

Liverpool Community Health NHS Trust

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Community health inpatient services

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Liverpool Community Health NHS Trust. 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 Liverpool Community Health NHS Trust and these are brought together to inform our overall judgement of Liverpool Community Health NHS Trust

Summary of findings

Ratings

Overall rating for Community Health Inpatient Services

Requires Improvement



Are Community Health Inpatient Services safe?

Good



Are Community Health Inpatient Services caring?

Good



Are Community Health Inpatient Services effective?

Requires Improvement



Are Community Health Inpatient Services responsive?

Requires Improvement



Are Community Health Inpatient Services well-led?

Requires Improvement



Summary of findings

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Summary of findings

Overall summary

Services were safe and there were suitable processes in place in terms of identifying and reporting incidents. In addition, systems enabled learning to take place from incidents including serious untoward incidents (SUIs). The risk data for inpatients highlighted falls as an area of concern and this has been highlighted and actions taken; the number of falls had been decreasing.

Staffing levels were suitable; in fact, numbers of nursing staff were in excess of requirements in certain areas. There was a commitment to ensure nurse staffing levels, and staffing in general, remained safe and a nationally recognised tool was being used to monitor this.

Medicines management and related processes had improved, particularly on ward 35, and administration of medicines was done safely. Appropriate training was in place for nursing staff including record keeping and use of controlled drugs.

We found the acuity of some patients on the wards to be greater than expected, to the extent that, on occasion, patients were admitted from nearby acute trusts only to be promptly re-admitted back to the acute trust.

The effectiveness of the service was variable. In terms of rehabilitating patients and preparing patients for discharge home or to a less acute healthcare setting, the service struggled to meet these objectives with many patients because of increased levels of acuity. Rehabilitation and related activities, such as encouraging patients to eat at a table or walking independently was less than expected. In addition, activities to support patients to remain engaged and relieve boredom were limited. The acuity of some patients was a key reason for reduced rehabilitation therapy but there also seemed to be a lack of direction and discharge planning with many patients.

We recognised the progress made in terms of staff training and support, particularly on ward 35, and staff we spoke with acknowledged the improvements made in ensuring staff had up-to-date skills and knowledge. Some progress had been made with clinical supervision, particularly for nursing staff, but further development was required.

We observed, in the main, positive interactions between staff and patients and the majority of staff were caring, respectful and supportive. However, there were some staff who were not as approachable and were unnecessarily abrupt.

The majority of patients spoke highly of the care they received and felt that staff worked hard to meet their needs. There were some themes from patient feedback and some patients felt there was a lack of stimulation / activities on the ward and patients were not always aware of their care plan / goals.

We observed staff providing emotional support to patients during the inspection but there was limited evidence within nursing documentation about how best to support some patients with their emotional needs. Some patients we spoke with felt that support in relation to their emotional needs could have been better.

Staff worked hard to meet the needs of people who used the service but the plans of care did not always accurately reflect the overall needs of people. For example, some patients had emotional and / or dementia related needs and these were not always fully addressed.

The rehabilitation needs of some patients, particularly for those wanting to walk more independently, were not always adequately being met because of a conflict between the need to prevent falls versus needing to actively encourage mobility. Physiotherapy staff felt that the increased focus on reducing falls was having a negative impact on rehabilitation which was lengthening people's stay unnecessarily.

The trust was making steps to review the service, its design and purpose, but at the time of the inspection many patients did not meet the correct criteria for rehabilitation.

Staff spoke positively about the new leadership team and increased visibility of senior staff. Staff were also positive about the changes in culture and it was described as more open and transparent.

Many staff were unclear of the vision and future strategy for the service which made some feel anxious. However, there was open consultation happening to discuss the future model of the service.

Summary of findings

There was a sense at ward level that clinical leadership could have been stronger, particularly in terms of patient

discharge and patient admissions. This had been recognised by the trust and changes were being made to support senior nurses on the ward in making such decisions.

Summary of findings

Background to the service

The in-patient beds (inpatients unit), within the trust, spanned three wards comprising a total of 77 beds across two sites; South Sefton and Liverpool. There was one community ward based within University Hospital Aintree and a further two wards based within the Broadgreen site of Royal Liverpool Broadgreen University Hospital Trust. The portfolio of inpatients services worked in collaboration with the wider Liverpool Community Health intermediate care services and acute providers to contribute to managing a whole system approach.

Patients were referred from acute trusts to continue their nursing intervention and rehabilitation (step down) or

from primary care (step up) with the ultimate aim of returning to their home, or other appropriate setting, with on-going support from community services if appropriate.

There were approximately 700 admissions each year across all wards within intermediate care supporting the wider agenda of inappropriate admissions or re-admissions to acute beds and supporting the care closer to home agenda.

The team was multi-disciplinary, comprising over 100 staff including advanced nurse practitioners, GPs, nurses, social workers, occupational therapists, physiotherapists, podiatrists, health care assistants, therapy assistants and ward clerks.

Our inspection team

Our inspection team was led by:

Chair: Fiona Stephens, Clinical Quality Director, Medway Community Healthcare

Head of Inspection: Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; School Nurse, Health Visitor, GP, Nurse, 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.

Why we carried out this inspection

Liverpool Community Health 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.

Summary of findings

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 Liverpool Community Health NHS Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between

13 and 15 May 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 23 locations including three community inpatient facilities ward 35 Aintree Hospital, and wards 9 and 11 in the Alexandra Wing, Broadgreen Hospital. The remaining locations included three walk-in centres and various community facilities. We carried out an unannounced visit on 13 May to the evening district nursing services.

What people who use the provider say

We spoke with several patients, and people's family and family friends, across the wards we visited. The majority of patients spoke highly of the care they received and felt that staff worked hard to meet their needs. There were

some themes from patient feedback and some patients felt there was a lack of stimulation / activities on the ward and patients were not always aware of their care plan / goals.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

- The trust should continue to work with partners to ensure appropriate patients are admitted to the intermediate care rehabilitation beds that fulfil the admission criteria and therefore benefit from rehabilitation.
- The trust should further refinement and embedding of the supervision arrangements is required on the inpatient wards.

- The trust should ensure that record keeping should be improved to reflect the needs of patients and the care they have received.

Action the provider **COULD** take to improve

- Ensure that patients are supported appropriately at meals times and provide assistance only where required.
- Support staff to recognise when their approach may not be as caring as it should be.

Liverpool Community Health 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

Services were safe and there were suitable processes in place in terms of identifying and reporting incidents. In addition, systems enabled learning to take place from incidents including serious untoward incidents (SUIs). The risk data for inpatients highlighted falls as an area of concern and this has been highlighted and actions taken; the number of falls has been decreasing.

Staffing levels were suitable; in fact, numbers of nursing staff were in excess of requirements in certain areas. There was a commitment to ensure nurse staffing levels, and staffing in general, remained safe and a nationally recognised tool was being used to monitor this.

The wards were visibly clean and staff had an appropriate level of understanding in relation to the infection control measures required to reduce the risks of cross infection, for example, hand hygiene and use of personal protective equipment.

Medicines management and related processes had improved, particularly on ward 35, and administration of medicines was done safely. Appropriate training was in place for nursing staff including record keeping and use of controlled drugs.

We found the acuity of some patients on the wards to be greater than expected, to the extent that, on occasion, patients were admitted from nearby acute trusts only to be promptly re-admitted back to the acute trust. However, the trust was aware of the pressures to admit unsuitable patients and was making decisive steps to improve the situation.

Incidents, reporting and learning

The trust provided data showing the number of incidents recorded via the trust's incident reporting system, Datix, for the six month period from 1 November 2013 to the end of April 2014. There were a total of 2511 incidents the bulk of which were patient and staff related (1716 patient related and 582 staff related). For in-patient services, known as

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bed-base, there were in the region of 180 reported incidents over the six month period. The majority of the incidents, for bed-base, were classed as minor; the number of major and moderate incidents was comparatively low. The trust had recently taken part in a national benchmark exercise for intermediate care but data from the exercise was not yet available at the time of the inspection.

The trust provided trust-wide information about incidents and complaints in an annual report (2013/2014) and this provided detailed information about complaints including lessons learnt and SUIs.

In relation to trust-wide serious untoward incidents (SUI's), pressure ulcers were the cause of most SUI's. In all cases, a root cause analysis investigation was undertaken and lessons learnt distributed. For inpatients, the interim manager informed us that there had been one grade 3 sore SUI for 2013/2014 and the incident was fully investigated and lessons learnt disseminated. There had been no grade 4 pressure sore SUIs for 2013/2014.

The interim manager for inpatients described how incident reporting and staff awareness of the need to openly report incidents had improved and the trust's approach to recording and learning from incidents had improved. On a weekly basis, harm meetings were held and attended by ward managers and the interim manager for inpatients. The harm meetings reviewed all incidents recorded during the relevant weeks and provided opportunity to pick up on any developing trends. The harm meetings were seen as a positive forum for reviewing incidents and from a general perspective, the interim inpatients manager had no evidence to suggest staff were not reporting incidents when they should.

We were informed that incidents relating to medication errors had increased but this was partly due to the introduction of new processes and an increased awareness by staff around reporting. In relation to pharmacy and incidents, we were informed that all medicine incidents (including minor events such as missing signature on administration record) were logged on Datix. The ward managers and pharmacists received regular safety alerts and these were openly discussed with staff on the wards.

In addition to weekly harm meetings, there were two weekly share and learn meetings. Such meetings provided opportunity for staff to discuss incidents and share the learning from incidents.

We spoke with nursing staff on the wards about safeguarding and the process in place that enabled safeguarding concerns to be identified and reported. Staff were clear about abuse, the different types of abuse and how to report concerns. A safeguarding issue occurred during the inspection and we observed correct procedures being followed in order to report the concerns and protect the people involved. The ward managers we spoke with said there had been increased awareness by staff in relation to safeguarding and training was provided to all relevant staff.

Cleanliness, infection control and hygiene

In relation to cleanliness and infection control, we found the ward environments to be visibly clean and staff understood key infection control practices, such as, the need for strict hand hygiene and isolation of patients with active symptoms of loose stools. Staff described how the infection control team were approachable and actively involved in improving practice on inpatients. We spoke with a member of the infection control team and it was recognised that bladder infections were a key risk for patients on inpatients and that urinary catheters were the most commonly used, and high risk, indwelling invasive device. The infection control team had developed a relatively new passport system where a patient carried a card showing their history of catheter use and previous infections; this was taken with the patient during any admissions to hospital or other healthcare facility.

We observed staff providing care and support to patients and found hand hygiene practices were to a good standard including use of alcohol hand rub and washing of hands using soap and running water. Gloves and aprons were also used appropriately.

We reviewed the infection control safety dashboard for between April 2013 and March 2014 and it was evident that infection control audits were regularly undertaken including hand hygiene and cleanliness. In relation to inpatients, catheter audit compliance for April 2013 was low but compliance had dramatically improved throughout the rest of 2013. In relation to cleanliness, the cleanliness scores for wards 9 and 11 were consistently acceptable but scores for ward 35 were red or amber in four out of 11 assessments.

Maintenance of environment and equipment

During the inspection we spoke with staff about equipment and observed key pieces of equipment such as beds,

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mattresses and equipment used to support people during occupational and / or physiotherapy sessions. Equipment was well maintained and in many cases relatively new. In many cases, physiotherapy and occupational therapy equipment looked very new and it was acknowledged by staff that equipment was intensively used.

Medicines

We closely reviewed medicines during the inspection across all of inpatients. We watched nurses across all three wards (9, 11 and 35) administering medicines and the medicines were administered safely during medicine rounds. Administration records on charts were always signed before the nurses took the medicines to the patient. Prescriptions were written clearly and signed. Morning medicines are prescribed at 8am. In practice, the morning 'round' started at 9 – 9.30am. There were no 'gaps' in administration records and a 'missed dose' audit is completed each night; this was done by the night nurses. In addition, medicines in the medicines storage rooms (keypad access) were all in locked cupboards or the locked medicine refrigerator. The trust's inpatient medication storage audit in February 2014 found that all wards achieved 100% compliance with fridge temperature recordings. We checked a sample of controlled drugs and looked at the controlled drug registers on the wards; stocks were correct.

Records

We reviewed records during the inspection, particularly nursing and allied healthcare professional records. Records including fluid balance charts, food charts and risk assessments, were completed accurately and the main notes were set out in a logical order. We reviewed care plans and the detail in them was variable. We spoke with patients about their care needs and their notes did not always fully reflect the care being provided. Two patients we spoke with on ward 9 were concerned about the lack of information in their records about their care. One patient was confused and lacked insight into what their care needs; their notes did not provide any information on how to manage / support the patient with their confused state. Some nursing notes we read also lacked a sense of empathy. For example, one patient had times when they would cry and there was very little information in the nursing records about the emotional support needed and how to support the person.

Assessing and responding to patient risk

We spoke with the interim inpatients manager about assessing and responding to patient risk. The trust, including inpatients, had an early warning score system, called MEWS, in place and this also formed part of the admission criteria. We reviewed the admission criteria and it was dated January 2014. The admission criteria had been developed to support the smooth transfer of care between accident and emergency departments / primary care providers and inpatients units provided by the Trust.

We had concerns across inpatients in relation to admitting of patients and the acuity of existing patients. Senior nursing staff frequently described situations where staff from nearby acute trusts would request patients to be admitted to inpatients who did not meet the admission criteria. Examples were provided where band 6 nurses from inpatients had reviewed patients at a nearby trust and determined that certain patients were not suitable for transfer. The nurses would then arrive on shift the following day to find the patient/s had been transferred regardless. In some instances, this meant the patient/s needed to be re-admitted back to the nearby acute trust.

We were also informed that staff at nearby trusts, on occasion, did not always provide a full picture in terms of patient's health status and inpatients would accept patients only to find their health status was worse than described. Again, this had led to patients having to be discharged back to the acute trust. Whilst on inspection on ward 11, on the 15 May, a patient was admitted who was a high risk of falls and who did not meet the admission criteria; nurses said the information passed to them prior to the admission was not accurate. It was likely the patient needed to be re-admitted back to the acute trust.

We reviewed staffing levels during the inspection across inpatients, including ward 35, and there was a suitable compliment of staff and skill mix. In some instances, staffing was above the required number and this was because a ward had recently been closed so extra staff were available. We spoke with the interim inpatients manager and it was the intention to ensure that nurse staffing levels were appropriately maintained. The trust used the Royal College of Nursing safer staffing tool and this was used as the benchmark.

If there were staffing pressures, ward managers were aware to escalate concerns to the interim manager for inpatients in order to assess the need for extra nurses.

Are Community Health Inpatient Services safe?

Deprivation of Liberty safeguards

We reviewed how inpatients took into consideration Deprivation of Liberty safeguards (DOLs). There was some positive work in this area, for example, an action plan had been developed assessing the impact of the changes in guidance, in relation to DOLs following the Cheshire West judgement.

We reviewed DOLs training schedules for May 2014 and it was clear that key staff were supported and trained in DOLs. Staff we spoke with on the wards had a reasonable understanding of DOLs but all were able to describe who they would contact for support.

Managing anticipated risks

Potential risks to the service had been considered including winter pressures and disruptions to staffing. There were examples where risks to service delivery had been considered and mitigating steps put in to place. For example, a ward recently closed and the movement of patients and staff was completed with minimal risk to patient safety.

Major incident awareness and training

There were processes in place to manage major incidents and training was available for specific staff. This ensured risk to patient safety were minimised if a major incident occurred.

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.

The effectiveness of the service was variable. In terms of rehabilitating patients and preparing patients for discharge home or to a less acute healthcare setting, the service struggled to meet these objectives with many patients because of increased levels of acuity. Rehabilitation and related activities, such as encouraging patients to eat at a table or walking independently was less than expected. In addition, activities to support patients to remain engaged and relieve boredom were limited. The acuity of some patients was a key reason for reduced rehabilitation therapy but there also seemed to be a lack of direction and discharge planning with many patients.

We recognised the progress made in terms of staff training and support, particularly on ward 35, and staff we spoke with acknowledged the improvements made in ensuring staff had the update skills and knowledge. Some progress had been made with clinical supervision, particularly for nursing staff, but further development was still required.

Evidence based care and treatment

We observed nursing care and that of allied healthcare professionals including physiotherapy and occupational therapy. The majority of practices were observed followed evidence based guidelines. However, there was a lack of clinical tools used by occupational therapy and physiotherapy staff.

We spoke with the interim inpatients manager about how the latest evidence based information was disseminated throughout the trust, for example, National Institute of Health and Care Excellence (NICE) guidance. When new guidance was introduced, an inpatients ward manager and / or a matron were involved in ensuring the guidance was implemented. For example, recently, new intravenous (IV) therapy guidance had been introduced by NICE and the IV therapy team, along with a matron, were responsible for ensuring its implementation.

We reviewed capacity to consent; this formed part of the admission criteria and there was a specific section referring to a patients' capability to consent to treatment. Implied

consent was also part of the care process and we observed nurses asking patients questions whilst supporting them with their care needs. In many instances, nursing staff did not simply assume what patient's preferences were.

In one set of notes we observed where a nurse had written 'verbal consent obtained.' However, there was no explanation as to why the patient was not able to write/ sign the documentation and or what alternative approaches could have used.

Pain relief

We found no issues with pain management. The patients we spoke with were comfortable and they described how staff responded promptly if they described feeling uncomfortable and/or in pain. A GP we spoke with on ward 35 was happy with the pharmacy service and they described how the pharmacists worked well with the multidisciplinary including pain management.

Nutrition and hydration

We reviewed patient documentation relating to nutrition and hydration including risk assessment tools. Of the documentation we reviewed, weight charts, fluid charts and food charts had been accurately completed. Nutritional screening tools were used and these were based on nationally recognised standards.

We spoke with the relative of a patient on ward 9 and their relative had been on the ward for about six months; they felt everything was okay and they had no worries about the care being provided. They described how their relative was fed and hydrated well. They also said the nurses were nice people, they were doing a good job and their relative was happy with the care provided.

Patient outcomes

We spoke with the interim inpatients manager about patient outcomes including the use of data to improve quality of services and benchmarking of outcomes. As discussed previously, the trust had very recently been involved with a national benchmarking group for community trusts but the final data was not available for review at the time of the inspection.

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There were processes in place to monitor patient outcomes including weekly harm reports. The harm reports provided useful information including total number of incidents reported and the level of harm, compliments and falls.

We spoke with a GP on the ward and they described how, on occasion, the nearby acute trusts had strong 'admission avoidance.' This was seen to have a negative impact on some patient's well-being. For example, there had been instances in the past where urgent treatment, for example with kidney failure, had been delayed because nearby acute trusts did not accept the patient. This then required staff on the trusts inpatient wards to admit the patient via accident and emergency which caused delays in treatment the consequences of which were serious.

There were a disproportionately high number of patients across inpatients who were not receiving any form of rehabilitation therapy because they were too unwell. We observed limited therapy activity for what should have been very active wards in terms of people being supported to walk around the wards and spending time with physiotherapists and occupational therapists. For example, one patient we observed was at risk of falls and was not having any rehabilitation. The patient had been on the ward for two months and was confused, had recently had an acute stroke and leg artery bypass. They also had a urinary tract infection, were diabetic and on intravenous antibiotics.

Performance information

There was an open culture in terms of incident reporting and learning from incidents. Information was disseminated to staff in a number of ways including ward meetings and harm meetings. The trust recognised that performance information relating to falls was a particular concern for inpatients and the Falls Safe Measures Audit 2013 supported this. The trust introduced a Fall Safe Care Bundle across the three bed-base wards to address safety concerns.

The trust had an annual clinical audit plan which included 52 audits of adult's services; these had been completed between September 2013 and February 2014. In relation to inpatients, recent audits conducted included falls, urinary catheters, environmental cleanliness and medication. The audits we reviewed were comprehensive and included detailed action plans where improvements were required.

Competent staff

We reviewed information in relation to staff training and professional development including induction, mandatory training, appraisal and clinical supervision. Training needs analysis had been completed for all staff and it was known what training each staff group was required to complete.

We reviewed mandatory training data for all three wards and overall compliance at the time of inspection was around 71%. This had increased from the previous year which was around 60%. We could clearly see the efforts being taken to improve delivery of and attendance at mandatory training and compliance figures were continually improving. Induction compliance figures for inpatients were acceptable.

There were also significant increases in attendance at non-mandatory training and focus on essential skills training for staff including catheter care, dementia awareness and wound assessment.

There had been a recent focus on developing the appraisal process and the trust had introduced a new performance appraisal process towards the end of 2013. We spoke with the ward manager for ward 35 and it had been recognised that during the previous year appraisals, mandatory training and essential skills training had fallen behind. However, there had been a focus on improving compliance and this had been achieved.

Plans were in place to improve supervision for staff and it was recognised that work still needed to be done to fully embed the process. A clinical supervision policy had been developed in 2013 but the priorities had been on mandatory training. Clinical supervision was happening with some nursing groups and there were plans to continue to develop compliance with clinical supervision; particularly for nursing staff.

Use of equipment and facilities

We spoke with ward managers and allied healthcare professionals including physiotherapists and occupational therapists. There were no concerns raised about equipment or the facilities available to support patients with their rehabilitation needs. However, we recognised that the facilities available were not used to full effect because many patients were not well enough to engage in rehabilitation activities.

Are Community Health Inpatient Services effective?

Multi-disciplinary working and working with others

We observed patient care and multi-disciplinary team working between nurses, GPs and allied healthcare professionals such as occupational therapists and physiotherapists. Staff commented that working relationships had improved with the new management structure.

We spoke with a therapies manager and they felt that structures and governance were much improved and the introduction of a therapies lead had enhanced working arrangements across inpatients, especially between nursing and allied healthcare staff.

In terms of working with others, the interim manager for inpatients described how steps had been taken to develop liaison with others including external stakeholders. For example, because of recent concerns about ward 35, the local clinical commissioning group were invited in to the trust to openly discuss the concerns and ways to improve the service.

Co-ordinated integrated care pathways

We spoke with staff about integrated care pathways and it was felt that, in general, discussions between multi-disciplinary teams were structured and the handover of patients was well co-ordinated. We observed positive and constructive working relationships between inpatients and social services in the planning of and integration of care.

The main area of concern was the relationship between inpatients and local acute trusts. There were examples where patient care was affected because co-ordination of care was not managed well. For example, some patients were admitted to inpatients from the nearby acute trust and promptly re-admitted; this was often due to poor communication and sharing of inaccurate information.

There were also some weaknesses in terms of discharge planning. Several patients on inpatients no longer required the levels of care and support they initially required and were suitable for transfer to other healthcare facilities or social care. In some instances, with some patients, there was limited discharge information and / or discharge planning.

Are Community Health Inpatient Services caring?

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

We observed, in the main, positive interactions between staff and patients and the majority of staff were caring, respectful and supportive. However, there were some staff who were not as approachable and were unnecessarily abrupt.

The majority of patients spoke highly of the care they received and felt that staff worked hard to meet their needs. There were some themes from patient feedback and some patients felt there was a lack of stimulation / activities on the ward and patients were not always aware of their care plan / goals.

We observed staff providing emotional support to patients during the inspection but there was limited evidence within nursing documentation about how best to support some patients with their emotional needs. Some patients we spoke with felt that support in relation to their emotional needs to have been better.

Compassionate care

We observed healthcare staff interacting with patients across all three wards and the compassion shown by staff varied. Some staff were compassionate in their approach and were respectful. However, on occasion, some staff, mainly nursing staff, were slightly abrupt with patients. We discussed our observations with the interim manager for inpatients and these issues had already been noted; the interim manager was planning to support staff to improve.

We spoke with patients and patient's relatives across all the wards and there was an overarching sense that nurses worked hard and did their best for the patients. One patient we spoke with said that "the day staff are very good but night staff had a bad attitude; they have no time for you." Another patient we spoke with said "nothing was too much trouble for the nurses" and staff supported them when they felt upset.

A theme that came out from discussions with patients were that some were bored and it was felt that stimulation / activities on the wards was limited.

During meal times we observed staff checking if meals were within easy reach of the patient and the majority of staff supported patients to eat and drink in a kind manner. We

observed some staff that were a little abrupt when supporting patients with their meals and sometimes positioned themselves at the side of the beds that made eye contact with the patient difficult.

Dignity and respect

Overall, we found that staff treated patients with dignity and were respectful. However, there were isolated examples of some nurses not communicating with patients very openly and focusing on the task they were required to do and not involving the patient. One patient we spoke with described how staff were very helpful and treated them with dignity. Another person said "We get treated with respect, they are proper nurses." A third patient we spoke with said staff were very pleasant but there were no activities on the ward; they passed the time by reading.

Patient understanding and involvement

Of the patients we spoke with, there were mixed responses as to the level of involvement they had in planning their care and their understanding of their care plan. Some patients had some idea of why they were in hospital but, overall, patient's awareness of their care plan and discharge plan was limited.

We observed meal times during the inspection and the support provided to patients was variable. On ward 9, we asked if we could see the ward menus but there weren't any available on the ward. A staff member said the menus should have been at the end of every bed. We asked about the process for ordering meals and how patients were offered choice. Kitchen staff spoke with all patients in the morning and read out the menu cards and noted down patients' preferred choices. A patient we spoke with did not like the menu being read out to them as they were capable of reading themselves. They would have preferred to have had a menu to read and make food selections in their own time.

Emotional support

During the inspection there were instances when patients required emotional support and staff were supportive and spent time reassuring patients and empathising. However, where patients were in need of on-going emotional support we found limited information or emotional support planning within patient's records. For example, one

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patient we spoke with was quite confused and had limited insight in to why they were in hospital; there was no information in the nursing records about this or how to manage the person's variable cognitive abilities.

Promotion of self-care

A central part of the in-patient service was to promote self-care and support patients to re-build skills and confidence prior to discharge home or a less acute healthcare setting. We found that a significant number of patients were not

able to engage in rehabilitation activities because of their health status. An occupational therapist we spoke with felt that there had been an increasing number of patients with cognitive impairment which affected the ability to provide rehabilitation.

On wards 9 and 11 on one particular day, there were no patients mobilising independently which gave some indication of the acuity level of the patients.

Are Community Health Inpatient Services responsive to people's needs?

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

Staff worked hard to meet the needs of people who used the service but the plans of care did not always accurately reflect the overall needs of people. For example, some patients had emotional and / or dementia related needs and these were not always fully addressed.

The rehabilitation needs of some patients, particularly for those wanting to walk more independently, were not always adequately being met because of a conflict between the need to prevent falls versus needing to actively encourage mobility. Physiotherapy staff felt that the increased focus on reducing falls was having a negative impact on rehabilitation which was lengthening people's stay unnecessarily.

Service planning and delivery to meet the needs of different people

There was some evidence of service planning and it was recognised that the current patient group, in many instances, did not meet the criteria for the service. For example, as noted previously, the wards appeared more like acute elderly medical wards as opposed to rehabilitation wards.

The needs of people in many instances were not being fully met because any plans for rehabilitation were often on hold due to patient's ill health. The issues for this were multifaceted but were a mixture of pressure from nearby acute trusts to admit patients, who were known to be unsuitable, and staff from inpatients not being supported to not accept certain patients.

Long term plans for the service have been discussed and admission criteria had been reviewed. The trust is part of the Healthy Liverpool Program and workshops were underway to discuss the future service needs for the Mersey area. The adult division was reviewing its design for the future and this could include having less inpatients beds and providing more care and support in people's homes.

Access to care as close to home as possible

We spoke with staff and patients about access to services. Patients we spoke with, in the main, said that their care had been provided within an appropriate distance from their home. Some patients had been transferred from larger nearby acute trusts but this still meant services were provided locally for most.

Staff described how they had good links with community teams and services. Once patients were discharged from inpatients, this meant there was reasonable continuity of care either in the patient's home or close to the patient's home.

Access to the right care at the right time

The needs of patients, in some instances, were relatively complex and, fortunately, most staff had the necessary skills to cope. However, some of the GPs we spoke with felt that they were overburdened in many instances because nurses had become deskilled. For example, GPs were called regularly to take bloods and insert cannula. Some GPs said their work-load and priority setting would be helped if the gaps with some nurse's clinical skills were addressed.

We found that staff, with some patients, were not clear about the reasons patients were still on the wards. Many patients were suitable for discharge and in some cases; delays in arranging social care support were holding things up. There was a lack of ownership of the problem of delayed discharges and staff felt there was some leadership lacking in terms of ensuring patients were discharged at the right time and in a timely way. However, the average length of stay for patients on inpatients was within average limits compared to other community trusts.

Community services were provided in people's home as needed and clinics and groups were established in community locations. We found generally good access to services across the trust, with some services proving flexible clinic opening times including weekends and out of hours.

Meeting the needs of individuals

We reviewed patient records and spoke with patients and relatives about their care. We found that the initial risk assessments, the results of which fed in to the care planning process, were completed accurately in most instances. However, some aspects of people's care, on occasion, were not covered in adequate depth within the care plans. Some examples were provided earlier but detail was often lacking when it came to emotional support.

As briefly discussed, people's needs were often met, at a basic level, including support with eating and drinking and personal hygiene. However, the service did not always

Are Community Health Inpatient Services responsive to people's needs?

provide what it was set up to do with many patients and that was to rehabilitate to prepare people to return home or to a less acute healthcare setting. For example, the key aim for one patient who had recently had surgery that affected their mobility was to support them to walk using walking aids. However, the person's assessment in terms of risk of falling meant that physiotherapy staff were limited with the amount of therapy they could provide. The balance of risk versus the need to rehabilitate was not ideal in this case.

This was true with other patients, in that the risk of falls assessments meant that rehabilitation input was limited. Many patients with a high risk of falls had a buzzer that alarmed if they stood up unaided; physiotherapy staff said that rehabilitation was slow because nursing staff were sometimes reluctant to detach the falls buzzer.

We reviewed the plans of care for some more vulnerable patients, for example, those with dementia. Again, the balance between falls safety and the need to provide

rehabilitation was not always suitable based on the overall objectives of the service to rehabilitate. In addition, for patients with dementia, care plans did not always provide clear guidance on how to meet people's dementia related needs.

Complaints handling (for this service) and learning from feedback

We found that the service (inpatients) had suitable processes in place to manage complaints, learn from complaints and disseminate learning to staff. Nurse managers we spoke with said the service did not receive a significant amount of complaints and feed-back in terms of compliments far out-weighed the number of complaints.

We discussed the complaints process with staff and they were familiar with the trust process and all described how patients could liaise with the patient advice liaison service (PALS) where necessary. We reviewed a number of complaints and observed that correct processes had been followed in-line with trust policy.

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.

Staff spoke positively about the new leadership team and increased visibility of senior staff. Staff were also positive about the changes in culture and it was described as more open and transparent.

Many staff were unclear of the vision and future strategy for the service which made some feel anxious. However, there was open consultation happening to discuss the future model of the service.

There was a sense at ward level that clinical leadership could have been stronger, particularly in terms of patient discharge and patient admissions. This had been recognised by the trust and changes were being made to support senior nurses on the ward in making such decisions.

Vision and strategy for this service

We spoke with a variety of staff about the vision and strategy for inpatients; there were mixed responses. However, there was a distinct acknowledgment by the majority of staff that things had changed and were changing for the better with the new management structure. Staff described how quality of care was central to the trust's vision and developing a more open culture.

A distinct and clear vision and strategy was not fully embedded but it was clear that the direction and purpose of the inpatients service was under review. The interim inpatients manager described how the 'care closer to home' agenda would need to be considered as the service moves forward.

Workshops were taking place in relation to re-designing the vision for the adult division and this was a positive sign in terms of engaging with staff and seeking people's views.

Governance, risk management and quality measurement

The existing systems and processes seemed to capture risk and measure quality to a reasonable extent. As discussed briefly earlier, staff reported incidents, Datix data was closely analysed and lessons learnt were clearly documented and disseminated.

We reviewed the risk register for inpatients and there were a total of 26 risks, of which 11 were deemed as high risk; not accurately knowing the acuity of patients being one of them. The risk register was adequately detailed and control measures were clear to see.

There was positive information sharing at ward level and discussions held at harm meetings enabled risk to be openly discussed.

In relation quality, monthly inpatients quality dashboards were produced and we reviewed the one for April 2014. It was clear to see that the key challenges for inpatients were around demand, patient acuity and occupancy. Other key challenges were staff sickness and falls.

Leadership of this service

We spoke with staff about existing leadership within the service and an overarching theme was that things were changing and time was needed for changes to embed. Staff described feeling unsettled to a certain degree as staff moved positions and leadership positions changed.

Particularly on ward 35, there was a disproportionate amount of nursing leadership positions (band 6 nurses) and this was a result of the ward closure described earlier in the report. The excessive number of band 6 nurses affected the balance in terms of leadership and the hierarchy for making decisions. Staff felt that senior leadership presence was lacking to a certain degree in some cases as no one person would make a clear decision, for example, with discharging patients who no longer need to be on inpatients.

Culture within this service

The vast majority of staff we spoke with described distinct improvements with the culture within the trust and throughout inpatients. Staff spoke highly of the increased visibility and more personal approach of the relatively new executive team.

Public and staff engagement

There was evidence of active steps being taken to engage with staff including ward meetings, staff surgeries and matron's surgeries.

Are Community Health Inpatient Services well-led?

Staff commented that the new executive team engaged with staff on a regular basis and visited departments in person to speak with people and engage face-to-face.

We were informed that patient surveys were undertaken periodically to gain the views of patients who had used services and that; on the whole, patient's views and experiences were positive. Results from surveys were disseminated to all staff and action taken to address identified shortfalls in service provision / quality.

Innovation, improvement and sustainability

The trust had introduced a leadership development programme for senior healthcare staff. The programme was called Licence to Practice and feedback from staff on the course was positive.