Barnet, Enfield and Haringey Mental Health NHS Trust

RRP

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RRPX1	Magnolia Unit, St Michael's Site, Gater Drive, Enfield, EN2 0JB	Magnolia Unit	EN2 0JB

This report describes our judgement of the quality of care provided within this core service by Barnet, Enfield and Haringey Mental 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 Barnet, Enfield and Haringey Mental Health NHS Trust and these are brought together to inform our overall judgement of Barnet, Enfield and Haringey Mental Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good l

Patients were supported and treated with dignity and respect and were involved as partners in their care. We observed many examples of compassion and kindness shown by staff. A member of the staff team had won the trust's 'compassion in care' award in 2015.

We found that patients were protected from abuse and avoidable harm. Staff were clear on their responsibilities to raise concerns and report incidents. There were appropriate arrangements in place to monitor incidents.

Risks to patients were assessed and monitored on a day to day basis. Staff responded appropriately to changes in their needs. There were systems in place to manage changes in demand and disruptions to services. We found that patients care and treatment was regularly reviewed and records were updated. Information about their care was routinely collected and used to improve services. We found patients rights were protected and consent to care and treatment was obtained in line with the current legislative framework. Staff were aware of, and procedures were in place to support staff in applying the principles of the Mental Capacity Act 2005.

The Magnolia unit participated in local audits. Information from audits and other monitoring activities was shared internally and externally and understood by staff. We saw several examples of how monitoring information from across the trust had been used to improve services.

Staff were qualified to do their jobs and supported to deliver effective care and treatment through training, supervision and appraisal. Staffing levels were appropriate at the time of our visit although there was high use of agency staff.

Patient's needs were met through the way services were organised and delivered. Services were planned and delivered to take into account local need. The premises were appropriate for patients who use services. Complaints and compliments information was displayed in the ward areas. The trust monitored complaints. Complaints were responded to in a timely way and improvements were made to people's care and treatment as a result of complaints or concerns.

Services were well-led at a divisional level. There were clear governance arrangements in place. Staff were aware of the trust's vision and values and the strategic goals of the trust. The Magnolia unit had a risk register in place to monitor and address current and future risks. However the manager of the Magnolia unit had been an interim manager for over two years. This post needed to be filled on a permanent basis in order to ensure continuity of leadership.

Staff reported that morale at the unit was high and there was a culture of openness and honesty. However, a lack of available funding had an effect on the unit's ability to introduce improvements and innovate.

Summary of findings

Background to the service

Information about the service

Magnolia unit is a unique inpatient service within Enfield providing short-term inpatient care from St Michael's primary care centre. The unit is an alternative to admission to an acute hospital for clinically stable patients who need nursing services.The focus of the service is on rehabilitation.

The unit aims toprevent avoidable admissions to acute hospitals where a patient cannot be looked after safely at home. The unit provides access to nursing, medical, therapy, specialist nursing services and short term step down care from acute hospitals. Care provision includes rehabilitation, lymphedema, palliative care, and care for people with infections. Services are only available to adults and older people above the age of 18 years who have a GP registered in Enfield.

The unit has 28 rehabilitation beds. It provides short term inpatient rehabilitation services for people who are medically well enough to leave hospital and receive care in a community nurse and therapy led unit. On discharge from the unit, people will be expected to return to their usual place of residence.

The unit is managed by nursing and therapy staff with medical cover provided by a GP practice. A medical professional will visit regularly during the week and cover any emergencies. There is no resident doctor on site. The unit is staffed by nurses permanently based on site who look after people's medical needs and provide assistance with medicines and personal care. Other members of the Magnolia unit team include: physiotherapists**;** occupational therapists**;** speech and language therapists (SALT); and dieticians. The therapy staff are only available Monday to Friday.

Our inspection team

The team that inspected the community based mental health service for older people consisted of six people: three CQC inspectors; a manager from the Department of Health; a nurse; and an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health and community inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, 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?

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

- visited the Magnolia Unit and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service and a visiting relative.

Summary of findings

- spoke with the manager of the Magnolia Unit
- spoke with nine other staff members
- looked at nine patients care and treatment records
- carried out a check of the Magnolia Unit's medicines management
- observed patients taking lunch
- observed a patient being provided with care and treatment from the tissue viability nurse and Magnolia Unit staff
- attended a multi-disciplinary meeting
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the provider say

- Patients and carers were very positive about the care and treatment they received at the Magnolia unit. Words and phrases such as "very caring," "very prompt", "happy with the care," were used extensively in their feedback.
- The Magnolia unit friends and family test (FFT) results dated November 2014 to October 2015, 98% of patients said they were treated with dignity and respect. 89% of patients said they received the information they needed. The average score for people who responded that they would be likely to recommend the service was 97%.

Good practice

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust **should**:

- The trust should ensure access into the unit was secure to prevent unwanted people entering the building.
- The trust should ensure staff continue to complete their mandatory training so they reach the trusts target.
- The trust should ensure a permanent manager is appointed to provide consistent on-going leadership at the Magnolia Unit.

Barnet, Enfield and Haringey Mental Health NHS Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found that the Magnolia unit achieved a good standard of safety. This was because there were robust methods of reporting, investigating and learning from incidents and near-misses that were well understood by staff and were embedded in their daily work. There was a risk register in place that ensured potential risks were known and assessed and appropriate controls were implemented. There were plans to deal with major incident or events that would disrupt the delivery of care.

We saw that patients were protected from the risk of infection. Equipment used in the unit was well maintained. There were safe systems of medicines management.

Records were accurate, comprehensive and current, and supported the delivery of safe care.

There were adequate numbers of suitably qualified, skilled and experienced staff to meet people's needs and staff had completed their mandatory training. There was an ongoing review of staffing numbers, an active recruitment programme and arrangements to ensure any staffing shortfalls were managed on an on-going basis to minimise the impact on patients.

Safety performance

- The Magnolia unit had a good level of safety performance over time. The unit submitted information to the patient NHS safety thermometer. This is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. We saw that the safety thermometer monthly results were prominently displayed on the Unit.
- The number of pressure ulcers over the from September 2014 to the end of September 2015 was three grade 3 pressure ulcers and one grade 4 pressure ulcer. In April and July 2015, there had been one new pressure ulcer acquired on the unit and none for the rest of the year.

Good

Are services safe?

- There were no falls with harm recorded between September 2014 to September 2015. The unit had a 'falls champion', which is a member of staff who had a specialist knowledge in the management of reducing the risk of falls.
- There was one new urinary tract infection assosciated with the use of a catheter recorded between September 2014 and September 2015. This was in April 2015 and the rate was zero for the other 12 months.
- Patient safety alerts issued by the central alerting system (CAS) were cascaded by email to the manager and the Magnolia unit clinical lead. The manager would have to respond to the email stating what actions had been taken in response to the alert. We saw CAS alerts in the unit's treatment room and staff signed and dated CAS alerts when they had read them.

Incident reporting, learning and improvement

- Incidents were reported using an electronic reporting system which also provided reports for managers on reporting activity and incidents. All staff we spoke with were aware of the system and told us they were confident in its use. Staff indicated they felt empowered to report any safety incident or near-miss without any fear of reprisal. This meant people could be sure that staff reported any safety incidents appropriately.
- Magnolia unit kept a record of all the incidents that had occurred in the service. These included details of the incident and how and why it occurred. Actions to mitigate against the risk of recurrence had been formulated and these were appropriate to the incident described.
- A total of 195 incidents had been reported between November 2014 and October 2015. 100% of these were classified as either low or no harm.
- We reviewed a sample of investigation reports submitted by the service. Root cause analysis (RCA) was completed as part of the investigation of incidents. RCA's identified learning from incidents and these lessons were shared across teams.
- Staff confirmed they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within the Magnolia unit.
- A standard agenda was used for staff team meetings. Learning from incidents was discussed and shared with staff at team meetings. We saw the notes of team meetings that demonstrated that incidents, their analysis, lessons learned and outcomes were discussed and communicated to staff. Staff we spoke with told us the discussion and consideration of safety events was frequently part of their routine.
- There had been no serious incidents in the previous 12 months. Staff told us the patient experience team monitored incident reports for themes to ensure incidents were investigated promptly. Learning was shared, for example, the trust's quarterly magazine included case studies from incidents. There were monthly departmental governance meetings. Safety and risk were standard agenda items at the meetings.
- We looked at the clinical governance arrangements for reporting risk. The unit had a risk register and high level risks were escalated to a trust risk register.
- The ward manager and clinical lead were aware of and able to explain the duty of candour. This is to provide to the service user and any other relevant person all necessary support and all relevant information in the event that a reportable patient safety incident occurs. The ward manager said that Magnolia unit always tried to inform patients and relatives of any incidents or concerns without delay.

Safeguarding

- Visitors were required to sign the visitor's book on entry to the unit. However, we gained access to the unit via the main hospital entrance and a corridor that provided access to the day room, as the day room door was unlocked. This meant people were at risk of unauthorised people gaining access to the unit.
- Staff were able to explain the process for making appropriate safeguarding referrals. Staff we spoke with were aware of the Trust's safeguarding leads and knew how to contact them. The leads were described by staff as being helpful and supportive with safeguarding issues.
- The Trust had an up to date safeguarding policy that was issued in June 2010 and due to be reviewed in June

Good

Are services safe?

2016. This meant the policy had not been reviewed in accordance with the Trust's policy. Staff we spoke with were able to explain their understanding of the policy and how they used this as part of their practice.

- Staff told us they received training in safeguarding as part of their mandatory training. All the Unit's staff received safeguarding adults' level one training. Staff received training updates at a level appropriate to their area of work. Staff we spoke with were able to describe the categories of abuse and how they would report potential safeguarding issues. Learning from safeguarding investigations was shared at team meetings and across the service where appropriate.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- The trust's website included contact details for the safeguarding adults' team and local authority safeguarding teams as well as advice for people who use services and their families.

Medicines

- Medicines rounds took place four to five times per day. A pharmacist visited regularly to do medicines stock checks and pharmacy audits. Up to date copies of the British National Formulary were available on the unit.
- Medicines were stored safely with room and fridge temperatures checked regularly and recorded. Medicines were being stored at the required temperatures. Nursing staff' training in medicines administration was up to date.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at the monthly governance meetings. Staff were open and reported medication incidents.
- We found that access to controlled drugs (CD's) was restricted to appropriately designated staff and CD's were secured inside a double locked cupboard. A compliant CD register was in place. We found no discrepancies between the stock, controlled drugs in the cupboard, and the CD register.
- People who wished to manage their own medicines had assessments in place. Medicines pods were available next to patients' beds to ensure patients' medicines were securely stored.
- Medicines for patients being discharged home were ordered in advance from the pharmacy. Patients received a month's supply of medicines on discharge and a discharge summary was forwarded to the patient's GP which included a summary of the patient's treatment and drugs the patient had taken home.

Environment and equipment

- All the equipment servicing records were up to date. Items of equipment had stickers to show when they had been serviced. The manager showed us records that a privately contracted company held the unit's medical device registers and sent reminders when equipment needed checks or servicing. The only equipment that did not have an up to date servicing record was a fire blanket. We drew this to the manager's attention and he made immediate arrangements for all fire blankets to be checked.
- Staff told us they had sufficient access to equipment and where needed replacement equipment would be received in a timely way.
- Clinical and domestic waste was separated and waste bins were covered and operated by foot pedal. Contaminated clinical waste awaiting collection was stored securely in a locked in a store.This ensured there could be no unauthorised access to hazardous waste materials.Sharps waste was disposed of in appropriate receptacles which were properly labelled.
- We noted that a cupboard storing medical gases was unlocked. We further noted that a fuse box cupboard marked "danger 400 volts" was unlocked. We drew this to the ward manager's attention and they immediately arranged for a key code lock to be fitted to the medical gases door and a locksmith attended during our inspection to fit a lock to the fuse box cupboard.

Quality of records

- Patients' records were stored securely on the wards in the nurses' office so confidentiality was maintained.

Good

Are services safe?

- People's personal records including medical records were fit for purpose. We looked at nine care plans and risk assessments, as well as five people's medical notes and referrals; medicine charts, and handover sheets. Risk assessments for falls were fully completed.
- Records were accurate and legible. Patient information was easy to find and was written in a person-centred manner.
- Patient's care plans contained daily rounding charts, these were daily checklists of essential care, for example, these included checks on: mattresses, cushions, skin, continence, fluids, and catheters. We found these were complete and up to date.
- The ward manager told us staff were trained in using the trust's integrated primary care and acute care electronic system; and the unit were working towards patient records being entirely electronic. Administration staff told us that while these systems were being fully implemented they had resorted to e-mailing patients discharge summaries as well as using the electronic system to ensure patients discharge summaries were received by GP's.
- Leaflets explaining patients' rights to access their medical records were available on the ward. The trust's website carried information on people's rights under the Freedom of Information Act 2000. At the time of the inspection 94% of the team had completed the mandatory training on information governance.
- Staff told us people's records were kept for seven years and then destroyed securely. We reviewed the trust's policies on record retention and found that records were kept and destroyed in accordance with the trust's policy.

Cleanliness, infection control and hygiene

- All the areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards during our visit. We observed the domestic supervisor doing a daily walk around to check standards of hygiene and cleanliness on the Unit.
- At the time of the inspection 73% of staff were up to date with the mandatory training on infection control.
- Monthly infection control audits were undertaken. For the year to November 2015 Magnolia unit was fully compliant with standards for infection control. Daily cleaning schedules were displayed on a notice board in the Magnolia unit corridor.
- We saw staff regularly washing their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to. Staff told us they actively challenged anyone who did not follow this policy. At the time of our visit, the unit was achieving trust compliance standards for hand hygiene. We saw that gloves, aprons, and other personal protective equipment (PPE) were readily available to staff. The importance of all visitors cleaning their hands was publicised and we observed visitors using hand gels and washing their hands.
- There were no reported cases of clostridium difficile (C. diff) in the past 12 months. However, staff told us they were providing care and treatment for a person with methicillin-resistant staphylococcus aureus (MRSA). Staff told us the person was being treated in accordance with the trust's policy on MRSA and outbreak management policy, including the person being kept in isolation.
- A programme of training and assessment was in place for 'aseptic no touch technique' (ANTT) for staff. Staff told us all side rooms on the unit could act as isolation rooms.

Mandatory training

- At the time of the inspection the unit had an overall compliance rate of 77% with mandatory training.
- The senior team leader told us the staff training matrix was checked monthly to ensure staff that required training updates were booked onto courses.
- An OT told us there had been delays in the arrangements for new staff receiving moving and handling training; but this had been resolved.

Assessing and responding to patient risk

- Patient's assessments were completed using templates that followed national guidelines. For example, skin integrity, falls risks, nutrition, pain management and activities of daily living. Records we viewed were completed in a timely way and at appropriate intervals.

Good

Are services safe?

- Staff were able to demonstrate an awareness of the key risks to patients. For example, risks of falls and pressure damage. Staff were aware of how to arrange further support by referral for specialist assessment or supply of additional equipment.
- An early warning traffic light system was in place to monitor patients. The system was colour coded; a red or blue outcome should be reported to the clinical lead or manager without delay.
- Risk assessments were fully completed for each patient, these included skin integrity, nutrition, pain assessment, falls risks and activities of daily living. For example, the unit used a skin bundle; this is a systematic assessment process to identify patients who were at risk of developing pressure ulcers.
- Patients who required assistance with moving and handling had detailed plans in place, identifying the number of staff required and equipment needed to assist patients.
- The risk of patients acquiring pressure ulcers was identified as a primary concern for Magnolia unit. Pressure ulcers assessed as a severity of grade two or above were referred for investigation as a serious incident and a RCA was undertaken.
- Therapists such as occupational therapy (OT) and physiotherapists did not provide services at the weekend. However, staff told us that all trained nurses were trained in walking assessments and could put equipment aids in place pending an OT assessment.

Staffing levels and caseload

- The Magnolia unit was a nurse led ward with input from GP's Monday to Friday. Out of hours medical cover was provided by an on-call GP.
- The sickness rates as at 31 July 2015 for the previous 12 months was 4%. The overall staff turnover rate reported for this time period was 15.8%.
- We looked at staffing rotas for the month of November 2015. We saw they were constructed to ensure there were appropriate numbers of staff at appropriate grades on duty to carry on the service. We saw rotas had been amended in the light of unforeseen absences to ensure that the service could continue to operate safely.
- The Magnolia unit's staff team was comprised of 18.64 WTE (whole time equivalent) qualified nurses and 16.46 WTE nursing assistants. This was the number of staff the trust has assessed the service as requiring to provide services based on the needs of the population being served. Information on the skill mix and workload was routinely collected and reviewed by operational managers.
- The ward manager and operational managers assessed the level and acuity of workload, and allocated staff resources to meet the needs of patients. Workload and the complexity of the caseload were discussed and where necessary staffing was flexible to ensure patients' needs would be met.
- The unit had 2.44 qualified nursing staff vacancies and 0.36 nursing assistant vacancies in November 2015. Staff confirmed that flexible staffing and reallocating resources was an option that was used to maintain safe working when necessary.
- When we spoke with staff they all reported that recruitment and retention was good.
- Staff told us they routinely recorded staffing shortages on the electronic incident reporting system. It is important that staffing shortages are recorded as incidents to enable the trust to monitor safe staffing levels and ensure staffing shortages do not pose a risk to patient care.
- The trust provided establishment and vacancy information for community health inpatient services for the previous three months. There were 130 shifts where bank or agency staff were used to cover staff absence or vacancies and six shifts were staff absence or vacancies had not been covered. The clinical lead told us the unit had long-term agency staff that knew the service. The unit had recently recruited an agency member of staff to the permanent staff team. The senior team lead told us if there were staffing shortages they would work on the unit to ensure patient care was not compromised.

Managing anticipated risks

- The Magnolia unit managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather.
- The unit had a winter plan in place. Planning included staff that lived closest to the unit covering the shifts of staff that were unable to get into work due to snow.

Good

Are services safe?

- The unit had a policy for managing deteriorating patients. This included comprehensive guidance for staff on the Trust's resuscitation procedures and staff roles and responsibilities.

Good

Are services effective?

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

Summary

- We found the Magnolia unit achieved a good standard of effectiveness. Overall, we saw that national guidance from government, the national institute of health and care excellence (NICE) were complied with and that staff showed awareness of relevant guidance in their work.
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- We found that overall quality of care was monitored through audits, which informed the development of local guidance and practice.
- Staff were supported through face-to-face meetings with their line managers and through an annual appraisal which generated a personal development plan for each individual. Staff were encouraged and supported by the trust to gain addition qualifications relevant to their role. There were robust systems to ensure professional staff remained registered with the relevant professional body; and a preceptorship programme for newly qualified nurses.
- We found that patients could access professionals relevant to their care through a system of integrated multi-disciplinary working; and that patients' care was co-ordinated and managed.
- There were systems to gain people's consent prior to care and treatment. Where patients lacked the capacity to give consent, there were arrangements to ensure that staff acted in accordance with their legal obligations.

Evidence based care and treatment

- The Magnolia unit used national institute of health and care excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. We saw evidence of references to the use of national guidelines within a number of the trust's policies. Staff could access guidance on the trust intranet.
- Staff referred to relevant codes of practice. Staff used nationally recognised assessment tools to screen patients for certain risks. For example, we saw from viewing patients records that the unit used the Bapen malnutrition universal screening tool (MUST). The Unit also used the Waterlow scale to assess the risk of patients developing pressure ulcers.
- Staff we spoke with understood how NICE guidance informed local guidelines. We observed staff following appropriate assessment guidelines when delivering care to patients. For example, a patient's care plan we viewed made reference to NICE guidance CG140 on the use of opoids in palliative care.
- Clinical procedures undertaken by nurses were based on best available evidence. Nurses followed NICE guidelines and specific guidelines for long term conditions management, for example, cardio obstructive pulmonary disease (COPD) Gold Guidelines. However, staff told us a community matron would provide care for patients with COPD or they would refer to the respiratory nurse for advice and guidance.
- The unit's wound care assessment chart followed the Royal Marsden's clinical guidelines for wound care.

Pain relief

- We saw individual patients' pain management plans being discussed at a multi-disciplinary team meeting we observed. For example, the use of a Butrans patch, this is a patch containing pain medication that is applied to the skin, was discussed due to the patient's increased use of a liquid pain killer.
- A senior physiotherapist told us opiate pain relief was used minimally and monitored closely by nursing staff due to the falls risks this could cause to patients. We observed a patient's pain relief being closely monitored by the clinical lead and nursing staff seeking advice and guidance from the clinical lead on the use of pain killers.
- We saw that patients requiring pain management had plans in place and these reflected good practice guidance. For example, one patient had a clearly detailed plan for a liquid pain killer containing morphine, to be administered to manage the patient's break through pain.

Good

Are services effective?

Nutrition and hydration

- The Magnolia unit used a recognised assessment tool supported by national guidance to review the appropriateness of people's nutrition. MUST is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. The nutrition and hydration assessments we viewed were completed appropriately. Care plans were in place for nutrition and hydration and were reviewed regularly.
- Where a need for additional support with nutrition and hydration was identified, for example people with diabetes, nursing staff referred them to a dietician.
- There was a wide choice of menu's available including menu's to meet people's cultural and specific dietary needs. For example, we viewed an Afro-Caribbean menu. People were asked about their menu choices a day in advance. Large print menus were available for people with visual impairments.
- Meals were taken in the dining room at 12 noon and 5.00pm. Staff told us people were encouraged to eat in the dining room as part of their rehabilitation. We observed the midday meal and saw that people were offered drinks to accompany their food. We also saw staff offering patients assistance with condiments and clothing protectors. Patients we spoke with in the dining room were positive about the quality of food and menu choices available. However, two patients we spoke with said the food could be improved.
- The unit used a red tray system to assist staff in identifying patients in need of support with eating or drinking.
- We saw people being offered tea and other hot drinks. These were accompanied with biscuits. Hot drinks were available all day in the visitor/patients room. Patients had fresh water available at their bedsides and staff told us the water was changed daily.
- The unit had a protected mealtimes policy to prevent patients being interrupted during meals. At this time visitors were asked not to plan visits, this was from 12 noon to 1.00pm.
- We spoke with the Magnolia unit cook who told us food was delivered in pre-packaged packs according to patient choices from the hospital caterers. Meals would then be reheated and tested with a temperature probe prior to being served to patients.
- We observed that a fluids thickener had been left on a patients table in the day room during lunch. This could have posed a choking risk if a confused patient had consumed a large quantity. We discussed this with domestic staff. They removed the thickener immediately.

Patient outcomes

- Audits were undertaken at the unit to monitor the outcomes of care and treatment patients received. Staff we spoke with confirmed that all staff were engaged in regular audits. Staff confirmed that clinical leads provided feedback to teams on the results of audit activity. For example, hand hygiene audit results were displayed on noticeboards in the corridor as well as the unit's 'heat map' dashboard.
- We viewed the Magnolia unit's 'heat map' dashboard which was used to monitor services. This included regular monthly audits including: safety thermometer; assessments and care plans; health checks and patient risks. This meant the unit was regularly auditing services to monitor patient outcomes.
- Safety thermometer results were discussed at team meetings and displayed on staff notice boards in the unit. We saw that the Magnolia unit had failed to meet the Trust's 95% target for harm free care in 11 out of 12 months between November 2014 to October 2015, with the unit average being 90%. The clinical lead told us the safety thermometer results were skewed by a patient who had been on the unit since July 2015 due to waiting for a residential care placement and that the unit was now meeting the trust's 95% target.
- Patients' progress and outcome goals were discussed at weekly multi-disciplinary team meetings. For example, we saw the team discussing the discharge plan of a patient with Parkinson's disease. The plan included a home visit with the patient to assess whether they could manage in their home environment and what care package would be required to enable them to remain at home.

Good

Are services effective?

Competent staff

- 100% of staff had attended a corporate induction programme.
- Competencies relevant to staff roles had been developed and there were systems to ensure competency was demonstrated and reviewed. Data from the trust's 2014/15 staff survey indicated that 94% of staff had received a formal appraisal in the previous 12 months.
- Staff told us they had regular, formal meetings with their line manager which were recorded.
- There was a process to assure the organisation that its registered staff remained registered with relevant professional bodies. Staff and managers were advised when trust records indicated registration was due for renewal and re-registration was verified.
- Staff told us they were supported to gain further qualifications relevant to their role.
- Patients we spoke with expressed confidence in the skills and competence of those caring for and treating them.
- Staff received an annual appraisal as part of their continuous professional development (CPD). We viewed minutes from a staff meeting on the 5 April 2015 confirming that the unit was in the process of providing annual appraisals to all staff. The senior team lead told us staff received an annual appraisal and six month review to ensure their professional development goals were on course.
- The service encouraged skills development. Staff of different grades confirmed that training needs were identified as part of appraisal, and staff could request further training that was relevant to their role. Staff were supported to continue their education. For example, a nursing assistant told us they had been offered the opportunity to train as a qualified nurse.
- Staff told us individual supervision took place every four to six weeks, and there was regular group supervision in team meetings. Staff said the managers and clinical lead would also offer ad hoc supervision.
- The Magnolia unit had two members of staff who were nursing preceptors. These are newly qualified nurses who receive a structured programme of development whilst being supported by experienced colleagues. A nurse preceptor told us they received weekly supervision from their Band 6 supervisor to review their progress. They had also received a two day induction from the trust and a month working as a supernumerary staff member when they had first commenced their employment.
- Domestic and kitchen staff told us they had three monthly team meetings. These were also attended by the manager, matron, and domestic supervisor. Kitchen staff had all attended food hygiene certificate training.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary team working supported the coordination of care pathways for patients. The service had close working arrangements with GP practices and with social services in supporting patient care and treatment in the community.
- Staff told us the unit worked effectively with other specialisms, this included integrated care pathways and joint assessments with allied health professionals including physiotherapists and occupational therapists (OT). Staff said they felt aligned with colleagues in other specialisms and part of an integrated team.
- Discharge planning stated as early as possible once a patient was admitted. This included therapy staff completing access visits to assess people's home's for equipment or therapy staff escorting patients on home visits to assess and enable patients to practice activities at home.
- Nursing staff told us they felt well supported by other professional staff that provided multi-disciplinary support.
- Multi-disciplinary team meetings could be convened to address the needs of patients with complex care needs. We observed a multi-disciplinary team meeting. We saw that the needs of all patients on the unit were discussed.

Referral, transfer, discharge and transition

- Magnolia unit was a 29 bedded ward, with an annual occupancy rate of 86%. The expected length of stay on the unit was up to two weeks. Discharge planning commenced on a patients admission to the unit, with patient goals being set and a provisional discharge date.

Good

Are services effective?

Patient goals were reviewed weekly by the multi-disciplinary team. The GP conducted an initial assessment on admission to the unit. Other medical interventions were assessed by the nursing staff and referred to the GP when required.

- The manager told us that the unit's average length of stay had reduced from 24 days to 21 days due to the unit having received winter pressures funding in 2014/2015. However, the extra funding had not been agreed at the time of our inspection for 2015/2016.
- Staff told us there were clear criteria for the referrals of patients which meant that inappropriate referrals could be identified. Staff told us that the Magnolia Unit had flexible admission criteria depending on the patient's needs.
- Referral for admission the unit could be accepted from any health, social care or supported housing professionals.
- Transfer arrangements from the acute hospital were supported by unit staff. For example, staff liaised closely with the acute hospital about transfer arrangements. Transfers had to be accompanied by documentation from the acute hospital saying the person was medically fit for transfer. Patients' records would be transferred with the person who received the service.
- The unit's policy was that people who were admitted must receive an initial assessment within 24 hours of admission and a full MDT assessment within five days of admission. Records we viewed confirmed that people had received assessments within these timescales.
- Discharges could be arranged Monday to Sunday. If a person was due to be discharged to their home address the staff liaised closely with the local authority social services in assessing people's social care needs. A discharge summary would be sent to the patient's GP within 48 hours of discharge.

Access to information

- Staff felt the trust intranet provided a good source of information to support their work. Staff told us they received briefings, newsletters, and updates about particular themes by email on a regular basis.
- Information displayed in the staff area was up to date and relevant. For example, we saw a falls algorithm displayed on the wall in the nursing station. This acted as a prompt for staff

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw evidence of verbal consent being obtained before care was delivered. For example, we saw staff asking a person they were assisting with repositioning if they could move the person. We reviewed consent information for a selection of patients as part of our review of records. We found consent was obtained and records were completed correctly.
- Where nursing staff used photography to obtain a record of the patient's condition and symptoms, this was done with the patient's written consent.
- Staff told us they had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff we spoke with demonstrated understanding of the MCA and of their responsibilities when a DoLS authorization was being sought. A mental capacity assessment was undertaken if nursing staff had a concern that a patient might not have capacity to make a decision.
- We observed a multi-disciplinary team meeting where staff discussed the need for a patient to have a 'best interests' meeting convened with the next of kin to discuss an application for an authorization of a DoLS. Best interest meetings are meetings to discuss decisions being made in the best interest of a patient who may lack the capacity to make a decision. One patient had a DoLS in place on the Magnolia unit.
- Managers were aware of the trust's responsibilities under the Mental Health Act 1983 code of practice. Staff told us that they would refer people experiencing mental health issues to the mental health team for assessment. Staff said they had a good working relationship with mental health services.

Good

Are services caring?

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

Summary

- We found that the Magnolia unit showed good standards of caring for the patients. This was because patients and carers we spoke with were positive about their experience of care and treatment, and feedback gathered via the friends and family test (FFT) showed high levels of patient satisfaction.

We observed staff responding to people with kindness and compassion. Patients told us they were treated with dignity and respect, and that they were involved in the planning and delivery of their care to the extent they wished to be. Patients told us their care and treatment was explained to them in a way they could understand. Patients had access to a wide range of published information.

Compassionate care

- Patients had access to nurse call bells next to their bedside and in bathroom areas. We saw patient call bells being answered promptly.
- Patients and carers we spoke with were positive about the care and treatment they received. Words and phrases such as "very good," "kind and considerate," "happy with my care," were used extensively in patients' feedback.
- We viewed the Magnolia unit friends and family test (FFT) results dated November 2014 to October 2015, 98% of patients said they were treated with dignity and respect. The average FFT score for people who responded that they would be likely to recommend the service was 97%.
- We observed staff being respectful to patients, and giving matters of dignity due consideration. For example, curtains were drawn around patients' beds when care was provided.
- We observed staff encouraging patients to eat during lunch and providing assistance by cutting up food.
- We observed the clinical lead providing care to a patient. We saw the clinical lead displaying rapport with the patient and responding to the patient with kindness and compassion.

Understanding and involvement of patients and those close to them

- Visiting times at the Magnolia unit were from 3.00pm to 8.00pm Monday to Friday; and 2.00pm to 8.00pm at weekends. However, the manager told us the ward was flexible to family visitors who could not visit between these hours due to work of family circumstances; visits could then be arranged by prior agreement with the unit manager.
- In the FFT results for November 2014 to October 2015, 89% of patients said the Magnolia unit provided them with all the necessary information about their condition or illness.
- Catering staff told us they had a meeting with patients to discuss developing a menu for people with smaller appetites, as some patients had said the meals the unit provided were too large. Catering staff told us work was in progress to develop a menu for smaller appetites.
- We saw staff demonstrating good communication skills during the examination of patients. Staff gave clear explanations and checked patients understanding.
- We saw nurses taking time to clarify patients understanding of their care and treatment; carers we spoke with told us they were reassured by the nurses' knowledge and advice.
- There was a large amount of printed information available to patients across the unit. Patients could also access information leaflets on the trust's website.
- In our discussions with staff, patients and carers we found that there was an appropriate rehabilitation focus and that patients were encouraged to be partners in their care planning and enabled to participate in care activities.

Emotional support

- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for

Good

Are services caring?

patients where this was needed. For example, we observed a health care assistant reassuring a confused patient by explaining where they were and explaining their family would visit later in the day.

- We observed staff responding to people in a kind and compassionate manner. All the patients and carers we spoke with were positive about the emotional support the staff provided.
- Staff and patients told us about the emotional support staff had provided for patients and carers. For example, a patient told us how staff had supported them emotionally through their rehabilitation.

Good

Are services responsive to people's needs?

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

Summary

We found that the Magnolia Unit offered patients' integrated care to ensure patients received truly joined up working from a multi-disciplinary team that was responsive to their individual needs.

There was a focus of providing rehabilitation services to ensure people were enabled to return to their place of residence. There was provision to ensure that essential care and treatment was available out-of-hours.

We found that consideration was given to the needs of people living with dementia, those with complex needs and patients for who English was not their first language. Feedback from patients was actively sought and acted on. Complaints were investigated and responded to. Staff were made aware of the issues raised by complaints and where appropriate changes were made as a result.

Planning and delivering services which meet people's needs

- The Magnolia unit managers told us the trust and unit worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate people who required support from mental health services or local authority social services.
- Patients received clear verbal and written information to guide their participation in their own care plan; information could be provided in formats appropriate to the individual.
- We viewed nine patients care plans and saw patients were given choices in regards to bathing and washing preferences and whether they required support with these tasks.

Equality and diversity

- The senior team lead told us equality and diversity training was mandatory for staff. At the time of the inspection 76% of the team were up to date with this training.
- People's cultural and religious needs were assessed as an aspect of people's initial assessments.
- The trust's accessible communications team could provide information documents in other languages, large print, braille and audio format upon request.
- We saw a wide variety of menu's available to patients. These included Afro-Caribbean, Jewish, and halal menus.
- The trust had a 'disability and discrimination policy and implementation plan' in place. This outlined the trust's commitment to ensuring people with disabilities received equal access to services.
- Staff were aware of how to book interpreters.

Meeting the needs of people in vulnerable circumstances

- Dementia awareness training was rolled out to all staff working at the Magnolia unit. We saw that on the service used the butterfly symbol to identify people who had been identified with dementia. The butterfly scheme provided a system for people living with dementia which enables staff to identify them quickly.
- Health care assistants were able to tell us how they had been trained in managing patients presenting challenging behaviour.
- The unit staff had access to a learning disability service that could provide specialist multi-disciplinary assessment and intervention to individuals aged 18 and over with learning disabilities and complex health care needs. The learning disability service could also provide advice and support to carers and other professionals.
- The unit was accessible to wheelchair users and bariatric patients and had access to bariatric wheelchairs.

Access to the right care at the right time

- Patients needed to be clinically stable to be admitted to the Magnolia unit. The unit took referrals from the hospital accident and emergency department if a patient was assessed as stable.

Good

Are services responsive to people's needs?

- Patients with diabetes or at risk of diabetes had access by referral to a specialist diabetes services, this included patients with renal disease, foot care, and retinal disease.
- The unit had access to a range of specialist who provided care and treatment. For example, podiatry and physiotherapy. We also saw patients receiving tissue viability services on the unit.

Learning from complaints and concerns

- The trust had complaints handling policies and procedures in place. All complaints to the service were recorded. Information on the trust's complaints policy and procedures was available on the trust's internet website.
- Information on the ward for people who use services included information about how to make comments and compliments or raise concerns or complaints. Most people we spoke with were aware of the complaints procedure.
- Staff we spoke with were aware of the trust's complaints policy and of their responsibilities within the complaints process. Formal complaints were directed to the trust's customer services department and informal complaints were dealt with at a ward level. Staff were aware of complaints patients had raised and of what was done to resolve the complaint.
- Staff could describe how services had changed as a result of action taken. The trust produced a monthly 'learning from complaints' briefing paper. We viewed the November 2015 briefing paper and saw this fed back learning from complaint investigations to staff via a circulated email.
- We viewed the Magnolia unit 'heat map' dashboard. This recorded that the unit had received three formal complaints between November 2014 and October 2015. The unit manager demonstrated how the complaints had been dealt with in accordance with the trust's policies on complaints handling.
- A patient we spoke with told us they had raised a concern with the ward manager about a staff member's attitude. The patient said the ward manager had apologised and spoken with the member of staff concerned immediately. The patient told us they were, "very satisfied", with the way their concern had been dealt with.

Good

Are services well-led?

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

Summary

Overall, we found that Magnolia unit was well led.

There was a clear vision and values that were shared by staff and demonstrated in their work. There was a clear articulation of the strategic direction for the service and staff felt engaged with the strategy. Consideration was given to ensure that services were sustainable. However, staff told us the trust's strategy had an effect on the unit's ability to introduce innovative practice.

There were systems to ensure good governance and monitoring of standards and performance.

We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues. Staff felt supported by their managers to deliver high quality care, and empowered to implement the trust's vision and values. Managers, including those at executive level, were described as being visible, open and accessible.

However, the ward manager and team leader had both been in post on a interim basis for two years. Whilst they were leading the service well, permanent appointments to these key leadership posts needed to take place to ensure that there was continuity of high quality care.

Service vision and strategy

- The trust's vision was displayed. The vision included: 'put the needs of our patients and their carers first, and involve them fully in their care; show kindness and compassion in all aspects of the care we provide;behave with honesty, integrity and openness;create a safe, friendly and caring environment, where people are treated with respect, courtesy and dignity;strive for excellence, recognizing achievements and valuing hard work;support our staff to be the best that they can be'.
- Most staff we spoke with told us the trust's vision and strategy was publicised on the intranet, and they incorporated the trust's values into their practice. For example, a HCA told us the trust's essential value was, 'compassion'. The ward manager told us, 'we have to live our values. We are very focused on working in partnership'.
- The trust had clearly defined strategic objectives. These included: providing excellent services; developing staff; and being clinically and financial sustainable. The unit manager and clinical lead were aware of the trust's strategic objectives and told us the service worked towards achieving the objectives.

Governance, risk management and quality measurement

- The Magnolia unit had governance and risk processes in place. The trust had an up to date risk management policy. The unit maintained a risk register and high level risks were escalated to the trust risk register.
- The ward manager told us they had monthly meetings with the divisional lead where locally managed risks were discussed. Trust wide risks were also linked to clinical governance meetings. Minutes from governance meetings were emailed to all staff at the unit. Key risks for the unit included the high use of agency staff.
- An annual plan for national and local audits of the unit was in place. Audit progress was reported monthly. Governance meeting minutes evidenced that audit plans were reviewed at the monthly meetings. Updates were provided for audits in progress.
- Regular team meetings were held. These meetings were recorded and included case discussions. Actions taken were documented and reviewed in subsequent meetings.

Leadership of this service

- The chief executive was well established in their role and known to staff in community services. Staff felt there was clear leadership at executive level. Staff we spoke with told us the trust board were visible and members of the board had visited the Magnolia unit in the previous 12 months.

Good

Are services well-led?

- The local leadership was effective and staff said their direct line managers were supportive. The senior management team provided leadership that was visible to staff.
- Managers and team leaders demonstrated a clear understanding of their role and position in the trust. However, the senior team leader and ward manager told us they had both been in interim posts for two years and were unsure whether they would be offered permanent roles. Whilst both managers were leading the service well, these posts should be filled to consistently maintain the high standards of care.

Culture within this service

- Staff generally reported a positive culture in the Magnolia unit. Staff were supportive of each other, there was a team ethic and they enjoyed their role. Staff were able to put forward ideas and discuss them as a team.
- Staff said the trust was good to work for, with an open and patient focused culture.
- Staff told they had were consulted about practice issues and felt involved in the decision making processes on the unit.
- Staff told us there was a culture of being honest and open. Staff said they were encouraged to report incidents and there was a "no blame" culture when incidents were reported.

Public engagement

- Information was available on the Magnolia unit on how patients and their carers or relatives could provide feedback on services; this included the contact details for the trust's patient experience team.
- We observed family and carer involvement being discussed at a multi-disciplinary team meeting. For example, the team discussed a patient who may require telecare and how the person's relative had been involved in considering possible care pathways.
- We viewed the FFT results for the period November 2014 to October 2015. The Magnolia Unit had regularly achieved 100% against a target of 85%. However, the 85% target had not been achieved between September and October 2015, with an average of 75% of patients reporting that they had felt involved in their care. The Magnolia Unit ward manager said this was due to a reduction in the number of patients who had responded to the FFT questionnaire in September. We noted that in April 2015 there had been 12 patient FFT questionnaire returns, whilst in October there had only been six FFT questionnaires returned.
- A former patient facilitated a knitting group in the unit's day room every Wednesday.

Staff engagement

- A Magnolia unit staff member had been awarded the trust's annual 'compassion in care' award due to, "always thinking about ways to make things better for others."
- Staff told us the chief executive met with staff on a bi-monthly basis to say "thank you" and receive feedback from staff.
- We viewed results from the trust's staff survey; these indicated that 79% of staff had responded that they had clear plans and objectives to do their job.
- Staff received a weekly bulletin via email; this gave staff weekly updates on developments in practice and what was happening at the trust. Staff also received a quarterly trust magazine this provided staff with information on learning from incidents and complaints.

Innovation, improvement and sustainability

- In the trust's staff survey 63% of staff responded that they felt they were able to make improvements to their areas of work. Staff on the Magnolia unit told us they could discuss improvements with the ward manager and the manager would listen to ideas.
- The ward manager and clinical lead told us they had discussed innovative practices and were intending to introduce some of their ideas in the future, but work had not yet commenced on any projects. The manager told us the current financial constraints had an impact on the ability of the managers and staff to introduce innovative practice and improvements.