detailed and managers told us the information had been used to discuss performance with staff and improve their service. Performance information had been discussed at team meetings.

Anne Marie Howes Intermediate Care Unit
The unit had displayed a range of indicators such as numbers of falls and infection rates. Some of the data was detailed and managers told us the information had been used to discuss performance with staff and improve their service. Performance information had been discussed at team meetings.

Good Hope Hospital Community Unit 27
Collated information about falls or other incidents had been discussed by the team and learning from other departments was shared following clinical team leaders reviews.

Heartlands Hospital Community Unit 29
The unit had displayed a range of indicators such as numbers of falls and infection rates. Some of the data was detailed and managers told us the information had been used to discuss performance with staff and improve their service. Performance information had been discussed at team meetings.

Moseley Hall Hospital
Monthly performance information was displayed for staff, patients and visitors. Where performance fell below the Trust's targets, this was discussed in staff meetings and plans put in place to address the shortfall.

West Heath Hospital
Monthly performance information was displayed for staff, patients and visitors. Where performance fell below the Trust's targets, this was discussed in staff meetings and plans put in place to address the shortfall.

Competent staff

There were effective induction programmes, not just focused on mandatory training, for all staff, including students, trainees and agency staff. The learning needs of

Requires Improvement

Are Community health inpatient services effective?

staff were identified but training was not always put in place to have a positive impact on patient outcomes. There were limited opportunities for professional development. The trust did not have clear mechanisms in place to ensure appropriate levels of supervision and appraisal of all staff.

On the intermediate care units, staff told us that mandatory training met their needs. However, some staff said that there was no specialist training in stroke care, learning disability and dementia care available. Not all areas had consistent systems in place for regular staff supervision. Some senior staff told us they did not receive regular supervision and had to request it. Junior staff said there were inconsistent supervision arrangements and not all staff had been supervised regularly. Staff did not always get a copy of the supervision notes. The majority of staff said informal support from their managers was effective and provided when they needed it. Some staff said they had had annual appraisals with a discussion about their learning and development needs, whilst others said they had one booked for the near future. Overall for the inpatients' service, 72% of staff had completed the trusts' mandatory training in April 2014, against the trust target of 85%. The trust had recognised this area as needing action and wards had action plans in place to address this issue.

At West Heath Hospital, staff told us senior staff were very supportive, listened to concerns and used constructive criticism to feedback. Senior staff told us that all staff had had an appraisal completed, and had had mandatory training. We checked four staff records and found that appraisals had been recorded and learning and development needs of staff had been identified and a development plan had been put in place. Following a skill mix review of staffing levels, senior staff said that changes in staff numbers had had positive benefit. We saw number of staff on duty displayed on notice boards in the wards. We found that performance concerns on one ward had been addressed recently by the trust and plans were in place to address the issues regarding staffing and culture.

In the community units, staff told us they had attended training about dementia which was relevant to the needs of patients in the ward. There were good arrangements to ensure new staff were inducted to the ward, including specific arrangements for temporary or bank staff. We saw examples of induction checklists having been completed for two staff.

At Moseley Hall Hospital, senior staff told us staff appraisals were being completed and that staff had clinical supervision on a 1-1 basis or in a group. Practice reflection sessions were held with clinical psychologists. Staff were encouraged to access to further training if required. Staff stated they were encouraged to raise concerns and that the ward had a very open culture.

The majority of staff had received an appraisal. For example on one ward at Moseley Hall Hospital we noted that 70% of staff had had an appraisal in the past year and staff had regular supervision with their line managers. Staff told us that said some training kept getting cancelled, for example, training for intravenous competencies.

Norman Power Intermediate Care Unit

There were inconsistent supervision arrangements so supervision was not held regularly. Staff said they did not always get a copy of the supervision notes. The majority of staff said informal support from managers was effective and provided when they needed it. Some staff had had annual appraisals with discussions about their learning and development needs, whilst others had one booked for the near future. One staff member said they had never had formal supervision, but did have an appraisal booked. Staff said induction process met their needs and were comprehensive. Senior staff did not receive regular clinical supervision. There was no specialist training for staff in caring for people that had had a stroke available.

Perry Tree Intermediate Care Unit

New nurses had one week supernumerary as part of their induction programme. Staff confirmed this when we spoke to them and said their induction had been comprehensive. Staff had access to dementia training and some staff in the team also had had training to be a dignity champion. Senior staff had had conflict resolution training but this was not generally accessible to junior staff. Some staff said more in depth dementia training was needed across the trust. Specialist stroke training or training to care for people with a learning disability was not provided by the trust. Supervision arrangements were variable and the unit was in the process of looking to introduce clinical supervision sessions for staff. There was no training provided for the completion of care plans. One staff told us that whilst they had had mental capacity act training, they did not feel confident to complete a mental capacity act assessment for patients. Junior staff told us they received a verbal and written handover about patients' needs for every shift.

Requires Improvement

Are Community health inpatient services effective?

Anne Marie Howes Intermediate Care Unit
Staff told us they had very good informal support from managers but that regular formal one to ones did not routinely occur.

Good Hope Hospital Community Unit 27
There were good arrangements to ensure new staff were inducted to the ward, this included specific arrangements for temporary or bank staff.

Heartlands Hospital Community Unit 29
Staff had attended training about dementia which was relevant to the needs of patients in the ward. There were good arrangements to ensure new staff were inducted to the ward, this included specific arrangements for temporary or bank staff.

Moseley Hall Hospital
Staff had had an appraisal completed, and had completed annual mandatory training. Patients were cared for by staff that were suitably trained and supported. For ward 9, the appraisals were being competed and clinical supervision was available on a 1-1 basis or in a group. Practice reflection sessions had been held with a clinical psychologist.

West Heath Hospital
Concerns had previously been raised about one of the wards. Systems were in place to closely monitor the ward to ensure staff were supported. Staff across the hospital stated they felt well supported by the matron.

Use of equipment and facilities

The resuscitation equipment we inspected was clean. Single-use items were sealed and in date, and emergency equipment had been serviced; equipment had been checked daily by staff. Throughout inpatient services we observed the staff and the environment to be delivering same sex accommodation in order to safeguard patient's privacy and dignity and, comply with the Government's requirement to eliminate mixed-sex accommodation. Sufficient pressure relieving equipment was available.

On some wards, there was limited space for rehabilitation activity; patients had therapy interventions at their bedside. There was limited space or rooms available for patients to discuss personal issues with therapists or other professionals. We found storage space to be limited in some wards, with wheelchairs and hoists stored in communal bathrooms and corridors.

Norman Power Intermediate Care Unit
There was no pharmacy on site, nor was there any porter's service. At this intermediate care unit, the environment was not suitable for wheelchair for bariatric patients unless they could walk through the doorways to the side rooms.

Perry Tree Intermediate Care Unit
The equipment and facilities were designed to meet the needs of the patients.

Anne Marie Howes Intermediate Care Unit
The equipment and facilities were designed to meet the needs of the patients.

Good Hope Hospital Community Unit 27
Most patients were having some therapy support during their admission in preparation for going home. The unit was based in a ward area with some side rooms. There was minimal space or access to a dedicated therapy gymnasium for rehabilitation and therapy work with individual patients. Therapy sessions were generally completed at the bedside.

Heartlands Hospital Community Unit 29
By providing therapy sessions at patient's bedsides in the ward area meant a lack of privacy during therapy sessions and less than ideal facilities for therapists to provide support. Therapy staff told us there was a store of equipment to support discharge but this had been relocated three miles away. An ambulance arrangement was no longer available to support home visits for people in preparation for discharge. Whilst the changes did not prevent specific patient activity it meant more time was spent on non-direct patient activity by the therapy teams.

Moseley Hall Hospital
The equipment and facilities were designed to meet the needs of the patients.

West Heath Hospital
There was limited storage space on Ward 12 so wheelchairs and hoists were stored in communal bathrooms.

Multi-disciplinary working and working with others

A multi-disciplinary team (MDT) approach was evident across all of inpatient services. We observed good MDT working in the wards we inspected. We observed nursing staff assisting with patient therapy sessions through encouragement of mobilisation and self-care activities and therapy staff assisting in patient self-care activities. On one

ward we observed a physiotherapist assisting a patient to make themselves a hot drink. Staff at all levels on the wards demonstrated an understanding of each patient's pathway.

MDT case conferences took place on the wards on a regular basis to review the progress of each patient towards discharge. Across all of the wards within inpatient services communication between the MDT team was integral to the patient's pathway. Some wards had introduced daily Project Jonah meetings where nurses, therapists and, usually, social workers would discuss each patient's progress and determine action points to assist with effective discharge planning.

The intermediate care units received referrals mainly from acute hospitals, but also from community nursing teams and GP surgeries, in order to prevent admission to an acute hospital. Criteria for admission to the intermediate care service was used so that patients were medically stable and able to benefit from rehabilitation. Assessment of need, including patients' cognitive ability, were carried out by hospital staff and community based staff but at times, staff from the intermediate care unit would also carry out their own assessment to ensure patients would be suitable for the service. A liaison nurse oversaw all the intermediate care beds so that patient referrals could be matched to available beds.

At West Heath Hospital, weekly MDTs were held and included summary of medical issues, management plans were discussed and future issues, outcomes and expectations identified. A doctor told us that the focus of the ward was on the best interests of the patients and the quality of care. They had had excellent opportunities to learn, and were well supported and had gained better insight into other team members contributions to the MDT approach.

At the community units, we found there was good MDT working. We observed an MDT meeting and saw comprehensive discussions about discharge plans and identifying and dealing with blocks to progress of discharge. There was early discussion regarding discharge arrangements. There was good multidisciplinary working supported by regular meetings, case reviews, team handovers and ward rounds. There were good arrangements to ensure that information was shared with patients and relatives. There was an open diary system for relatives to arrange meetings with the patient's medical consultant to discuss progress. In the office staff used a large information board to keep track of key aspects of all patients' care and discharge plans. There were information charts at the back of each patient's bed so that aspects such as mobility and nutrition were clear for all staff providing care. Some information was coded to protect people's privacy and dignity.

Norman Power Intermediate Care Unit
Daily Project Jonah meetings were being held during the week where nurses, therapists and, usually, social workers would discuss each patient's progress and determine action points to assist with discharge planning. These meetings lasted half an hour and all 32 patients in the unit would be discussed. The nurses used a communication book for GP visits. Therapists told us that MDT working was more effective with the introduction of the project Jonah meetings on the unit.

Perry Tree Intermediate Care Unit
Daily Project Jonah meetings were being held during the week where nurses, therapists and, usually, social workers would discuss each patient's progress and determine action points to assist with discharge planning.

Anne Marie Howes Intermediate Care Unit
Daily Project Jonah meetings were being held during the week where nurses, therapists and, usually, social workers would discuss each patient's progress and determine action points to assist with discharge planning.

Good Hope Hospital Community Unit 27
There were good arrangements for multidisciplinary working with regular reviews of care and planning for discharge. A new electronic system to support the daily review and record of care and plans was being introduced.

Heartlands Hospital Community Unit 29
There was good multidisciplinary team (MDT) working. At MDT meetings we observed comprehensive discussion about discharge plans and identifying and dealing with blocks to progress of discharge. We saw there was early discussion about discharge arrangements.

Moseley Hall Hospital
Multidisciplinary team 'goal setting' took place so a plan of rehabilitation set realistic long term expectations. Relatives were involved in care planning and also the patient if they had capacity. Unified approach to patient care by nurses

and therapists. There was a collaborative approach towards multi-disciplinary team working and we observed the teams worked well together this ensured patients had access to a range of health care professionals.

West Heath Hospital
There was good multidisciplinary working supported by regular meetings, case reviews, team handovers and ward rounds. There were also good arrangements to ensure that information was shared with patients and relatives. There was an open diary system for relatives to arrange meetings with the patient's medical consultant to discuss progress. In the office staff used a large information board to keep track of key aspects of all patients' care and discharge plans. There were information charts at the back of each patient's bed so that aspects such as mobility and nutrition were clear for all staff providing care. Some information was coded to protect people's privacy and dignity. There was a collaborative approach towards multi-disciplinary team. We observed the teams worked well together this ensured patients had access to a range of health care professionals.

Co-ordinated integrated care pathways

In the care records we saw some integrated care pathways. There was a multi-disciplinary discharge checklist that set an estimated length of stay and set out goals for safely achieving this. Care plans did not always record how patients were involved with reviewing their progress throughout their inpatient stay. At the weekend the pharmacies for the wards were closed, but there was an on-call pharmacist available out of hours. If necessary an on-call pharmacist would come in to dispense medicines for discharge if patient was unexpectedly to be discharged. Doctors told us that team working was very strong; people worked well together and were supportive. Weekly meetings facilitated effective communication across all disciplines to facilitate coordination of care pathways for patients.

Norman Power Intermediate Care Unit
Senior staff said there were not clearly defined care pathways for staff to follow but that this was being considered.

Perry Tree Intermediate Care Unit
Staff said therapists set rehabilitation goals but that apart from these, there were not clear care pathways to follow.

Anne Marie Howes Intermediate Care Unit
Senior staff said there were not clearly defined care pathways for staff to follow but that this was being considered.

Good Hope Hospital Community Unit 27
Regular MDT meetings were held across all wards to ensure patients received co-ordinated care.

Heartlands Hospital Community Unit 29
Regular MDT meetings were held across all wards to ensure patients received co-ordinated care.

Moseley Hall Hospital
Regular MDT meetings were held across all wards to ensure patients received co-ordinated care.

Good

Are Community health inpatient services caring?

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

Summary

Overall inpatient services at the trust were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases. Where concerns were identified this was usually on the community units, which whilst providing compassionate care was sometimes not patient centred. Patients on the community units were not always aware who their named nurse was and were not involved in decision about their care.

Compassionate care

People who used the service and those close to them were treated with respect, including when receiving personal care. Most people who used the service feel supported and well-cared. Staff usually responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way. The majority of staff were kind and had a caring, compassionate attitude and had positive relationships with people using the service and those close to them. Staff spent time talking to people, or those close to them. Patients valued their relationships with staff and experienced effective interactions with them. Staff respected people's individual preferences, habits, culture, faith and background. People felt that their privacy was respected and they were treated with courtesy when receiving care in their own home. Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.

We spoke with 89 patients and 15 relatives. Patients were positive about their experience within the inpatient services. We carried out two observation exercises over a lunchtime period in two separate units and found the way staff interacted with patients varied. During the first observation we found that out of 13 staff interactions with patients, there were only two positive, person centred interactions. However, for the second observation, seven out 10 staff interactions with patients were positive with three being negative as the staff approach was not person centred.

We observed one occasion when we heard a nurse using an irritated tone of voice with a patient. After seeing us, the nurse changed how they spoke to the patient. However, other members of staff we observed interacting and caring for patients were respectful in their approach. We saw relatives in the dayroom with patients, sitting in small groups talking and at lunch time patients were encouraged to eat in the dining room. We saw examples where patients had tailored exercise/ therapy plans to address motility issues.

In the community units, staff spoke in a kind and considerate manner with patients. Meal times on the enhanced assessment ward were protected times so that patients could be supported to eat meals without interruptions by visitors or therapy or medical interventions. This also meant that patients who needed time to improve their abilities were supported to take meals without visitors being present. The majority of patients were positive about the care they received on the ward.

Norman Power Intermediate Care Unit

We observed a positive staff interaction between a patient and therapist technician who supported the patient to make a hot drink. They supported the patient at their own pace and were encouraging and respectful. We spoke with four patients over lunchtime, and all were complimentary about the staff and the help they provided. One patient told us "It is lovely here. I would recommend this place to other people". We carried out an observation exercise over a lunchtime period in the unit. We found that out of 13 staff interactions with patients, there were only two positive, person centred interactions. Most interactions were neutral and not recognising the individual, for example staff said "Here is a drink" with no reference to the person's name and "Yours is coming, staff haven't forgotten you" when a patient asked where their meal was. Staff said feedback from the patients' satisfaction survey about the unit was generally positive.

Perry Tree Intermediate Care Unit

Most staff interactions we saw were positive and respectful. We carried out an observation over lunchtime and found that seven out 10 staff interactions with patients were positive with three being negative as the staff approach was not person centred. On one occasion, staff moved a

Good

Are Community health inpatient services caring?

patient's legs onto a wheelchair footplate without speaking to the patient. Another staff member told a patient whilst they were standing to "Push, push" without referring to their name.

Anne Marie Howes Intermediate Care Unit
Staff interactions we saw were positive and respectful and most were person centred. A few interactions were task orientated such as a drinks round where one staff gave five patients a drink. Patients were very happy with the staff and care provided they told us.

Good Hope Hospital Community Unit 27
Staff spoke in kind and considerate manner with patients. Patients were treated with dignity and respect. Curtains were used for privacy and staff clearly respected privacy when supporting people with personal care. Meal times on the enhanced assessment ward were protected times so that patients could be supported to eat meals without interruptions by visitors or therapy or medical interventions. This also meant that patients who needed time to improve their abilities were supported to take meals without visitors being present. We found there was little activity for patients who were admitted for many weeks. One relative told us, "the current level of inactivity and lack of stimuli contributed to a noticeable decline". The relative told us they had not been advised what mobility practice was allowed or being promoted to aid recovery. Patients told us they sometimes waited for help. One patient said, "They make me wait and wait for the toilet, I shout and shout but they won't come until they are ready."

Heartlands Hospital Community Unit 29
Staff spoke in a supportive, caring and kindly way with patients and relatives. There was little activity for patients who were admitted for many weeks. Staff told us that they were able to support patients well as they got to know their needs over many weeks and worked with them over this time.

Moseley Hall Hospital
Patients said that the nurses were kind and helpful. Staff were observed encouraging patients with diet, and fluid intake. Patients were offered alternative choices for main course if they did not like the food offered. Nurses demonstrated awareness of patients' idiosyncrasies and utilised management strategies to support patients effectively. We observed in all the ward areas we visited that patients and relatives received compassionate care and support.

Patients said that staff "Were nice, they help me" and "Staff are very caring, this is an amazing unit". Another told us ""they are brilliant here, it's very clean, no complaints they are brilliant".

West Heath Hospital
The majority of patients were positive regarding the quality of care, and we observed compassionate care being delivered. There were one or two examples where this wasn't the care, for example we saw one patient being supported to walk by a junior staff member with little communication from the staff member, mainly pointing. One patients' family told us they had been upset about poor communication from staff about their relative's discharge plans.

We observed one occasion when we heard a nurse using an irritated tone of voice with a patient. After seeing us, the nurse changed how they spoke to the patient. However, other members of staff we observed interacting and caring for patients were respectful in their approach. We saw relatives in the dayroom with patients, sitting in small groups talking and at lunch time patients were encouraged to eat in the dining room. We saw examples where patients had tailored exercise/ therapy plans to address motility issues.

On the whole we observed patients and those close to them received compassionate care. We reported incidences of poor care to the Matron.

Dignity and respect

We observed staff treating patients respectfully and with dignity on most occasions. Curtains were used for privacy and staff clearly respected privacy when supporting people with personal care. Staff were welcoming towards patients and supported them in a professional and sensitive manner. We noted that there were good working relationships between different professional groups, and there was an apparent mutual respect between staff. We observed staff introducing themselves and interacting with them in a warm and positive manner.

One patient who told us they were vegetarian said that they were often given ordinary meals and that they "ate round the meat". In one intermediate care unit, we observed a

Good

Are Community health inpatient services caring?

sing along with patients and a visiting church choir, which most people enjoyed, however, one patient said they had not been asked if they wanted to take part and where not given the opportunity to do an alternative activity. Another person said "I have asked for a haircut and my nails cut for four to five weeks now, but is still has not been done". One patient told us staff encouraged her to do things for herself, although on our observation this was limited due to their medical condition.

Norman Power Intermediate Care Unit
We observed a sing along with patients and a visiting church choir, which most people enjoyed, however, one patient said they had not been asked if they wanted to take part and where not given the opportunity to do an alternative activity.

Perry Tree Intermediate Care Unit
The unit had dignity champions within the staff team to promote patient's dignity. Patients' dignity was respected during our visit.

Anne Marie Howes Intermediate Care Unit
There were positive interactions between staff and patients. Patient's dignity was respected when they were supported with personal care tasks.

Good Hope Hospital Community Unit 27
Staff spoke in a kind and considerate manner with patients. Patients were treated with dignity and respect. Curtains were used for privacy and staff clearly respected privacy when supporting people with personal care. One patient who told us they were vegetarian said that they were often given ordinary meals and that they "ate round the meat".

Heartlands Hospital Community Unit 29
Staff spoke in a supportive, caring and kindly way with patients and relatives.

Moseley Hall Hospital
In all wards we observed we saw that privacy and dignity was maintained for patients. We observed curtains drawn whilst personal care was being delivered. Patients told us they were called by their preferred name and encouraged to be as independent as possible.

West Heath Hospital
In all wards we observed we saw that privacy and dignity was maintained for patients.

Patient understanding and involvement

Staff involved people who used the services as partners in their own care and in making decisions, with support where needed. Most patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment. Staff communicated in a way that people could understand and was appropriate and respectful. Verbal and written information that enabled people who used the service to understand their care was available to meet people's communication needs. There was a lack of literature available in different language formats.

Patient information packs were available at each bedside and staff told us they were given to patients on admission. Most areas had a named nurse system so patients and their relatives knew who was looking after them. We found one intermediate care unit had not yet introduced a named nurse system and relatives we spoke to did not always know who was in charge of the unit and to direct questions about their relative's care to.

In the community units, medical staff took time to explain to patients and relatives the effects or progress of their medical condition which meant that people understood why rehabilitation or changes of arrangements were required prior to safe discharge from the units. In one unit, three of the patients were unaware which nurse was allocated to their overall plan of the care. Some patients were not always clear about their plan of care. There was little activity for patients who had been admitted for many weeks. We found that generally, patients were not closely involved in the multidisciplinary meetings and decision making about their plan of care and discharge. There was no consistent routine for including patients or informing them about the multidisciplinary decision making.

Norman Power Intermediate Care Unit
The unit had not yet introduced a named nurse system whereby patients would know who was looking after them. The unit had intended to start a named nurse system in May, but were still working to introduce the system. Therapists said each care goal was discussed with the patient and would be reviewed on a weekly basis with them but this was not always evidenced in the patient notes. Relative we spoke with were not always clear on whom they should speak with regarding the relatives care.

Good

Are Community health inpatient services caring?

Perry Tree Intermediate Care Unit
This unit had introduced a named nurse system and staff worked in defined teams, so patients had greater consistency of care from staff that supported them on a regular basis.

Anne Marie Howes Intermediate Care Unit
Patients and those close to them told us they feel involved in making decisions about their care.

Good Hope Hospital Community Unit 27
Three of the patients we spoke to were unaware which nurse was allocated to their overall plan of care. Patients were not always clear about their plan of care and were not always clear about their plan of care.

Heartlands Hospital Community Unit 29
Medical staff took time to explain to patients and relatives the effects or progress of their medical condition which meant that people understood why rehabilitation or changes of arrangements were required prior to safe discharge from the units. Patients were not closely involved in the multidisciplinary meetings and decision making about their plan of care and discharge. There was no routine for including patients or informing them about the multidisciplinary decision making. Patients told us they didn't know who their named nurse was. Patients told us they did not know their plan of care, rehabilitation goals or discharge plan.

Moseley Hall Hospital
At Moseley Hall Hospital, patients said that the staff had been helpful, and they knew how the day was structured and understood what they would be doing. One patient managed what care they were able and then was assisted by the staff; they told us that they and their family knew through 'goal setting meetings' about progress and plans in place prior to discharge from hospital. There were organised activities for patients to participate in to aid cognition and promote independence. These activities ranged from a music group, a breakfast club which was risk assessed for patients who could make their own tea/ breakfast. One relative told us "I was terrified when my partner was admitted here, I have never been anywhere like this. They spent a lot of time with me, and answered my questions and involved me in everything, I am not scared anymore and my partner is showing signs of improvement already in a short space of time"

West Heath Hospital
Patients we spoke with told us they were happy with their treatment and felt involved in their care.

Emotional support

Most patients we spoke with were very positive about the support they had been offered by the multidisciplinary team. We saw evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care. Visiting times were flexible which allowed for relatives of elderly patients to maintain family contact throughout long periods of admission.

In one community unit, patients were admitted for approximately four weeks and had minimal stimulation or activities. In addition many patients were in the ward recovering from an illness or injury which meant a level of change of their abilities and likely future lifestyle. Staff told us that there were few occasions that counselling or mental health staff were involved in supporting patients. We found minimal record of assessment of emotional needs in patient records. Staff told us that they would arrange support if it became clear that patients had significant emotional needs.

The INRU ward had good access to a clinical psychologist and there were quiet areas for discussion with patients and relatives. Wards had access to a chapel and multi faith rooms on site. We saw cultural information files available, with details of religions and their naming conventions, beliefs, rites and rituals and end of life beliefs. Staff said they have had training and support in this area.

Norman Power Intermediate Care Unit
The unit's visiting times allowed good access for visitors. Staff would inform the senior nurse if anyone required support.

Perry Tree Intermediate Care Unit
The unit had visiting times from 11 am to 12o'clock, 2pm to 4pm and 6pm to 8pm, with meal times being protected. Staff said emotional support for patients was provided from within the staff team. Support from community psychology services could be requested if required, but generally there would be a long wait for these services.

Anne Marie Howes Intermediate Care Unit
The unit's visiting times allowed good access for visitors. Staff would inform the senior nurse if anyone required support.

Good

Are Community health inpatient services caring?

Good Hope Hospital Community Unit 27
Visiting times in the enhanced assessment wards was very flexible which allowed for relatives of elderly patients to maintain family contact throughout long periods of admission.

Heartlands Hospital Community Unit 29
Patients were admitted for approximately four weeks and had minimal stimulation or activities. In addition many patients were in the ward recovering from an illness or injury which meant a level of change of their abilities and likely future lifestyle. Staff told us that there were few occasions that counselling or mental health staff were involved in supporting patients. We found minimal record of assessment of emotional needs in patient records. Staff told us that they would arrange support if it became clear that patients had significant emotional needs.

Moseley Hall Hospital
Across all areas of the hospital we visited we saw staff sensitively support patients and those close to them. A chapel and multi-faith room were available and staff received training and support from a dedicated member of staff to enable them to meet the emotional needs of the diverse local population.

West Heath Hospital
Staff supported patients appropriately and sensitively, being receptive to their emotional needs.

Promotion of self-care

Patients were encouraged to do as much as they could for themselves. White boards above the patient's bed were used to communicate personal goals to staff and patients. Whilst we considered that this may be undignified and breaching confidentiality for the patients, no concerns were raised by patients or their relatives regarding the display of such information.

On some of the wards, patients were supported to develop social links and take part in activities. We saw there were different activities for patients and relatives to attend if they wished in some wards. We saw evidence of patients being supported to take part in group activities.

Norman Power Intermediate Care Unit
Patients were encouraged to self-care as much as they could, however, there were not clear systems in place for patients to self-medicate if they wished to and were able to. Staff told us all patients had medication administered by nurses apart from those patients that used inhalers.

Perry Tree Intermediate Care Unit
Therapists involved patients in goal setting, although some patients were not able to tell us what their individual goals for rehabilitation were.

Anne Marie Howes Intermediate Care Unit
Therapists involved patients in goal setting, although some patients were not able to tell us what their individual goals for rehabilitation were. There were not clear systems in place for patients to self-medicate if they wished to and were able to.

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29
Patients were encouraged to do as much as they could for themselves.

Moseley Hall Hospital
Patients said they were encouraged to do things for themselves. On ward 9 patients were actively encouraged as part of their rehabilitation programme to take part in activities and to do as much for themselves as they could. Across other areas of the hospital patients were encouraged to do as much as they were able to supported by nurses and therapists.

West Heath Hospital
Patients were encouraged to do as much as they could for themselves.

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

Good

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

Summary

Services were delivered from inpatient units across Birmingham, and the majority of patients were from the local area. Services met the needs of patients, though as noted this wasn't always the case for patients who had suffered a stroke. There was a lack of activity for some other patients. Whilst the inpatient units were open 7 days a week, not all therapy or pharmacy staff did which impacted on the timeliness of some care delivery.

Staff on some wards were involved in Project Jonah which was a multidisciplinary process for ensuring patients were discharge effectively. This had had a positive impact on reducing the length of stay for patients. Admissions to the intermediate care units were often based on referral date rather than patient dependency and clinical complexity of need.

We observed a multidisciplinary integrated approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacists. Concerns and complaints were often dealt with at ward level by the ward sisters, often resolving the issue and avoiding the need for a more formal complaint. Information was available for patients regarding how to make a complaint.

Service planning and delivery to meet the needs of different people

Staff understood the different needs of the people it serves and acted on these to plan, design and deliver services. The trust planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible, in line with their preferences, and wherever possible provided accommodation that was gender specific, and ensuring the environment and facilities were appropriate and required levels of equipment were available promptly.

Patients were admitted to inpatient services from either a nearby acute trust or from their own homes or residential care, referred by their GP or a community nurse. The reason for the patient's admission was assessed, using specific referral criteria. We were told by the ward sisters that using referral criteria sometimes helped to avoid inappropriate admissions that may delay rehabilitation services for another patient. However, the ward sisters were concerned that stroke patients were included in the referral criteria especially when staff, both nursing and therapy, had not had specific training in stroke care.

We observed an integrated approach to care delivery across all the wards involving nursing staff, therapists, medical staff and pharmacy and a commitment to facilitating a timely, safe and person-centred discharge for the patient. Home assessments were conducted with the patient, relative and a member of the multidisciplinary team before discharge to assess the need for equipment or further community support after discharge.

Norman Power Intermediate Care Unit

This unit provided 32 beds for patients requiring rehabilitation; 95% of admissions were from the local acute hospital. Patients were assessed by the hospital using the unit's admission criteria, with patients being medically fit and over 18 years of age. Patients referred would need to be able to benefit from a rehabilitation programme and could have mild to moderate cognitive impairment but would be able to engage with the rehabilitation programme. A minority of patients were admitted from the community, either via GP referrals or from an advanced nurse practitioner. These referrals were made to reduce the number of people being admitted direct into hospital. The three intermediate care units had a liaison nurse who oversaw all bed vacancies and referrals and at times people were offered a bed in another unit if one was available.

Perry Tree Intermediate Care Unit

This unit provided 32 beds for patients requiring rehabilitation. Most admissions were from the local acute hospital, Good Hope hospital. Patients were generally assessed by the hospital using the unit's admission criteria, with patients being medically fit and over 18 years of age. Patients referred would need to be able to benefit from a rehabilitation programme and could have mild to moderate cognitive impairment but would be able to engage with the rehabilitation programme. Staff from Perry

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

Good

Tree would go and assess new people referred if needed, normally within 24 hours of referral. The unit also took referrals from the community from GPs or the community nursing Rapid Response team.

Anne Marie Howes Intermediate Care Unit
This unit provided 32 beds for patients requiring rehabilitation. Most admissions were from the local acute hospital. Patients were generally assessed by the hospital using the unit's admission criteria, with patients being medically fit and over 18 years of age. Patients referred would need to be able to benefit from a rehabilitation programme and could have mild to moderate cognitive impairment but would be able to engage with the rehabilitation programme.

Good Hope Hospital Community Unit 27
There were clear systems to arrange admission to the enhanced assessment units. An electronic referral message system was in place which the clinical manager checked regularly. This meant that admission to the wards was timely but controlled to ensure people were admitted for appropriate reasons to the assessment units.

The ward environment and the general routine of care meant that patients had minimal activity during spells of admission often lasting many weeks. We saw that patients in the enhanced assessment wards were being cared for in a hospital environment with an expected admission length of four weeks. There were separate dining areas which could be used but patients and relatives told us there usually was little to do. Patients did not have access to televisions in the ward bays or side rooms. We saw that staff had arranged for some radios with headphones for patients to use. This meant that patients who were recovering from illness or injury were not usually involved in gainful activity to promote motivation during their time of convalescence and preparation for going home.

Heartlands Hospital Community Unit 29
There were clear systems to arrange admission to the enhanced assessment units. An electronic referral message system was in place which the clinical manager checked regularly. This meant that admission to the wards was timely but controlled to ensure people were admitted for appropriate reasons to the assessment units.

The ward environment and the general routine of care meant that patients had minimal activity during spells of admission often lasting many weeks. We saw that patients in the enhanced assessment wards were being cared for in a hospital environment with an expected admission length of four weeks. There were separate dining areas which could be used but patients and relatives told us there usually was little to do. Patients did not have access to televisions in the ward bays or side rooms. We saw that staff had arranged for some radios with headphones for patients to use. This meant that patients who were recovering from illness or injury were not usually involved in gainful activity to promote motivation during their time of convalescence and preparation for going home.

On the enhanced assessment wards there was limited space for rehabilitation activity. Patients generally had therapy interventions at their bedside. There was also limited space or rooms available for patients to discuss personal issues with therapists or other professionals.

Moseley Hall Hospital
On ward 9, staff had developed a reminiscence area, for people living with dementia. Patients on all wards had access to a central courtyard area, to enable them to be able to go outside. We were told that if patients had pets at home they were able to bring them in to the courtyard.

West Heath Hospital
Referral and admission protocols were clear and the wards had processes in place to review referrals so that patients' could be appropriately placed in these wards.

Access to care as close to home as possible

The trust was committed to ensuring inpatient services were delivered as close to home as possible. Ward sisters told us part of the triage process involved consideration of where the patient lived to reduce the amount of travelling visiting relatives may have to do. On one ward the ward sister told us how they were involved in reviewing the waiting lists at the nearby acute trust. This engagement allowed them to plan services on the ward appropriately. The intermediate care units and community units provided locally based services for the community and patients and relatives were positive about the location of these units as they were close to home. Some wards did not have access to extra capacity beds, which meat at times patients were admitted to services some distance from their homes.

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

Good

Norman Power Intermediate Care Unit
The unit was set up as part of the trust's "Care Close to home" initiative and ideally, patients would be placed in the unit that was closest to their relatives and their home. Patients and visitors spoke well of the service and the fact it was close to where they lived.

Perry Tree Intermediate Care Unit
This unit took referrals from the local hospital as well as from GPs and local community nursing rapid response team. Patients said they preferred to come to this unit, as it near their homes in the local community.

Anne Marie Howes Intermediate Care Unit
This unit took referrals from the local hospital and local community, via GP services, and staff endeavoured to ensure people were accommodated as close to home as possible. Senior staff told us that if one intermediate care unit had no available beds, patients' would be offered places at another unit that was close to their home.

Good Hope Hospital Community Unit 27
Whilst the service was usually flexible in supporting patients and relatives. One relative told us they had been refused access to visit at lunchtime 'due to the inspection visit'. Permission had previously been granted to visit her grandmother to help her with eating lunch.

Heartlands Hospital Community Unit 29
These wards provided locally based services for the community and patients and relatives were positive about the location of these units as they were close to home.

Moseley Hall Hospital
Staff endeavoured to ensure patients received care close to home if bed capacity allowed. Referral and admission procedures were in place.

West Heath Hospital
Staff tried to ensure patients received care close to home if bed capacity allowed. Referral and admission procedures were in place.

Access to the right care at the right time

People were able to access the right care at the right time. The referral systems to the units generally supported choice and enabled people to access the right care at the right time, dependent on bed capacity of individual wards and units. There was an effective approach to managing referrals, assessments, and bed allocation and use of inpatient provision; plans were in place to tackle any problems identified.

Staff told us MDT case conferences occurred daily in some areas but weekly in others. This allowed for an early assessment of the patients plan of care, discussions with the patient and their relative and, to identify any potential barriers to discharge. Access to medical support overnight was dependent on the location of the ward with some wards having 24 hour access to medical support from other areas of the hospital site. In those wards where medical cover wasn't easily accessible 999 services would be contacted.

Therapy services provided by physiotherapists and occupational therapists varied across inpatient services. The trust timescale for therapy assessment was within 24 hours, however as therapists did not work over weekends, this did not always happen. Pharmacy services were provided Monday through to Friday and included pharmacy technician support. The pharmacist we spoke with described their role in the discharge process as ensuring medications were available on discharge and in a format suitable for the patient. In one intermediate care unit, staff told us there was no clear discharge planning. One intermediate care unit was able to demonstrate that with the introduction of Project Jonah meetings, the average length of stay of patients had reduced from six weeks to four weeks, with patients returned home following their treatment plans.

Norman Power Intermediate Care Unit
Referral and admission procedures were in place. New referrals were assessed to and the unit's eligibility criteria applied to make decisions about whether the patient referral was appropriate to the unit. There was generally effective MDT working with daily Project Jonah meetings being held. The unit had protocols in place so that patients' could have a review by a doctor when required. Some staff said there was not clear discharge planning.

Perry Tree Intermediate Care Unit
Referral and admission procedures were in place. MDT working was generally co-ordinated so that the needs of the patients' could be recognised and met, and the unit had GP cover arrangements for when a patient may review a review.

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

Good

Anne Marie Howes Intermediate Care Unit
Referral and admission procedures were in place. MDT working was generally co-ordinated so that the needs of the patients' could be recognised and met, and the unit had GP cover arrangements for when a patient may require a review.

Good Hope Hospital Community Unit 27
Medical support for patients in the enhanced assessment ward was good. Both wards were located within an acute hospital site and this meant that medical staff were available through the 24 hour period to support in case of emergency or deterioration of condition. Staff told us that the consultant staff and their teams attended when required. There were clear systems to arrange admission to the enhanced assessment units. An electronic referral message system was in place which the clinical manager checked regularly. This meant that admission to the wards was timely but controlled to ensure people were admitted for appropriate reasons to the assessment units.

Heartlands Hospital Community Unit 29
Medical support for patients in the enhanced assessment ward was good. Both wards were located within an acute hospital site and this meant that medical staff were available through the 24 hour period to support in case of emergency or deterioration of condition. Staff told us that the consultant staff and their teams attended when required. There were clear systems to arrange admission to the enhanced assessment units. An electronic referral message system was in place which the clinical manager checked regularly. This meant that admission to the wards was timely but controlled to ensure people were admitted for appropriate reasons to the assessment units

Moseley Hall Hospital
On ward 9 patients are assessed prior to admission to ensure the process is planned. Staff on the other wards told us they try not to receive patients after 9pm from the main hospital, but sometimes patients are admitted directly from home overnight. This could, at times, have an impact on the correct medication being available. Doctors told us that admissions late at night could impact on medication as there was not always effective communication and the units did not always get required transfer documentation and not be able to liaison with the patient's own GP. Staff told us that waiting lists could impact on patient admission times. For example, out of hours doctors could not liaise with GPs to ask about patient's condition. Sometimes, transport issues could impact on admission times.

West Heath Hospital
Doctors told us that admissions late at night could impact on medication as there was not always effective communication and the units did not always get required transfer documentation. Staff told us that waiting lists could impact on patient admission times. For example, out of hours doctors could not liaise with GPs to ask about patient's condition.

Flexible community services

Staff stated that sometimes following discharge, there was a six week delay in getting community therapy support for people to continue their rehabilitation on their return home.

Doctors told us that admitting patients directly from home did not always feel appropriate, if they had not been seen by their own GP. This could have led to delayed medical management and they said that admission to an acute hospital may be more appropriate. Staff tried to ensure that patients were not transferred from the main hospital after 9pm though had no control over patients admitted from their homes.

Norman Power Intermediate Care Unit
The trust was reviewing the long term future of the three intermediate care units as the overall cost of the service was expensive. Staff were not able to tell us about the timescale for this review, or what other local community service options were being considered.

Perry Tree Intermediate Care Unit
New referrals were screened for dementia and the unit could accommodate those people living with dementia that had low level needs but the extent of the cognitive impairment could impact on their rehabilitation potential. Staff told us the longer term plan for the unit was to be able to provide more rehabilitation services for people living with a dementia.

Anne Marie Howes Intermediate Care Unit
The unit provided a locally based rehabilitation service for the local population and patients said they preferred to be able to stay in a ward close to their home. Staff reported that at times there could be a delay in people receiving

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

Good

rehabilitation support from community based therapists once they had returned home. The unit did make referrals to the community team in a timely manner in order to facilitate ongoing community support for people.

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29

Staff told us that the enhanced assessment unit was well used to support and prepare people who were not ready physically or facilities were not in place for them to return home after a period of acute admission. Patients and relatives told us that the service was helpful in providing a place for recovery before going home. Staff told us that community unit 29 was to be closed in the near future and there was to be a service reconfiguration but they did not know any timescales for this.

Moseley Hall Hospital

Patients and relatives told us that the service was helpful in providing a place for recovery before going home. Patients generally stayed on ward until they were ready to be discharged home. Some patients stayed on the ward beyond their planned discharge date mainly due to delays in setting up appropriate social care home care packages.

West Heath Hospital

Patients and relatives told us that the service was helpful in providing a place for recovery before going home. Patients generally stayed on ward until they were ready to be discharged home. Some patients stayed on the ward beyond their planned discharge date mainly due to delays in setting up appropriate social care home care packages.

Meeting the needs of individuals

People who used the service were asked about their spiritual, ethnic and cultural needs and their health goals, as well as their medical and nursing needs. Their care and treatment was planned and delivered to reflect these needs. The needs and wishes of people with a learning disability or of people who lacked capacity were understood and taken into account, although some staff said they needed more training in this area, particularly regarding documentation. Therapists' assessments were generally carried out within 24 hours of admission (during the week) and within 48 hours if patients were admitted on the weekend. We did not see clear care pathways that were designed to be flexible to make sure that different services worked together to meet patients' changing needs. The wards worked with other care agencies to make sure that patients' needs continued to be met when they moved between services but delays in establishing social care packages at home had led to some patients' remaining on the wards past their planned discharge date.

Across all wards we observed a commitment to providing services to patients who did not have English as their first language, though we did not always see information on display concerning interpreting services. Staff told us they knew how to access interpreting services and how to use them to support patients who needed to make decisions about changes to their care pathway. In the care records we reviewed the patients' religious needs were assessed on admission. Staff told us patient care would be tailored according to their needs. A multi faith room was available to patients to use on the intermediate care units. There was effective liaison with local GPs and district nurses to support people to return home with an appropriate level of community support in place. Translation services were available, either through the support worker or a 24 hour translation service. Picture chart with phonetics and language were produced for the main languages in the area which meant patients could either read the word, point to a picture or staff could say the word to enable patients and staff to communicate.

Norman Power Intermediate Care Unit

Staff told us that there was effective liaison with local GPs and district nurses to support people to return home with an appropriate level of community support in place. Senior staff told us that patients had to wait for a therapist assessment over the weekend as no therapists worked at weekends. Staff would follow the therapy assessment that had been previously carried out at the hospital for these patients. Due to the size of the doorways, the unit could not accommodate bariatric patients using wheelchairs unless the patients could stand and walk through the doorways. All literature in the unit was in English, but staff said they could access some alternative language leaflets via the trust's online system if required. We found that care plans for people living with a dementia were not person centred and did not always give staff appropriate guidance to meet the patient's needs.

Perry Tree Intermediate Care Unit

Staff had access to interpreter services and said literature in different languages could be printed off from the trust's internal website as required. The unit accommodated people with a learning disability at times, and received

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

Good

support from community teams to be able to meet patients' needs. Staff said support from other health professionals regarding people living with a dementia was variable and there was a lack of community psychiatric support, particularly where staff sought support for managing difficult behaviours of patients' living with a dementia. We found that care plans for people living with a dementia were not person centred and did not always give staff appropriate guidance to meet the patient's needs.

Anne Marie Howes Intermediate Care Unit
Where patients required help to make decisions for themselves relatives were involved where possible, but staff told us they could access advocacy services to support patients if required. The unit had access to interpreter services, although this service was rarely required, staff told us. Patients told us there was a lack of activities and things to keep them occupied during the day. We found that care plans for people living with a dementia were not person centred and did not always give staff appropriate guidance to meet the patient's needs.

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29
Where patients required help to make decisions for themselves relatives were involved where possible, but staff told us they could access advocacy services to support patients. Although there were unclear arrangements for sharing decisions from multidisciplinary meetings staff told us that they developed close relationships with patients during long stays of four weeks or more and that consultant medical staff were compassionate and supportive in explaining arrangements to patients and relatives.

Moseley Hall Hospital
At Moseley Hall Hospital, there was early supported discharge of targeted patients who were suitable to be able to leave hospital early. Patients were involved in goal 'setting meetings' about their diagnosis and considered patients' expectation. MDT approaches were in place and action plans identified. The service had been designed to meet the needs of individuals. Diversity files had been produced and staff had received training to meet the needs of the local population.

Ward 9 had a named nurse system with the nurse visiting the patient before admission to the ward, to start initial work until they are admitted to the ward. One patient spoken with remembers the nurse coming to visit them.

West Heath Hospital
The service had been designed to meet the needs of the individuals. Staff had diversity files and had received training to meet the needs of the local population. A new dementia friendly unit was in the process of being built to meet the needs of people living with dementia. Staff were working with the trust's Dementia Steering Group so that the new unit would reflect best practice to provide an appropriate dementia care service.

Moving between services

Some patients at West Heath and Moseley Hall Hospitals we spoke with told us they were involved throughout their care pathway and theirs and their relative's wishes were considered. On the intermediate care units, staff said weekend discharges for patients did happen, but they had to be planned carefully in advance given the reduced level of physician cover at weekends available to the intermediate care units. Some discharges were delayed due to having to wait for a social care assessment and a home care package and waiting for equipment at times. Staff told us that the external provider of equipment sometimes had transport delays for larger pieces of equipment, such as hoists, but that commissioners were aware of this issue.

Wards had systems in place to decrease delays in discharge medicines being dispensed for patients, with systems in place for doctors to plan ahead and write patients' prescriptions. We found that those patients were admitted to wards and stayed until rehabilitation treatment had been completed to a point where they can be discharged.

Norman Power Intermediate Care Unit
There was inconsistent discharge planning and plans were not clearly linked to rehabilitation goals. The introduction of the Project Jonah meetings had improved discharge planning and communication with patients and their relatives. Discharge summary letters were given to the patient and a copy sent to their GP and associated healthcare professionals. Staff said weekend discharges for patients did happen, but they had to plan carefully in advance given the reduced level of physician cover at weekends available to the intermediate care units. Senior staff told us that any patients with a delayed discharge were discussed in the Project Jonah meetings.

Perry Tree Intermediate Care Unit
There was inconsistent discharge planning and plans were not clearly linked to rehabilitation goals. The introduction

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

Good

of the daily Project Jonah meetings had improved the MDT working so that discharges could be planned more effectively and action points for the various professionals were identified in order to facilities the patient's discharge home.

Anne Marie Howes Intermediate Care Unit
There was inconsistent discharge planning and plans were not clearly linked to rehabilitation goals. For example, one of the rehabilitation goals we saw was "to return home". Effective MDT working was facilitated by the daily Project Jonah meetings and staff identified those patients' with fluctuating medical conditions that could impact on the planned discharge plans and took appropriate action to resolve the concerns.

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29
Referrals to units were assessed appropriately and managed in a timely way through an electronic referral system from acute ward areas. The units had dedicated social service staff working with patients and families and other professionals to prepare any required packages of care for when patients were discharged. Some patients were in the unit for extended periods as onward placement had been difficult to arrange either due to personal funding or implementation of facilities in the home.

Moseley Hall Hospital
Systems were in place to ensure patients were transferred home in a timely manner. Systems were in place for doctors to plan ahead and write discharge medicine prescriptions to decrease delays in these medicines being dispensed for patients. Staff said "Sometimes patients are delayed in being discharged because we are waiting for a safe place to discharge them to".

West Heath Hospital
Patients received rehabilitation support until they are able to go home or to an alternative, such as a care home, if they were not able to return home.

Complaints handling (for this service) and learning from feedback

Patients knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care. Complaints procedures and ways to give feedback were in place. People were supported to use the system and to use their preferred communication method. This included enabling people to use an advocate where they needed to. People were informed about the right to complain further and how to do so, including providing information about relevant external second stage complaints procedures.

The trust reviewed and acted on information about the quality of care that it receives from patients, their relatives and those close to them and the public. Not all wards were able to show consistently the difference this had made to how care was delivered. Some staff did not receive feedback or information from complaints or what had been done to address the concern.

Across inpatient services we saw many examples of compliment letters and thank you cards displayed in ward areas. There was a complaints procedure on display in all of the wards. Staff told us that during their admission process patients were routinely given a leaflet containing information on how to make a complaint. Patient feedback was generally very positive about the staff and service. Staff said complaints and incidents were not regularly discussed at team meetings so the wards were not always able to show how lessons had been learning and shared from complaints. Patient satisfaction surveys were carried out in all areas.

The trust collected patient feedback using the Friends and Families Test, a single question survey that asks patients "How likely is it that you would recommend this service to friends and family?" The trust reported that it was achieving "net promoter" scores better than NHS Midlands and East for all but one month. On one of the wards we visited we observed their net promoter score to be the maximum of 100. We saw one example where a patient's relative had made useful comments about gaps in care such as emotional support for patients. This was not a complaint but the relative had been invited to discuss their thoughts so that staff could learn from the perspective of patient and relative. The net promoter score (NPS) for inpatients' services in March 2014 was 70, against the trust wide score of 75. Maximum scores of 100 were achieved by four wards.

There were weekly checks on patient satisfaction on some wards. Staff said senior nurses investigated complaints and the outcomes were usually discussed with staff. Wards had "You said we did" board on display so visitors and patients could see how their comments were being acted upon.

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

Good

Norman Power Intermediate Care Unit
Patient feedback was generally very positive about the staff and service. Most staff told us they knew about the complaints' process and were able to advise patients and relatives about it. We saw the unit had complaints procedures in place and these were on display. Ward performance boards reported on patient feedback.

Perry Tree Intermediate Care Unit
The unit had had no complaints for nine months and had received a number of compliments. We saw 38 compliment cards and letters on display. A patient experience audit was carried out weekly and the results were shared at staff meetings. The net promoter score for the unit for the previous month was 50%, which was below the trust average and senior staff were looking into why this score was lower than usual for this month.

Anne Marie Howes Intermediate Care Unit
Patients and visitors were complimentary about the staff and the care given. We saw the unit had complaints procedures in place and these were on display. Ward performance boards reported on patient feedback.

Good Hope Hospital Community Unit 27
There were weekly checks on patient satisfaction. This was completed by the patient experience team for the trust who completed the friends and family test survey with discharged patients. Although patients were admitted for many weeks there were no other routine methods by which staff obtained the views of patients.

Heartlands Hospital Community Unit 29
Staff meetings included discussion about complaints that had been received by the trust to share learning across teams. One patient's relative had made useful comments about gaps in care such as emotional support for patients. This was not a complaint but the relative had been invited to discuss their thoughts so that staff could learn from the perspective of patient and relative.

Moseley Hall Hospital
The hospital encouraged patients and people close to them to provide feedback about their care. "You said, we did" boards clearly displayed information regarding complaints that had been made and how the wards had addressed those complaints.

West Heath Hospital
The hospital encouraged patients and people close to them to provide feedback about their care. "You said, we did" boards clearly displayed information regarding complaints that had been made and how the wards had addressed those complaints.

Good

Are Community health inpatient services well-led?

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

Summary

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in improvements to the service and did not receive feedback from patient safety incidents.

All staff were committed to delivering good, safe and compassionate care. Some staff spoke of 'back to the floor' visits by the Chief Executive and members of the wider executive team.

The trust had acted rapidly in response to staff concerns about the quality of care on one ward. On this ward the managers had made effective changes to the structure and had made staff changes to ensure patient safety.

We found that the wards within inpatient services were working with very little engagement between wards. This did not allow for shared learning to take place across inpatient services.

Vision and strategy for this service

The trust overall had a forward looking statement of vision and values, driven by quality and encompassing key elements such as compassion, dignity, respect, and equality, but not all staff were aware of this vision.

All the ward sisters told us they felt part of the trust and most staff described a trust that listened to, valued and supported staff. All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed. Not all staff were aware the trust's values and vision, though some were very aware and stated that the vision and values had been part of their interview process. At a local level, staff said senior nurse's feedback to staff about trust issues such as the values tool kit and staff charter. Senior staff said the chief executive understood the service and issues of concern, and at Moseley Hall Hospital, the clinical director undertook on-call shifts. Trust executives had been to local staff meeting staff. We found that at the local ward level, there was a clear vision.

Norman Power Intermediate Care Unit

Senior staff said that the board and senior trust executives were visible and accessible. Junior staff were not fully aware of the aims, values and visions of the trust and did not consider the board understood their concerns or were listened to.

Perry Tree Intermediate Care Unit

Senior staff said board members did visit but the unit did not have "back to the floor" visits whereby senior managers would work at the unit for a day. Most junior staff were not aware of the vision of the trust, and saw themselves as working for the unit, as opposed for the trust. They told us "We hear about this unit, not about the rest of the trust." Senior staff said that staff see themselves working for Perry Tree and not the wider trust.

Anne Marie Howes Intermediate Care Unit

Staff told us they were committed and dedicated to the unit where they worked to support their local community but not all staff were fully aware of the trust's vision and overall strategy.

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29

There was clear leadership in the units by the clinical team leaders and also through quality systems that were seen by staff to be promoted and supported by trust managers. We found that staff at all levels were aware of key issues such as safety, infection control and providing a service responsive to patients wishes and needs.

Moseley Hall Hospital

Staff felt the service was well led by the matron and senior nurses on the wards. Some staff told us communication was delayed from the trust. Staff were aware of the trust values but most staff we spoke with had not been involved in the process of devising them.

West Heath Hospital

Staff felt the service was well led by the matron and senior nurses on the wards. Some staff told us communication was delayed from the trust. Staff were aware of the trust values but most staff we spoke with had not been involved in the process of devising them.

Good

Are Community health inpatient services well-led?

Governance, risk management and quality measurement

Ward sisters across all inpatient services demonstrated an awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, contributing to the trust risk register and undertaking audits. However, on some wards we found that there was a lack of understanding in relation to how learning from incidents was implemented as in some intermediate care units, staff were not aware of learning from incidents being regularly discussed at team meetings. Local wards did not have their own risk registers in place. Not all staff were aware of the trust wide risk register therefore were not sure what risks were judged for their services.

We found that the service was not benchmarking itself against other services within the trust; we were told that meetings between inpatient wards rarely happened.

At a local level, there were good arrangements to investigate and learn from incidents. The ward clinical leads and other managers such as a trust safety officer ensured full assessment of the circumstances of the incident and a pathway was followed to ensure relevant staff were informed about any learning from the analysis. The cause of each incident was analysed and information was shared with staff in the ward and across other trust departments to promote learning and avoid future similar incidents.

Wards had display boards showing performance and patient safety information, including actual and planned staffing levels and showed how the units had listened and responded to feedback from patients and their relatives. Staff said performance information and learning from complaints was discussed regularly at team meetings, but this was not consistent across the service.

Norman Power Intermediate Care Unit

Staff said the introduction of Essential Care indicators (ECIs) had led to an improvement in compliance with the trust's key safety and risk indicators through the service. Each ward and unit would receive monthly summaries of the audit so that areas of concern were identified and actions taken to address the concerns. Most senior staff were able to explain how these ECIs informed service delivery improvements, but staff at junior grades did not consistently know about them. Some staff said they got feedback from incidents. We saw that a team brief had taken place and been minuted two weeks prior to our visit and that ECIs had been discussed. The therapist service had not produced annual reports on performance and risks to contribute to the trust's clinical governance processes.

Perry Tree Intermediate Care Unit

Staff reported that by using the ECIs, overall the unit's safety performance had improved and themes were identified so action could be taken. However, not all staff were able to explain how lessons had been learned from incidents, and said they did not always get feedback.

Anne Marie Howes Intermediate Care Unit

The ECIs had led to an improvement in the quality of care and the documentation that underpinned the care delivery. However, some staff felt the ECIs were not holistic and only focused on a few key areas of risks such as falls, observations, skin care and nutrition. The ECIs made staff focus on these areas rather than look at holistic nursing needs assessments and care planning for individual patients. The ECIs did not inform the wards safety thermometers we were told. This ward had a Harm Free care total of 96.8% for May 2014, which was above the trust target of 95% Harm Free care. Local wards did not have their own risk registers, but staff could escalate concerns to the corporate risk register.

Good Hope Hospital Community Unit 27

There were clear displays of the quality of service indicators in the ward area. We saw that nursing staff had discussed the performance information and learning from incidents at staff meetings. There was minimal data recorded about quality or effectiveness of the therapy services provided.

Heartlands Hospital Community Unit 29

There were good arrangements to investigate and learn from incidents. Staff were aware of incident reporting procedures and we saw that incidents were reported on a computer system. The ward clinical lead and other managers such as a trust safety officer ensured full assessment of the circumstances of the incident and a pathway was followed to ensure relevant staff were informed about any learning from the analysis. The cause of each incident was analysed and information was shared with staff in the ward and across other trust departments to promote learning and avoid future similar incidents.

Good

Are Community health inpatient services well-led?

Moseley Hall Hospital
The hospital analysis information gathered on the wards to identify any risks which may impact on the quality of care provided.

West Heath Hospital
Regular governance meetings were held and the wards were planning new audits around resuscitation and diabetes management. Staff were aware of the ECIs and the ward Safety Thermometer. Staff were aware of the trust wide risk register but were not sure what was on it.

Leadership of this service

Staff and leaders in the wards prioritised safe, high quality, compassionate care and promoted equality and diversity. Senior leaders understood what the challenges were to delivering high quality care and were taking action to address them. The majority of staff felt respected, valued and supported. Local leaders communicated effectively and were visible to teams and staff. Almost all staff felt able to raise problems and concerns without fear of being penalised, bullied or harassed. Teams generally had clearly defined tasks, membership, roles, objectives and communication processes.

Candour, openness, honesty and transparency were at a high level and challenges to poor practice were the norm. There was swift and effective intervention to deal with behaviour and performance inconsistent with values and vision, regardless of seniority and including any issues relating to bullying, harassment or discrimination.

On one ward we saw that trust managers had acted rapidly in response to staff concerns about the quality of care. On this ward the managers had made effective changes to the structure and had made staff changes to ensure patient safety. The senior nurses on the ward and new staff were carefully selected to ensure patients were cared for safely and with compassion. Most of the wards we inspected were well-led at a local level. Staff reported good support from their line manager and spoke positively about leadership at ward level. On one intermediate care unit, staff said there had been inconsistent local leadership, but that had been recognised by the trust and plans had been put in place to address this.

At West Heath Hospital, staff were able to talk about trust values, and felt that ethos had a positive impact on the high quality and standards of care that patient experience. They said that they would be "Happy for my own relative to be on the ward". An area of concern had been raised by a qualified nurse about the attitude of some members of staff with regards to not take responsibility or accountability for their own actions. Plans had put in place to address this concern and promote team cohesiveness.

At the community units, staff told us that senior managers and directors took part in the ECI audits in ward areas and there was a good team working culture with all professionals involved and integrated in discussing and planning care. Staff told us they could speak openly and make suggestions in the team.

Staff told us they felt well supported by their line managers and the matron and could approach line managers at any time and spoke positively about the service and were proud to work there.

Norman Power Intermediate Care Unit
Staff said there had been inconsistent local leadership, but that had been recognised and plans had been put in place to address this. Additional support for the staff team had been put in place with a matron spending four days a week at the unit. Matrons attended a monthly matron's meeting with the chief nurse. Senior staff told us they felt excluded from decision-making about their units and that the trust was a reactive organisation.

Perry Tree Intermediate Care Unit
Staff were well supported by local managers and communication was effective within the unit. Staff told us that qualified nurses were more likely to know the overall trust position and this was not always cascaded down to junior staff. Plans were now in place to address previous leadership issues. Staff said they often had to work long days and that their breaks were not always managed effectively. The shift patterns also meant that people would work a late, followed by an early and these issues had been ongoing for some time.

Anne Marie Howes Intermediate Care Unit
Staff were well supported by local managers and that communication was effective within the unit. Staff felt able to raise concerns and that they would be listened to. Staff felt well supported by their managers.

Good Hope Hospital Community Unit 27 and Heartlands Hospital Community Unit 29
There was clear local leadership in the enhanced assessment units. Unit managers were committed to improvements in service and used quality of care

Good

Are Community health inpatient services well-led?

information to inform staff. There was good medical cover in each unit to support patient management towards discharge, and for out of hours cover as required if patient's condition changes.

Moseley Hall Hospital
Staff felt the hospital was well led and they had clear guidelines about their roles and responsibilities. They felt well supported by the senior nurses.

West Heath Hospital
At West Heath Hospital, staff were able to talk about trust values, and felt that ethos has a positive impact on the high quality and standards of care that patient experience. They said that they would be "Happy for my own relative to be on the ward". An area of concern had been raised by a qualified nurse about the attitude of some members of staff with regards to not take responsibility or accountability for their own actions. Plans had put in place to address this concern and promote team cohesiveness.

Some staff could clearly describe the trusts visions and values. Staff on ward 12 felt there had been problems within the team but overall the team was well run and worked well together. They felt they were well supported by senior staff.

Culture within this service

Across all of inpatient services staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Staff felt listened to and involved in changes within the trust; staff spoke of involvement in staff meetings, and receiving ward newsletters.

Norman Power Intermediate Care Unit
Staff told us there had been a closed culture and that they had not always been consulted and engaged in the development if the unit, but this had been recognised and plans were in place to improve the team cohesiveness. We saw plans were in place to facilitate enhanced team working and team building and that regular team meetings were now planned. Matrons said they had good peer support.

Perry Tree Intermediate Care Unit
The unit had reintroduced regular team meetings and weekly staff briefings. Most staff were clear about their roles and responsibilities but therapists said there were no clear delineation for the roles and responsibilities for each of their disciplines.

Anne Marie Howes Intermediate Care Unit
Staff spoke positively about the unit and their colleagues. A daily "huddle" meeting took place in the mornings and this was used to share important information and to provide support for staff.

Good Hope Hospital Community Unit 27
Staff told us they were well supported by the unit manager and matron for the service. We found there was good multidisciplinary working across nursing, therapy, medical and GP staff providing care in the unit.

Heartlands Hospital Community Unit 29
Senior managers/directors took part in the essential care indicators audits in ward areas. There was a good team working culture with all professionals involved and integrated in discussing and planning care. Staff told us they could speak openly and make suggestions in the team. Student nurses were well supported in the ward, they told us they enjoyed the placement and felt they were given good opportunities and support for learning.

Moseley Hall Hospital
Staff spoke positively about the service they provided. They told us they were encouraged to speak out if they felt there were any risks to patient care. We saw evidence of a good team working culture across all areas that we visited. In Ward 9, staff were clear on individual roles and responsibilities and were proud of where they work and the work they did.

West Heath Hospital
Staff felt well supported and there was good communication with local leaders. The trust had responded to an area of concern in one ward and plans were in plan to facilitate effective communication and team working.

Public and staff engagement

The trust and all staff recognised the importance of the views of patients and the public. A proactive approach was taken to seek a range of feedback with participation and involvement with both the public and staff. The voices of staff were encouraged, heard and acted on, including all equality groups. Information on patient experience was reported and reviewed alongside other performance data. Not all staff were able to tell us how learning from incidents or complaints was shared.

Patients were asked for their views about the care they received. Views were displayed on a 'You said We did' board

in patient areas. For example in one community unit the menus for meals had been amended to provide more traditional food that elderly patients were familiar with. This was a result of responding to patient feedback about the type of food they would like to eat.

Not all the staff we spoke with assured us they understood the trust whistleblowing policy and would feel comfortable using it if necessary. We saw information displayed on the wards advising staff of the whistleblowing procedure.

Norman Power Intermediate Care Unit
The unit had clear display boards showing performance and patient safety information, including actual and planned staffing levels and showed how the unit had listened and responded to feedback from patients and their relatives. On the day of the inspection, the unit reported that it had been 183 days since a patient had developed a new pressure ulcer. Staff communication systems had not been consistent with staff reporting a lack of effective communication and team meetings not being held regularly, however most staff felt confident they could voice concerns to managers. Staff were not clear on their roles and responsibilities but work was underway to enhance team communication and team working.

Perry Tree Intermediate Care Unit
We saw patients were asked for their views about the care they received. Views were displayed on a 'You said We did' board in patient areas. Patient safety and Harm Free care information was displayed, for example, there had not been pressure ulcer on the unit for 24 days on the day we visited, and there had not been a fall for seven days.

Anne Marie Howes Intermediate Care Unit
Performance and safety data were clearly shown on the ward notice board, including actual and planned staffing levels and feedback from patients. Staff were clear on their roles and responsibilities and said there was good communication with local leaders.

Good Hope Hospital Community Unit 27
There were fortnightly visits by the patient experience team to assess satisfaction with the service. Results were displayed in ward areas. In response to patient views, staff had arranged for some radios and headphones for patients to use, and were intending to commence regular coffee morning social event. The menus for meals have been amended to provide more traditional food that elderly patients are familiar with. This was a result of responding to patient feedback about the type of food they would like to eat.

Heartlands Hospital Community Unit 29
There were fortnightly visits by the patient experience team to assess satisfaction with the service. Results were displayed in ward areas. Patient feedback was displayed on ward noticeboards and discussed at staff meetings.

Moseley Hall Hospital
We saw patients were asked about their views about their care. Family members we spoke with told us they were always included and asked for their opinions about care. The wards had information displayed about how they had listened and responded to concerns form patients and those close to them.

West Heath Hospital
We saw patients were asked about their views about their care. Family members we spoke with told us they were always included and asked for their opinions about care. The wards had information displayed about how they had listened and responded to concerns form patients and those close to them.

Innovation, improvement and sustainability

All the ward sisters talked of involving staff in service developments and shared learning from incidents. One ward sister told us how, in order to involve staff, they were arranging an away day for all staff to focus on developing the service to facilitate more effective team working. On the intermediate care units, not all staff felt they were able to contribute ideas to enhance the service. Some staff felt they were not engaged in key decisions made about their service.

The future of some of the units was under review but not all staff felt they could have a say in the planning for future design of the service. Not all staff were able to tell us about the trust's strategic plans for their service.

The inpatient neuro rehabilitation unit (Ward 9) had been proactive in designing an effective and responsive service to meet the needs of this group of patients and had robust systems in place to review the quality of the service. In this ward, clinical outcomes were implemented and being measured, for example for stroke care. The ward used a flexible two week multidisciplinary assessment period to inform the rehabilitation plan for patients. Each patient had

Good

Are Community health inpatient services well-led?

a keyworker to ensure good communication between patients, their relatives and therapists and discharge planning started from the assessment phase with most patients being discharged back to their homes following treatment.

Norman Power Intermediate Care Unit
Not all staff felt they were able to contribute ideas to enhance the service. Some staff felt that they were not engaged in key decisions made about their service. One staff member told us "We have great ideas but we are entrenched".

Perry Tree Intermediate Care Unit
Senior staff told us they did not contribute to trust policy and procedure development and trust policies were not always linked to local practice and local knowledge of their patient groups.

Anne Marie Howes Intermediate Care Unit
Staff did not feel they were able to contribute to new procedure or policy development.

Good Hope Hospital Community Unit 27
Staff felt able to contribute ideas to improve the service.

Heartlands Hospital Community Unit 29
The unit was based in a ward area as part of Heartlands Hospital. The trust was investigating an alternative base as the area was required for acute service use. Ward managers told us that commissioners were supportive of the enhanced assessment unit activity particularly in view of the release of pressure on acute wards during winter pressure periods.

Moseley Hall Hospital
Staff felt they were able to contribute ideas to improve the service.

West Heath Hospital
A new purpose built dementia unit was in the process of completion and was designed to support people living with a dementia, used best practice guidance to inform the design of the environment and also the way that care was to be delivered.