Solent NHS Trust

Quality Report

Western Community Hospital
William MacLeod Way
Millbrook
Southampton
SO164XE
Telephone: 0300 123 5008
http://www.solent.nhs.uk

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

Summary of findings

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Summary of findings

Overall summary

Snowdon Ward is an inpatient unit situated in the Western Community Hospital comprising of 14 beds in total. The unit admits people for neurological rehabilitation including stroke and head injury. Care and rehabilitation is provided by a multidisciplinary team of specialist clinicians, nurses, therapists and support staff.

We found that services were safe. Patients and relatives told us they felt safe and had high confidence in the staff team. There was good monitoring of incidents such as falls and staff were open about how they could prevent incidents or accidents. Specialist equipment and rooms were available to support people in their rehabilitation. There was very detailed assessment of patient needs by the team of specialists which enable risk management to be part of the care and therapy planning process.

The service was effective because there was a strong team of specialist professional staff working closely together to meet patient's short and long term goals. There was also effective collaboration with acute hospitals on admission and with community teams regarding discharge. Progress towards discharge, as rapidly as possible for the individual, was the key driver for patients and staff.

The service provided was caring. Experienced senior clinical specialists provided comprehensive programmes in which patients were supported with rehabilitation of their physical, social and emotional needs. All staff were aware that the plans of care and therapy were agreed with the patient and consent was obtained at each stage.

Services were responsive. There was a wide range of patients on the ward as the service was flexible to manage complex rehabilitation needs for people who had neurological injury. This included patients who had suffered a stroke, head injury or other nerve injury. We saw that individually tailored plans of rehabilitation were devised by the multidisciplinary team.

The service was well led as there was clear direction from senior staff. The ward matron, in collaboration with the consultant in rehabilitation, managed the admission process and all staff contributed to detailed planning towards discharge. Trust managers monitored the performance of the service through performance information and clear rationalised line management of the clinical teams. Patients and staff knew who to contact if they had any concerns about the service. Staff told us they were well supported through training, supervision and appraisal. They said it was a good place to work because they felt included as part of the team.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Services were safe as staff were aware of policies and procedures for safeguarding of vulnerable adults. Patients and relatives told us they felt safe and had confidence in the staff team. Patients were supported to make progress in their rehabilitation in a safe environment where specialist equipment was available. Incidents such as falls were investigated thoroughly to protect the individual and learn any lessons.

Are services effective?

Services were effective as there was detailed assessment and planning by the multidisciplinary team working closely with patients. There were sufficient staff with specialist skills and knowledge to promote effective rehabilitation and positive outcomes for patients. We saw that the multidisciplinary team was effective in managing rehabilitation and planning for discharge.

Are services caring?

Services were caring because staff worked together with a focus on the needs of the patient. Patients told us that they felt cared for and had intensive support to achieve their goals. Patients were fully involved in making decisions about the plan of care and arrangements for discharge.

Are services responsive to people's needs?

Services were responsive because they were strongly focussed on the needs of patients. There was detailed assessment of patients problems and specialist staff worked together to plan individual programmes of rehabilitation for patients. There was open flexible access for those patients who would benefit from the specialist service. Patients and their relatives or carers were closely involved at all stages of care planning with the key driver being arrangement and preparation for discharge.

Are services well-led?

Services were well led because clinical and operational managers were visible to staff and patients and staff said they could raise issues when required. There was regular monitoring of the quality of care which was reported to trust managers and performance was challenged where needed. There was a culture of providing high quality rehabilitation service and using current best practice as learnt through networks and sharing practice

Summary of findings

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

Community inpatient services

We found that services were safe. Patients and relatives told us they felt safe and had high confidence in the staff team. There was good monitoring of incidents such as falls and staff were open about reporting incidents and how they could prevent incidents or accidents.

Specialist equipment and rooms were available to support people in their rehabilitation. There was very detailed assessment of patient needs by the team of specialists which enable risk management to be part of the care and therapy planning process. Staff and managers were working on reducing the risks for people who may be confused or lack awareness of dangers and mobile enough to walk out of the ward area.

The service was effective because there was a strong team of specialist professional staff working closely together to meet patient's short and long term goals. There was also effective collaboration with acute hospitals on admission and with community teams regarding discharge. Progress towards discharge, as rapidly as possible for the individual, was the key driver for patients and staff.

The service provided was caring. Patients told us they were well supported by the team of staff. Experienced senior clinical specialists provided comprehensive programmes in which patients were supported with rehabilitation of their physical, social and emotional needs. All staff were aware that the plans of care and therapy were agreed with the patient and consent was obtained at each stage.

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Summary of findings

What people who use the community health services say

Patients told us it was very apparent that there was a strong cohesive team in the ward which made them feel safe and well supported.

We received specific comments on feedback cards from five patients in the ward who said that staff were very caring and enthusiastic. We spoke by telephone with patients who had been discharged. They told us that the team on Snowdon worked very closely together to provide support and an environment where they could express their wishes and be supported to regain skills of daily living and rehabilitate to enable them to get home.

The Friends and Family Test which asks patients how likely are they to recommend the service to friends and family if they needed similar care or treatment was reported for all areas. For Snowdon ward it had been high for most of the year 2013-14 but had dropped slightly in January and February 2014.Patients we spoke with were very satisfied with the support they received on the ward.

Areas for improvement

Action the community health service SHOULD take to improve

The Trust should manage the risk to prevent vulnerable patients who may be confused from leaving the inpatient ward area. An effective door security or staffing arrangement is required that also allows access to authorised people and patients who are able and not a danger to themselves. Although detailed risk assesments were made and mitigating actions had been put in place a patient had still left the ward.

Action the community health service COULD take to improve

The Trust could review the use and availability of information management systems to facilitate clinical staff recording of incidents such as falls or pressure sores. We saw that staff were entering reports some days after the date of incident as systems had not been available when needed. Additional computer terminals in the ward area and the Snowdon at home office would enable staff to access policies, training and reporting systems at the time they were required.

The service could display performance and staffing information in public areas of the ward to enable patients, visitors and staff to be aware of the quality of service provided.

The Trust could provide some mandatory training sessions to supplement the e-learning that all staff were expected to complete. Some staff noted that although they had completed mandatory training this was not always personally effective, as it was not their preferred style, and it was not easy to set allocate time to focus on the learning.

Good practice

Our inspection team highlighted the following areas of good practice:

Patients benefitted from very detailed planning of their rehabilitation and discharge. There was a very strong multidisciplinary approach to providing patient care such that all professional staff were fully involved in the planning and implementation of patient's care and support. Detailed planning meant that patients were discharged to a safe environment with support to manage their daily living and continuing rehabilitation.

The facilities on Snowdon were very well designed to provide an environment where people could practise and

regain their skills of daily living. There were excellent therapy areas, lounge, dining and kitchens which were well used to provide variety and stimulation and appropriate experience for people's rehabilitation.

Solent NHS Trust

Detailed Findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Stephen Dalton, Chief Executive Mental Health Network, NHS Confederation

Head of Inspection: Anne Davis, Care Quality Commission

The team included CQC inspector, three specialist advisors; a doctor, an occupational therapist, and a speech therapist, and two 'Experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting

Background to Solent NHS Trust

Snowdon Ward is an inpatient unit situated in the Western Community Hospital comprising of 14 beds in total. The unit admits people for neurological rehabilitation including stroke and head injury. Care and rehabilitation is provided by a multidisciplinary team of specialist clinicians, nurses, therapists and support staff.

Why we carried out this inspection

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

How we carried out this inspection

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

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

The inspection team looked at the following core service area at inspection:

- Community inpatient services

Before visiting, we reviewed a range of information we hold about the trust services and asked other organisations to share what they knew about the location. We carried out an

Detailed Findings

announced visit 17-18 March 2014. During our visit to Snowdon ward we observed how people were being cared for and talked with staff, carers and/or family members and reviewed personal care or treatment records of patients.

Community inpatient services

Information about the service

Snowdon ward is a 14 bedded specialist neurological rehabilitation inpatient service. It is consultant led and admits patients as they are discharged from acute units in the area. The ward matron undertakes visits to potential patients to assess whether the ward would be able to provide care relevant to the patient's needs and to plan the appropriate time for admission. The ward is a base for staff providing intensive rehabilitation at home to support transition and adjustment into the patient's home environment.

We visited on two days and spoke with patients, relatives and staff working in the ward. We examined care documents, observed care being provided and attended meetings at which care was being planned.

Summary of findings

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Safety in the past

There were clear arrangements in place for protecting people from abuse and avoidable harm. Staff we spoke with were able to describe reporting processes they would follow is they suspected abuse of any form. Staff said they had completed training regarding abuse as part of mandatory computer based training.

There were clear policies for staff to follow such as those relating to safe discharge, manual handling, mental capacity, resuscitation and patients missing from the ward area. Staff told us they were aware of procedures they had to follow in implementing the Mental Capacity Act 2005. Staff understood the Deprivation of Liberty Safeguards that would be used where required to protect patient's rights.

The matron told us that few patients develop pressure sores in the ward. Data for the year prior to our visit showed that in most months any reported pressure sores had been graded minor or below. Many patients in the neuro-rehabilitation ward are by the nature of their condition susceptible to developing sore skin. The results indicated that people had been cared for safely.

Learning and improvement

There were clear processes for staff to report safety incidents and collated figures were monitored by the trust. We saw that falls had been reported and the manager showed us examples of investigations undertaken. There was a clear procedure for staff to follow in completing a post falls checklist and to ensure remedial action was taken to prevent avoidable falls. We checked in patient's records that we knew had fallen and saw that staff had completed all appropriate forms to protect the patient's safety at the time of their fall, recorded an updated assessment of risk and put measures in place to prevent further falls. The reported level of falls in the year had been roughly similar to the previous year which may be a feature of

rehabilitation as patients are trying to improve their mobility through the course of their admission. Staff told us of measures already implemented such as ensuring appropriate design beds and safety mats, and pressure sensors to alert staff that supervision of the person may be needed. We saw that staff were aware of patient's needs for example drinks and call bells were as a matter of routine place within patient's reach.

The ward had responded to audits of infection control by ensuring particular areas in rooms, and all parts of equipment were cleaned after use where required. Staff told us they had completed training in mandatory topics that ensured safe care such as infection control and moving and handling.

Systems, processes and practices

There were systems to protect people from infection. Patients were screened for hospital acquired infections as most patients are admitted from other hospitals. Any infections were managed and reported as part of local and national surveillance. There were regular audits of the ward environment to assess for safety with respect to infection control. The use of urinary catheters was assessed as their use could increase the risk of infection.

There were regular checks of equipment to ensure safety. Patients coping with neurological injury may need to relearn basic skills such as standing and balancing and walking. The ward had several pieces of specialist equipment to support people in their therapy. Staff were all trained in the use of relevant equipment and we saw that hoists were checked and maintained every six months to ensure safe operation.

Patients told us they were happy with the design of their room and equipment available which enabled them, depending on the phase of their rehabilitation, to improve their own mobility in a safe environment.

Monitoring safety and responding to risk

The ward manager told us that staff levels were sufficient to provide safe care. We examined staff rotas for the two weeks prior to our visit and found adequate staff levels including senior nurse cover for each shift. This was confirmed by other staff who said there were occasional staff problems but agency staff were used to ensure safe levels. We saw that new staff had been recruited and junior staff told us they could quickly have staff requests approved to match the needs of patients.

Staff told us they were aware of the need to report incidents and key performance monitoring information. We saw that the trust managers reviewed monitoring reports monthly to indicate performance on a range of indicators such as pressure sores or patient satisfaction. The reports were discussed at the trust assurance committee and issues raised for management action if needed.

Urinary catheters were required for some patients to manage continence after neurological injury and would be dependent on the individual needs of that patient. A detailed audit had been completed checking the rationale for use of the catheter, the length of time it was in, and correct documentation. As a result of the audit work, additional education for staff about use of urinary catheters had been arranged.

Anticipation and planning

The service used a recognised dependency tool to assess the needs of patients and enable planning for appropriate resources in the future. Data was being collected to enable comparison with similar wards elsewhere in the country and ensure appropriate categorisation for commissioning of the specialist care and treatment being provided.

Patients had their vital signs checked regularly at a frequency determined by the stability of their condition. Staff showed us the early warning scoring system used to monitor for any deterioration in condition. Care assistants had clear guidelines to follow to estimate scores and at what stage to report a change in condition. Medical staff were called by the nurse if scores changed significantly. We observed that the ward had medical staff in attendance through the day. The manager explained that out of hours a GP service would be called to provide assistance, or if urgency required, then an ambulance would be called to transfer the patient to an acute hospital.

Staff told us about the resuscitation training they had attended. Staff with different professional skills had attended training at different levels. Health care assistants told us they attended annual refresher training in emergency life support.

There were areas outside the ward that were accessible for patients to test their mobility on different surfaces and to get fresh air when they wished. Whilst promoting this, and access to other areas of the building, such as the restaurant, the staff were required to protect the safety of patients who may be unaware or confused. Although the

ward did have a locked door it was a busy thoroughfare and so there was a risk of vulnerable patients walking out from the safety of the ward towards the main building exit. Staff were aware of this risk and had instigated some controls but this had happened in the week of our inspection with a patient leaving the building. The trust had requested maintenance staff to provide alternative door security that would assist staff to keep patients safe. Until the door security provided an acceptable safe solution we felt there should be improved risk assessment, and robust procedures such as supervision to avoid such risk where possible.

Are community inpatient services effective?
(for example, treatment is effective)

The service was effective as there was detailed assessment and planning by the multidisciplinary team working closely with patients. There were sufficient staff with specialist skills and knowledge to promote effective rehabilitation and positive outcomes for patients. We saw that the multidisciplinary team was effective in managing rehabilitation and planning for discharge.

Evidence-based guidance

Care and treatment provided in the ward was based on good practice and evidence based guidelines. We spoke with physiotherapy, occupational therapy, speech and language therapy staff who all described the recognised assessment tools they used and the recommended therapy sessions for individual patients during the course of rehabilitation. Staff told us that National Institute for Health and Care Excellence (NICE) guidelines were followed for pathways of care such as for people who had suffered a stroke. We saw that patients had scheduled sessions of therapy which matched the recommended support for each type therapy they required.

The ward staff told us that policies and procedures were available on the trust intranet. Staff said that they could not always access a terminal when they needed to refer to a policy so some policies were printed out in hard copy. This meant there was a risk that staff may follow out of date procedures. We saw that staff followed accepted guidelines with respect to hospital acquired infection with appropriate screening. One staff nurse stated that if a patient had to return to the acute hospital for care but returned then screening would be repeated. We saw that there were adequate facilities for hand washing and staff washed their hands at appropriate times between caring for people. This meant that department of health guidance was being followed to prevent and control infection.

Monitoring and improvement of outcomes

We examined trust performance reports and found that the service delivery was monitored and reviewed each month by service line and operational lead managers. Reports included information about pressure sores, infection rates, incidents such as falls, and the outcome of patient satisfaction surveys. The ward matron said they were intending to commence display of information about staffing and performance in the ward area so that patients and visitors would be aware of the quality of service.

Paper records were kept by therapy teams of the intervention and support with patients. Some data was being collected on computer systems to enable improved reporting of the productivity and outcomes of their work. Staff told us that additional administration support and computer hardware had been requested to improve the collection of this data. The rehabilitation consultant maintained data about patient's complex needs and the outcomes of the multidisciplinary efforts to promote people's progress towards discharge. This data was benchmarked with other services nationally and would be used to validate funding for the service. Staff were able to see this information at multidisciplinary meetings and it was a driver for the team to maintain high quality rehabilitation care and effective working.

Staffing, equipment and facilities

There were appropriate induction, training and appraisal systems in place to ensure staff were prepared to care for patients in the ward. Staff told us they had completed mandatory training about infection control, resuscitation, moving and handling and safeguarding of vulnerable adults.

The therapy staff provided a seven day per week service which meant that patients continued their therapy to maintain progress against their goals. NICE guidance was followed for example for patients with a stroke to have 45 minutes of each therapy five times per week. Therapy support assistants continued to support people particularly out of hours. Staff told us that the team had also taken a half day to develop closer working to improve the consistency of approach to care and therapy.

Community inpatient services

We saw there were very good facilities for clinical specialists to meet with patients or provide a wide variety of therapy. Patients needing therapy could use different rooms and exercise areas. There were specialist couches and equipment that therapists would use to support people's progress. There was a mock up kitchen with various heights to enable people to test their abilities with various tasks. Some specialist equipment had been procured using money from donations including various wheelchairs that people used during their stay on the ward. We saw that people were encouraged to use a dining and lounge area as more normal day of activity rather than stay in their bedrooms. There was specialist equipment available such as a possum device to promote communication where people could not speak or write clearly.

Staff in the trust were aware of translation facilities and we saw that ward staff had been supporting people whose first language was not English. We spoke with the manager of the translation team who said the local team was available five days per week. Staff told us they could access language line at other time. We examined patient feedback about the service. Patients had reported they were very happy and with many described the local translation service as excellent.

Multidisciplinary working and support

Patients benefitted from intensive support from therapy and nursing staff and were reviewed daily by the medical team. Each therapist or specialist made their assessment to decide on specific rehabilitation needs but the team worked together to make a coherent plan of rehabilitation.

We observed a multidisciplinary meeting at which the plans and care of all patient's in the ward was discussed. There was open discussion between specialists and we saw that the focus of effort was to enable patients to progress to a level of recovery that would enable them to go home. Discussion was very detailed and broad ranging in order to facilitate discharge, from how alternative or new accommodation would be arranged and social support, to the specifics of how a person would be able to open their medication container when they were at home. This meant that patients were very well prepared for their discharge, support was arranged to enable the person to live at home, and readmissions were avoided if at all possible.

Patients told us that it was evident, in how well they were cared for, that the team communicated and worked well together. All staff had input to the planning of the patient's programme of rehabilitation and decisions were made, with the patient included, at joint meetings with staff of the different disciplines.

Are community inpatient services caring?

The service was caring because staff worked together with a focus on the needs of the patient. Patients told us that they felt cared for and had intensive support to achieve their goals. Patients were fully involved in making decisions about the plan of care and arrangements for discharge.

Compassion, kindness, dignity and respect

Patients told us that they were looked after well; they felt safe and supported to attempt their rehabilitation. We observed staff supporting patients and saw that positive reinforcement was given at all stages to continually encourage progress. It was clear that staff had developed good understanding and awareness of patient's individual needs.

The service encouraged support from patient's relatives. Patient's relatives were encouraged to visit and take part in the rehabilitation and familiarise themselves with techniques and coping strategies that would help the patient when they went home. Staff supported relatives and carers as it was recognised they may play a key role in the patient's life on discharge. Patients were encouraged to have mealtimes together but relatives were generally excluded as some people may find it embarrassing when trying to eat as their movements may have been compromised by their neurological injury. To balance this and encourage family cohesion patients and their relatives could take meals together occasionally in the hospital restaurant.

In most interactions we observed the staff were kind and paid attention to the experience of the patient. Patients told us they felt well supported. We observed some interactions that appeared not to protect patient's dignity. We saw patients being wheeled backwards in wheelchairs by care assistants on their way to dining area or bathroom and they were clearly disconcerted at not seeing in the direction they were being pushed. In other situations we observed that staff spent appropriate amounts of time to provide good physical and emotional support to patients.

Community inpatient services

Informed decisions

The rehabilitation service had a clear principle of agreeing goals with patients. Whilst staff provided expert professional advice, treatment, therapy and care, all staff also recognised and adhered to the wishes of patients. Early in their admission, following a period of assessment, at about ten days, all patients had a meeting with the multidisciplinary team to decide on the plan of rehabilitation and clarify short and long term goals. We examined records of these meetings and subsequent review meetings and found that patient's views were central to the agreed plans. Where the patient agreed their relative or carer was involved in these meetings. We saw in patient's daily record of care and therapy that they had been asked for their consent before staff provided support.

In the ward the patients were able to make choices about their daily routine. We observed for example that patients could get up late in the morning if that was their usual or preferred routine at home. Patient's schedule of support and daily activities were displayed in their room so that they were aware of their different therapy sessions. Patient's told us this was helpful as a reminder and they recognised the high level of support they were receiving.

We saw that there had been clear and comprehensive record of patients wishes regarding their care and other significant decisions. Where a patient was not able to communicate or express their wish then full documentation of discussions with relatives and professionals had been recorded. We examined care plans and found that where relevant there had been clear documentation of the decision regarding not resuscitating a person if that had been their expressed wish, or the decision of relatives with professional advice. We saw that records had been fully completed for such decisions and signatures of the patient and all relevant people had been recorded. We examined other documentation which showed detailed discussion with a patient's relative about promoting health and welfare where the person lacked awareness of risks.

Emotional support

Patients told us they were extremely well supported on the ward by the team of staff. They said it was clear there was strong teamwork as all staff were providing consistent support. Each shift staff were allocated to the same patients which meant that patients were able to develop a trusting relationship with their professional staff and assistants. There was a nominated key worker allocated from the professional team for each patient who provided an overview of arrangements to ensure progress was made on the actions agreed by the team and the patient towards discharge home.

The focus for patients admission was to prepare for discharge home. Although goals were agreed for rehabilitation in the ward, patients could go home with support from therapists to continue rehabilitation once at home. This meant that patients could get back to their home environment and family as soon as practicable even though some of their rehabilitation goals were not fully met. The service worked closely with other teams providing community support such as the outreach team from the ward or specialist community stroke teams if relevant.

Clinical psychology specialists worked with the community and inpatient neurological rehabilitation services. Clinical psychologists provided support to people undergoing rehabilitation as motivation of the patient is a key factor in progress. One patient told us that they had been assessed for memory problems and that the psychologist had been sensitive and supportive in undertaking the assessment. In addition other counselling support was arranged for patients and relatives where required.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Services were responsive because they were strongly focussed on the needs of patients. There was detailed assessment of patients problems and specialist staff worked together to plan individual programmes of rehabilitation for patients. There was open flexible access for those patients who would benefit from the specialist service. Patients and their relatives or carers were closely involved at all stages of care planning with the key driver being arrangement and preparation for discharge.

Meeting people's needs

The clear aim of the rehabilitation team was to meet patient's needs. This was very apparent in the way all staff spoke about the role they had in the team with the patients at the focus of their activity. Therapy, nursing and medical staff were experienced specialists who were able to assess patient's needs and abilities. We saw in patient records that

a wide range of detailed assessments were used to establish patient's needs before rehabilitation and to check progress. Patients had the processes explained so that they were fully aware of the short and long term goals of therapy. All staff we spoke with conveyed a spirit of collaboration with the patient and the wider team in the ward and community.

The ward matron provided an outreach service to assess patients in acute hospitals locally. Using specific criteria and clinical expertise the matron was able to agree with the rehabilitation consultant to admit patients to the ward who would benefit from the intense support available. There was a well established home rehabilitation service which provided a similar intensity of support for patients who could go home from acute units or on discharge from Snowdon ward. This team worked very closely with the inpatient staff to share knowledge and collaborate on providing effective transition for patients to their home.

Access to services

There were clear access criteria for the ward based service. Patients who lived in the catchment areas defined by local commissioning were able to be admitted if they had a condition which meant they would benefit from the specialist rehabilitation service. Staff told us that the ward was generally accepted to provide a resource that is adequate for the catchment area. At times some patients may not be able to be admitted due to bed availability or their condition although the team told us they were flexible in trying to meet people's rehabilitation needs. Staff collaborated to endure effective discharge with the home neuro rehabilitation service or other community based teams depending on location of the patient's home.

The criteria for admission were flexible although a key issue was the likelihood of actual progress being made in rehabilitation. Staff told us that some issues that could affect the potential progress in rehabilitation were the patient's age or cognitive ability. This meant that people who were very confused or living with dementia may not be suitable for admission to the service.

Care co-ordination

There were good arrangements to ensure effective discharge. The multidisciplinary team monitored progress daily, undertook weekly reviews. There were also more detailed reviews with the patient involved at ten days into admission and then approximately every two weeks to plan the care and rehabilitation programme. The team liaised closely with social services and community therapy staff to ensure any resources required to facilitate discharge were ordered and secured so as not to delay discharge. At multidisciplinary meetings where the patient was not present a key worker or nurse in charge was tasked with ensuring the patient and family were informed of progress towards discharge.

Learning from experiences, concerns and complaints

We saw that the trust was proactive in gaining the views of patients and relatives. At this service there was a weekly meeting for patients at which patients or relatives could raise issues about the running of the service or their experience of care. We found there was an open culture and that all staff could raise issues or discuss the way care was provided. Patient survey results were collected monthly and these were reported to senior managers. Patients told us they knew the staff well, had a key worker they could discuss issues with but they also knew how to complain if the need arose.

There were examples of how the service had developed ways of providing the service that met the needs of their patient group. We saw that communication boards were installed in each patient's room which patients told us had improved their understanding of the schedule for their day and key issues they were concentrating on in the rehabilitation. Low profile beds were available to all patients as there was an increased risk of falls in the type of patient admitted to the ward. The slight restriction on arrangements for mealtimes, whilst having open visiting, was in place to promote social interaction whilst encouraging physical rehabilitation.

Are community inpatient services well-led?

The service was well led because clinical and operational managers were visible to staff and patients and staff said they could raise issues when required. There was regular monitoring of the quality of care which was reported to trust managers and performance was challenged where needed. There was a culture of providing high quality rehabilitation service and using current best practice as learnt through networks and sharing practice

Community inpatient services

Vision and strategy

Senior managers told us about the priorities for the trust and how these had been represented on the 'Solent Wheel' to explain and remind staff and service users. We saw this information was displayed in the ward noticeboards and office. We saw that key objectives from the trust overall priorities were included in staff personal appraisal and development plans. Staff told us they were focused on patient care and that providing a good service to patients and meeting their needs also met trust priorities.

Key priorities were clearly evident in reporting and in actions to improve patient care. For example the intention of the trust to reduce the incidence of avoidable pressure sores. Staff told us they had appropriate beds for the type of high risk patient they cared for and that they could secure equipment and advice from the tissue viability specialists when needed. Staff knew there was increased scrutiny on this issue. There was review of performance and actions to reduce sores by pressure ulcer panels which further raised staff awareness.

Governance arrangements

The trust board assurance committee reviewed performance of all services using a monthly review of quality, safety and patient feedback indicators. Serious incidents were investigated within nationally required timeframes and specific notes made for lessons to be learnt across service areas. We saw that managers of the different service areas met regularly to compare performance and learning at a peer quality review meeting. A dashboard of performance that service managers review includes patient satisfaction, clinical outcomes including dependency scores, and compliance with 45 minutes therapy five times per week for those patients on a rehabilitation programme.

Leadership and culture

Staff were aware of the management structure and were confident that their service line manager was aware of issues in the clinical area. Patients told us that they knew the ward manager and matron sufficiently well to raise any issues of concern. Staff told us they felt supported to develop skills in the clinical practice of the ward and we saw they were included in team meetings, and planning meetings about patient progress.

Staff told us that mandatory training for some topics was through computer based elearning training. However many staff told us they did not have time allocated to undertake the training effectively and some said it was not their preferred style of learning. The arrangements were new but some staff felt that there should be an option to attend alternative methods such as face to face training to ensure learning about key topics was effective.

Acting on feedback

The service held a patient meeting each week and there was continual dialogue with patients by all the multidisciplinary team about their care plan. This meant that patients told us they had been able to make their views known about the service and have their preferences met where possible.

Trust senior managers reviewed the results of patient feedback each month. The Friends and Family Test which asks patients how likely are they to recommend the service to friends and family if they needed similar care or treatment was reported for all areas. For Snowdon ward it had been high for most of the year 2013-14 but had dropped slightly in January and February 2014. Patients we spoke with were very satisfied with the support they received on the ward.

Continuous improvement and innovation

Clinical staff we spoke with told us they used current guidance in the planning of patient care and staff in different services at the trust confirmed that pathways of care were applied consistently. Staff said that they shared ideas and discussed care with colleagues at meetings between teams in different localities. They told us about an open day where rehabilitation teams from across the trust had met to hear presentations and share good practice. Some clinical staff and managers were linked with regional clinical networks for rehabilitation professionals. Senior managers told us they met with operations directors every two weeks to review lessons learnt across the different services in the trust.