Central Surrey Health Limited

1-199797673

Dorking Community Hospital

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)
1-506761958	Dorking Community Hospital	Dorking Community Hospital	RH4 2AA

This report describes our judgement of the quality of care provided within this core service by Dorking Community Hospital. 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 Dorking Community Hospital and these are brought together to inform our overall judgement of Dorking Community hospital

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

Overall, this core service was rated as good. We found the Dorking Community Hospital was good for safe, effective, caring, responsive and well led.

We inspected the regulated activities of diagnostic and screening procedures and treatment of diseases, disorders and injuries.

The provider, Central Surrey Health has been established as a social enterprise and the staff working for this organisation are co-owners and are referred to as such throughout the report.

During our inspection we spoke with nine patients who were using the service and two of their relatives. We spoke with 21 co-owners including nurses, doctors, and therapy and administrative staff.

Our findings were as follows

- Systems to report incidents were used effectively and, when indicated, practice was changed.
- Generally, patients received their medicines safely and there was good governance of medicines although some aspects of medicines management needed improvement.
- Facilities were well maintained and there were good infection prevention and control practices which staff understood.
- There were systems for assessing and mitigating risks and initiatives were taken to keep patients safe within the hospital.
- Care was provided in line with national best practice guidance. A rolling programme of local audits ensured standards of care were maintained. Patient outcomes were monitored.
- There was a continual focus on professional development and clinical competence of co-owners and their performance was appraised.
- There was good multidisciplinary working with access to specialist services when required. The team worked cohesively together.
- Patients were very positive about their experience. They were treated with kindness, respect and dignity and were included in decisions relating to their care and treatment.
- Services were planned and delivered to meet individual needs and which ensured a focus on rehabilitation in an environment that was appropriate.
- There was a shared vision and philosophy of care in the service which supported a multi-disciplinary approach with strong co-ownership engagement. Senior leaders were visible and co-owners were positive about the leadership structure.

However we also found:

- The ward environment could be made more dementia friendly.
- The temperature of rooms where medicines were stored were not monitored.

Summary of findings

Background to the service

Central Surrey Health Limited is the registered provider for Dorking Community Hospital. The hospital provides a community inpatient service on Ranmore ward which has 22 beds. On the day of inspection, an additional four beds had been opened in response to increased demand and 26 beds were in use. The services provided include intermediate care, palliative care and rehabilitation.

Patients are admitted to community inpatient services from acute hospital or from their own home. At Dorking Community Hospital medical cover is provided by a local General Practitioner Practice.

Central Surrey Health has been established as a social enterprise and the staff working for this organisation are co-owners and will be referred to as such throughout the report.

Our inspection team

Our inspection team was led by Shaun Marten, CQC inspection manager and comprised of two inspectors and one specialist advisor with expertise in community therapy services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information.

During the inspection visit the inspection team:

- Visited Dorking Community Hospital looked at the quality of the care environment and observed how staff were caring for patients
- Spoke with nine patients and two relatives who were using the service
- Reviewed 11 comment cards
- Spoke with 21 co-owners including nurses, medical staff, occupational therapist, physiotherapist, therapy technicians and administrative staff.
- Attended a multi-disciplinary meeting
- Looked at five care and treatment records of patients

Reviewed a range of policies, procedures and other documents relating to the running of the service.

Summary of findings

What people who use the provider say

Patients we spoke to were consistently positive about their experience. A typical comment received was 'All staff are kind and friendly and nothing is too much trouble'. One patient described the team as 'wonderful' and another patient commented that the physiotherapist 'went above and beyond' what she expected of her treatment.

Comments included the comment by one patent who said on arrival at the hospital, "I was greeted by all the staff and made to feel an individual again by their caring, kind, smiling, attitude and slowly regained confidence". Another patient described herself as lucky to be at this particular hospital and said, "The nurses are very caring, and help us in every way" and several patients commented on the happy atmosphere and the care from the physiotherapist team.

One patient's relative said the care given to her parent was exceptional and the staff had cared for the family by giving time and clear explanation of treatments. Another relative praised the support she received in finding an appropriate care home for her family member.

Patients told us they were included in discussions and decisions relating to their care and treatment.

A patient's relative praised the "excellent caring" and was pleased with how his relative was doing saying there was no need to bring anything in as, "Everything is provided,a phone is brought to the bedside if that is required". They also commented on convenient visiting times and easy free parking

Dorking Hospital received four reviews on the NHS Choices website, three of which were positive and one was negative, the ward manager responded to the feedback and in the case of the negative comment apologised and stated they would investigate.

Good practice

- We saw that there was an imaginative approach on managing the risk of patient falls with the desktop mapping of the ward using Lego enabling co-owners to identify where falls had occur and where there might be increased risk for the patients. This heightened the awareness of all the co-owners to patient falls and not only enhanced the safety of the patients it was a learning tool for staff that was had a good practical application.
- The introduction of the 'blue moon' project that enabled staff to identify patients with cognitive impairment such as dementia meant that by the wearing of a blue wristband co-owners could easily identify that certain patients needed additional support to be safe in their surroundings. We saw this as enhancing safety for particularly vulnerable patients.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider should:

- Monitor the ambient temperatures of rooms where medicines are stored to ensured they are kept in optimal condition
- Consider making the ward environment more dementia friendly

Central Surrey Health Limited

Dorking Community Hospital

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Overall we judged that safety at Dorking Community Hospital to be good.

- There were systems for the reporting of clinical and other incidents and co-owners were aware of and confident in these. Incidents were investigated appropriately and root cause analysis was used to review serious incidents. There were mechanisms for feeding back to individuals and staff teams. We saw that lessons learnt were widely disseminated and we saw examples of when practice had been changed.
- There were robust safeguarding structures and procedures and all co-owners we spoke to were aware of their responsibilities in relation to these. We saw a positive approach to ensuring staff were kept aware of how to escalate any concerns.
- Medicine management was generally managed safely with appropriate governance in place. Clinical co-owners underwent relevant training and practices supported by audit and consistent monitoring.
- The hospital was clean and tidy with cleaning checks in place. Cleaning standards were kept under review and corrective action taken if necessary. Standards were supported with appropriate infection prevention and control practices and audit.
- Statutory and mandatory training for co-owners was monitored. Time was made for the completion of training and compliance was good.
- Staffing levels were maintained at an agreed level that enabled staff to meet the needs of the patient safely. There was adequate medical cover and medical assistance could be accessed if required.
- There were systems to identify, monitor, and manage risk to patients. Risks were identified and recorded on the risk register. We saw examples of risk assessments that were regularly reviewed and noted that control mechanisms were in place.

Safety performance

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. The hospital collected data for NHS patients. The submission included data on patient

falls, pressure ulcers, and catheter and urinary tract infections. For the period of February 2016 to December 2016 we saw that the percentage of harm free care varied from 82% to 100%.

- We saw that the NHS safety thermometer data was completed every month and was tracked from 2012 enabling clinical co-owners to identify trends. We saw that there was no increase in the occurrence of new pressure ulcers and the incidence of falls and new venous thromboembolism (VTE) was decreasing.
- Co-owners we spoke with were aware of the NHS safety thermometer and discussed initiatives such as those to manage the risk of patient falls which included the use of sensor mats on chairs and in beds to indicate when a patient might be moving without supervision and would be more at risk of falling.

Incident reporting, learning and improvement

- During October 2015 to October 2016 there was one reported serious incident requiring investigation. There were no "never events" reported in the past year. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We saw a monthly incident report for clinical co-owners information. There were 11 incidents related to Dorking Community Hospital the accompanying narrative report identified what incidents were and actions taken.
- We saw an annual report of incidents that showed on transfer from the NHS trust hospitals, patient information was not always adequate. This accounted for 30% of the reported incidents. We were told that senior members of the ward team were working with the local NHS trust hospital to address this and that the outcome would be monitored through the incident reporting system. The second most commonly reported category was slips trips and falls.
- In response to the risk of falls, we saw a desktop initiative where the ward area was mapped out to scale using Lego and the patient activity and flow was analysed to highlight areas where patients might be at risk of falling. This was in response to previous incidents and reflected the co-owner team approach to improving safety and care. Clinical co-owners spoke positively about this as a measure to identify risk and enable them to consider what measures could be put in place to minimise risk.
- The community inpatient service used an electronic incident reporting system. All co-owners we spoke with were knowledgeable about the process and could tell us how and when to report incidents.
- We saw that a root cause analysis (RCA) investigation was performed for serious incidents. We saw examples of these investigations and saw they were comprehensive and detailed. They all contained an action plan. One example showed following a patient fall, the cause was identified as incomplete prescribing of the patient's medication on admission. A new checking process ensuring that drugs had been prescribed correctly had been made more rigorous with double-checking of medication charts on admission.
- Co-owners told us they received feedback when they reported an incident. We looked at minutes of staff meetings and noted there was a standing agenda item where reported incidents and their outcomes were discussed.
- There was evidence of learning from previous incidents. For example, co-owners implemented a new policy for medicine rounds that meant patients should be discouraged from taking a shower during this time to reduce the risk medicine doses would be missed or delayed.

Duty of Candour

- Regulation 20 of the Health and Social care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. This regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the person in relation to the incident and offer an apology.
- There was policy for providing care in line with duty of candour legislation. The policy was in date and readily available to co-owners.
- We asked a number of clinical co-owners about their understanding of candour and all were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency.

Good

Are services safe?

- We were given one example of an incident where duty of candour was exercised appropriately.

Safeguarding

- CQC received no safeguarding alerts or concerns in relation to Dorking Community Hospital between 19 October 2015 and 18 October 2016.
- We saw there was a robust structure and arrangements in place to safeguard adults and children from abuse. There were clearly designated leads for safeguarding titled safeguarding advisors that worked across Central Surrey Health and visited Dorking Community Hospital on a regular basis.
- The safeguarding lead role had established links with the leads in the local trust hospital to ensure their own knowledge was kept up to date and for training purposes
- We saw all safeguarding alerts were reported on the electronic incident reporting system. In addition this was monitored by using a database to enable any trends to be identified. There was a system of checks and alerts in place to identify how issues arising in one area may potentially affect others. We saw evidence that safeguarding alerts were monitored and how trends had been identified.
- Co-owners received appropriate training in safeguarding adults and children as part of the statutory and mandatory training programme. Level one adult and children safeguarding training was provided for all co-owners at induction. Level two safeguarding training was provided for all clinical co-owners of grade five or above. Safeguarding leads were trained to level three. All co-owners undertook two-year refresher training.
- Safeguarding training included responsibility for PREVENT which is training to safeguard people and communities against the threat of terrorism.
- Training rates for adult safeguarding level one were 96% and for level two were 100%. Safeguarding PREVENT training compliance was 91%.
- We saw evidence of quarterly safeguarding meetings and we were told the report from this meeting was reviewed at the clinical governance committee.
- Safeguarding concerns and alerts were reported to the Multi-Agency Safeguarding Hub (MASH), the single point of contact for all professionals to report any Adults and Children's safeguarding concerns. This group was accountable to the Surrey Safeguarding Board. There were representatives from the provider on that board.
- The safeguarding leads participated in appropriate working parties, which reported through to the Governance Committee.
- The senior team included safeguarding updates and information in monthly core briefs to co-owners. We saw evidence of recent promotional materials that were circulated to co-owners to remind them of the correct safeguarding escalation process including prompt cards, mouse mats and posters.
- Co-owners we spoke with were aware of the principles safeguarding and could describe what action they would take if they suspected abuse.

Medicines

- The pharmacy service for community inpatients was supported by a registered pharmacist employed by Central Surrey Health (CSH) who worked across all three community hospital sites including Dorking Community Hospital. This role was advisory to clinical co-owners and patients and was responsible for the training of clinical co-owners and overall medicine management including leading the medicine management committee. This role gave oversight on medicine management policies, medication ordering, prescribing and audit.
- We saw systems of antibiotic stewardship with a monthly audit checking which antibiotics had been prescribed, checking that guidelines had been followed. Results were variable and ranged between 50% and 100% compliance. The small numbers of prescriptions made the variance more evident. The corporate pharmacist told us that this was discussed at the governance meeting. Following the antibiotic audit we saw evidence of an email to prescribers showing results and asking for corrective action.
- There was a service level agreement (SLA) in place with a local hospital to supply medication and an SLA with a third party to supply pharmacist support one a week. We saw that this weekly visit ensured stock levels were maintained, ensured medication chart checks were made and reconciliation was completed and gave

advice when necessary. We saw stock checks were done monthly. We saw medicines were delivered on same day as ordered that these were signed for and stock checks were done monthly.

- We saw an appropriate person was the accountable officer for controlled drugs.
- All nurses completed medicine management training and calculation competencies on joining the hospital and compliance was 100% and we saw records that confirmed this.
- Medicines were stored securely in locked cupboards or trolleys. We observed that these storage facilities were locked and that access to keys was controlled by the nurse in charge.
- The ambient temperature of the room where the medicines were stored was not checked. This meant that medicines could be stored at inappropriate temperatures, which could adversely affect their efficacy.
- We saw that medicines were stored in dedicated medication fridges when applicable. Fridge temperature monitoring was done daily and when asked staff knew what to do if the temperatures were found to be outside the recommended range. We checked the fridge and all medicines were in date and appropriately stored.
- Co-owners used a 'do not disturb' tabard when administering medicines. We saw that no medicines were left at the bedside. This complied with 'Standards for medicines management' issued by the Nursing and Midwifery Council (NMC).
- We checked three medicine charts and saw that prescribing was in line with national guidance. We saw that charts were marked as being reviewed by a pharmacist who had documented input regarding the medication. There were no omissions in giving medicines.
- We looked at controlled drugs (CDs) which are medicines liable to be misused and requiring special management in wards. We noted the CD order book did not have a signed receipt of drugs. CD registers were accurately maintained and CDs were stored appropriately and balances were regularly checked.
- We saw there was a system for obtaining and checking of medicines to be taken out (TTOs). TTOs were prescribed by the doctor, checked by pharmacy and checked when delivered.
- We saw a current signature list had been sent to pharmacy but no copy was on the ward which meant that signatures could not always be validated and identified.
- We saw medication storage checks were being completed weekly which included checking completion of medication charts and a check of controlled drugs. At the time of our inspection compliance was at 100%.

Environment and equipment

- The Dorking Community Hospital services premises and grounds were generally well maintained however the external waste collection area was untidy. There were numerous pieces of old equipment, for example patient bed trolleys, heaped together within a fenced area that was secure but exposed to the outside, there was no assurance of when this was being collected. The provider told us this equipment was in a designated collection point for the community equipment provider and collection times and arrangements were outside their direct control.
- Patient led assessment of the care environment (PLACE)is a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of teams to assess how the environment supports the patient's privacy and dignity, food, cleanliness and general building maintenance. PLACE assessments for 2016 awarded a score in 'condition, appearance and maintenance' of 88%, worse than the national average of 93%.
- Co-owners received health and safety training as part of the statutory training programme; this showed a compliance rate of 96%.
- Co-owners described systems for reporting concerns and repairs to us and told us that problems were addressed in a timely manner. We were given an example of a fridge requiring repair on Christmas day and this being done.
- The general ward area including the kitchen was seen to be generally clean and tidy.

Good

Are services safe?

- We saw and checked two patient hoists and saw these had been serviced. We saw that wheelchairs were regularly maintained on contract.
- We saw that the resuscitation trolley was located in the main ward area, in a central location and that equipment was readily available. We saw that daily checks of the defibrillator were to be made but seven checks were missing in December and at least two checks were missing in the preceding month. We saw two checks were missing on the checking of the trolley contents. This was bought to the attention of the staff at the time of inspection.
- Random stock checks were correct and the attached oxygen cylinder was full and in date. We saw storage of medical gases was appropriate with cylinders secured to the wall.
- Equipment in sluice room was clean and tidy this area contained a spillage kit which was in date.
- We saw evidence of correct management of specimens. Patient detail, sent and received date was seen to be complete showing a complete audit trail.
- Co-owners completed weekly environment and safety checks such as testing call bells, this was seen to be complete with no omissions.
- The ward had visiting times to ensure patients were kept safe out of hours. This meant the entrance to the ward was locked from 5.30pm daily and all visitors between then and 8.30pm were screened by co-owners.
- Risks associated with site management out of hours were not fully mitigated. For example, co-owners on the ward were in the building by themselves overnight. Although the site was locked, there were no security staff available and co-owners told us poor lighting at the entrance meant they had to walk to and from their car in darkness. This risk was partially mitigated by access to an on-call estates manager and secured internal and external doors but co-owners told us they did not always feel secure. Co-owners told us although they could feel isolated out of hours, when they had needed to contact the on-call manager, they had received a suitable response. For example, one co-owner had called the manager overnight when the intruder alarm had been activated. They told us, "[The on-call manager] took over the problem so we could get on with caring for the patients."

Quality of records

- Records were stored securely in accordance with the Data Protection Act 1998 and were accessible to clinical co-owners when needed.
- Co-owners were aware of their responsibilities in relation to information governance and 96% had completed training in this area.
- We viewed five sets of patients records and found them to be complete and accurate with good evidence of a multi-disciplinary approach. Therapist notes were a combination of written and electronic records and were easy to follow. Onward referrals for treatment were sent electronically.
- Nursing records contained admission assessments, relevant care plans and risk assessments and were generally of a good standard with notes dated, timed and signed
- A "Do not attempt cardiopulmonary resuscitation" (DNACPR) form was seen in one set of notes appropriately filled out signed and dated in line with national guidance.

Cleanliness, infection control and hygiene

- There have been no cases of Meticillin-resistant Staphylococcus aureus (MRSA) or Clostridium difficile (C. diff) in the last year.
- The community hospital premises appeared clean and hygienic. Patients and relatives we spoke with commented positively about the cleanliness of the environment. Results from the patient-led assessment of the care environment (PLACE) in 2016 achieved a score of 97% for cleanliness in line with the national average.
- Cleaning checklists for each day were seen to be completed for current and previous month. We saw there was a completed deep cleaning schedule for the ward area. Records showed that cleaning standards were audited monthly and scores showed a satisfactory level of performance with compliance at 97%.

Good

Are services safe?

- We saw an environment audit was done in August 2016 and an action plan resulting from this audit was seen to be fully complete. This meant that cleaning standards were kept under review and we saw evidence of corrective action taken when necessary.
- We checked areas on the ward used for storage and saw that clean and dirty items were kept segregated. We saw the use of "I am clean stickers" when equipment was cleaned before being put back in storage.
- Cleaning and nursing co-owners clearly understood their responsibilities in relation to cleaning. We saw checklists, which clearly set this out. We saw these checklists were consistently completed.
- Infection prevention and control training was part of the statutory training for clinical co-owners. We saw records that showed that there was overall compliance rate of 78%.
- We saw that co-owners used personal protective equipment when appropriate. We saw that co-owners decontaminated their hands in line with the World Health Organisation's guidelines (Five Moments for Hand hygiene). Hand hygiene audits were carried out on a regular basis the most recent in December 2016 showed a compliance score of 95% when observing ten members of clinical staff. We saw that actions to be taken were then shared with the clinical team.
- We were told that any patients needing isolation would be moved from the general ward area and nursed in one of the side rooms, but were unable to test this during our visit.
- There was a lead nurse in post for infection prevention and control (IPC) and an IPC link person for the ward who attended quarterly meetings and was supported by the lead nurse in completing relevant audits.
- The infection control lead nurse was based on the ward one day per week. This individual provided targeted support to co-owners and conducted hand hygiene and environmental audits to encourage continual compliance with good practice guidance. This nurse told us they felt infection control practice had improved as a result of co-owners feeling more empowered to challenge bad practice, such as when a colleague entered the ward with long sleeves and another individual did not gel their hands.
- There were appropriate systems and arrangements for the segregation and disposal of domestic and clinical waste. External to the building, clinical waste was seen to be correctly managed with locked bins and weekly collections.
- There were good processes in place for sharps management which complied with the health and safety Sharp Instruments in Healthcare Regulations 2013.

Mandatory training

- Statutory and mandatory training was monitored and all co-owners were expected to attend on an annual basis. Records indicated that statutory training compliance was 94% and mandatory training compliance was 85.5% against a target of 95%.
- Co-owners were required to undertake statutory training courses, which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, safeguarding adults and children at risk.
- Mandatory training was required training and role specific and both statutory and mandatory training was a combination of electronic and face-to-face training depending on the subject.
- We found time was allocated for co-owners to attend training and that a current record was kept on display ensuring that co-owners could monitor compliance.

Assessing and responding to patient risk

- We saw comprehensive risk assessments were carried out on patient admission and kept in the patient records. This included assessing the patient for example against the risk of falls, moving and handling, use of bedrails, skin integrity and pain assessment. In the four sets of patient records we looked at, risk assessments had been regularly reviewed and co-owners noted that specific control mechanisms were in place.
- We saw an initiative of using coloured wristbands to enable co-owners to easily identify how much support patients needed when walking. For example, a green wristband indicated the patient was independent, a yellow wristband indicated the patient required supervision and a red wristband indicated the patient

needed assistance. We spoke with three patients and they all said they had given consent for the wristband to be in place and understood what the wristband meant and why it was in place. Co-owners we spoke with were positive about this initiative and said it helped them monitor patients more easily.

- For those patients that were identified to have cognitive impairment such as dementia, we saw evidence of an initiative called 'blue moon'. Blue wristbands were used for these patients enabling co owners to manage the patient's risks accordingly. We were told that at night the nurses would sit in the patient bays to ensure that patients identified by a blue wristband were kept under closer observation and kept safe. At night there was lighting underneath the beds to help co-owners see any patient movement.
- Co-owners introduced a 'cohort' system to the ward as a strategy to reduce the risk of falls overnight This meant patients with similar risks were cared for in the same bed bay so they could be observed together more closely. For example, the bay nearest to the nurse station was used for patients at high risk of falls and during the night a co-owner was based within viewing distance of the area. This enabled them to identify if patients were trying to get out of bed or were unsettled more quickly.
- There were three daily nursing handovers, one at the beginning of the day, one at lunchtime and the other towards the end of the day. We saw the handover paper information that each co-owner used and saw that it contained up to date information on all patients including the nursing plan, discharge date and other relevant information. Co-owners told us this helped to keep them up to date with the patient's condition.
- Attached to the handover notes were prompts of recent relevant information for example reminding co-owners that patients at risk of pressure sores on their heels would have signs behind their beds and to use their clinical judgement and to gain consent from the patient first. This acted as a prompt to co-owners to remind them of the preferred practice to 'float the heel' by putting a pillow under the calf.
- We saw Medicines and Product Regulatory Agency (MHRA) alerts were a standard agenda item on the medicine management committee which enabled alerts to be reviewed and actioned where appropriate.
- The hospital used a national early warning system (NEWS) track and trigger flowchart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enabled co-owners to identify patients who were becoming increasing unwell, and provide them with increased support. We reviewed five sets of patient's notes and found that generally the NEWS score was calculated; however, in one set of notes the respiratory rate was not recorded on at least two occasions which means the overall scoring might not be accurate.
- Co-owners were confident that NEWS was established and would effectively highlight patients at risk. Examples were given and we reviewed the notes of a patient that was urgently referred to the local trust hospital accident and emergency department when signs of deterioration were identified.
- Co-owners actively learned from the monitoring of patients to avoid deterioration. For example, where they identified an early infection through NEWS, they presented this to colleagues and demonstrated how the tool could improve patient outcomes.

Staffing levels and caseload

- There was no acuity or labour management tool in use on the ward to assess staffing requirements. However the ward manager was able to describe how staffing levels were managed using a risk based approach depending on patient numbers and acuity. Activities on the ward for that day were taken into account.
- We looked at off duty rotas over the last two months and saw that during the day the nurse to patient ratio was between 1:3.5 and 1:5 and at night this was 1:7 or 1:8 depending on how many beds were open. The Royal College of Nursing guidance on Safe Staffing for Older People's Wards (2012) suggests ratio of staff to patient should not exceed 1:7 and at an optimal level should be 1:3.8 depending on acuity. The hospital was generally complying with the guidance.

Good

Are services safe?

- We noted that registered to unregistered staff ratios were maintained at least 1:1 and that the minimum number of registered nurses on duty at any time was two.
- We were told if more staff are required there is a named agency that they book staff from and they will try to ensure continuity of staff. A flexible workforce coordinator assisted with finding staff.
- The ward had capacity to open an additional six beds during times of exceptional demand, and there was standard operating procedure to guide this process. This included an additional twilight shift being added to the nursing numbers when the extra beds were open. However, the ward manager had escalated the risks associated with short staffing when additional beds were opened at short notice. This was because it was often not possible to significantly increase staffing levels at short notice, which meant that staffing levels did not meet the planned numbers. Although an additional occupational therapist had been provided for the latest increase in bed capacity, there had not been a resolution for nurse levels at short notice.
- Patients we spoke with felt their needs and requests for help were responded to promptly. This was corroborated by interrogating the call bell system to see how quickly calls were responded to.
- Staffing levels for therapy staff was seen to be adequate with a Monday to Friday service and the therapist supported by a technician. We noted use of locum staff was funded in response to winter pressures.
- Medical cover was provided by the local General Practitioner medical practice with two GPs providing most of the daily cover based on the ward area from 8.30am. We spoke with the visiting GP. Out of hours cover was provided by a third party provider. Co-owners told us this worked well and they could access medical assistance if required.

Managing anticipated risks

- On the day of inspection, we saw that the previous week additional beds had been opened in response to demand. We saw that co-owners were informed of this on the handover prompt sheet and that allocation of staff was managed accordingly.

Major incident awareness and training

- There was a major incident and business continuity plan in place. This had been updated in the previous year and provided guidance to staff on how to seek urgent help in the event of an evacuation or the building became uninhabitable. An on-call manager was available at all times and had access to an escalation process in the event a major incident interrupted the service.
- There had been no recent scenario training for clinical emergencies such as cardiac arrest and anaphylaxis. We were told that this was being organised. All co-owners were up to date with life support and anaphylaxis training.

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

- Care was provided in line with national best practice guidance and was benchmarked nationally against other community hospitals. The hospital performed better than the national average in average length of stay and delayed transfers of care.
- Co-owners used a rolling programme of local audits to establish the standards of care and patient outcomes using recognised professional tools. Results indicated the service had improved patient outcomes in measures against mobility and the ability to perform daily tasks.
- Patients' nutritional needs were assessed using a nationally recognised tool and patients were provided with food to meet their needs. Co-owners monitored nutrition and hydration using recognised risk assessment tools and the catering service provided food to meet modified diets.
- A dedicated discharge coordinator liaised with the multidisciplinary team to ensure discharges were safe, timely and in the patients' best interests.
- There was a continual focus on the professional development and ongoing clinical competency assessment for co-owners at all levels.
- Co-owners undertook an annual appraisal and a professional development review (PDR).
- Patients were cared for by a multidisciplinary team including a tissue viability nurse, a mental health practitioner and specialist Parkinson's nurses. This helped to ensure patients received specialised input in addition to the care, treatment and rehabilitation provided by co-owners.
- Consent to care was documented consistently and care was provided in line with the requirements of the Mental Capacity Act (2005). Care plans and guidance policies were available for staff to provide care to patients with a Deprivation of Liberty Safeguards authorisation in place.

Evidence based care and treatment

- Central Surrey Health participated in national benchmarking of inpatient services against the national Community Benchmarking Network standards. This enabled the service to compare performance in activity, quality and outcomes, staffing and finance against 72 other community organisations.
- Co-owners provided care and treatment using the Department of Health "Essence of Care" benchmarks as a baseline for safety and experience. More up to date guidance from the National Institute of Health and Care Excellence (NICE) and other professional organisations was used to supplement the essence of case benchmarks and co-owners maintained up to date knowledge of these.
- Co-owners used best practice guidance and tools to assess and provide care. For example, many patients were at risk of developing pressure ulcers. To reduce this risk, co-owners used the Pressure Ulcer Programme of Research (PURPOSE-T) risk assessment tool that could be adapted as a primary or secondary evaluation tool.
- Palliative care was provided in line with, and benchmarked against, NICE clinical guidance 31 in relation to care of the dying adult. This included a quarterly multidisciplinary palliative care forum attended by the local ambulance service, speech and language therapists, a heart failure nurse, adult social care, clinical nurse specialists, pharmacists, student nurses and district nurses. We looked at the minutes for the three meetings prior to our inspection and saw they were well attended and included a clear focus on patient wellbeing and outcomes.
- Between April 2016 and September 2016, clinical and non-clinical teams conducted 27 local audits. This programme included audits to establish standards and benchmarks of patient care such as a ward-based intervention audit and an elderly mobility scale audit for the physiotherapy team. Audits were also carried out to identify areas of good practice and areas for improvement amongst the co-owner team, such as an audit of clinical supervisions and a record keeping audit.

Good

Are services effective?

- Co-owners had the opportunity to participate in audits to develop their skills. For example, the medicine management audit was rotated through the nursing team and individuals had contributed to developments as a result of learning from results, such as adding nutritional supplements to the audit.
- The ward manager analysed the results of re-audits to identify improvements and areas where improvements were needed. This enabled co-owners to benchmark standards of care against their own data as data available nationally was more commonly associated with acute hospitals. For example, the service analysed the numbers of patients who were transferred back to accident and emergency after being admitted from there initially. In addition, patients who were discharged with the maximum package of care but were re-admitted after a fall were investigated to identify how the discharge process could be improved.

Pain relief

- Clinical co-owners were trained in nurse-led pain management and a pain scoring tool was used during medicine rounds and to administer "as needed" pain relief medicine. We observed this in practice. The physiotherapy team assessed patients for pain during rehabilitation sessions and provided pain relief in advance of planned therapy sessions.
- Co-owners used a specific care pathway to manage pain in patients who received palliative care. This included consideration of non-pharmacological pain management and a pain assessment tool based on patient behaviour. We saw these in use.
- The ward manager had adapted the national early warning scores (NEWS) system for the community environment to enable co-owners to more effectively identify and respond to pain.
- Co-owners had access 24-hours, seven days a week to a GP and hospice for advice and guidance on providing support to patients on a palliative care pathway. The multidisciplinary team also provided anticipatory medicines to ensure patients remained comfortable. We saw these in use in patient records and saw they were prescribed appropriately.

Nutrition and hydration

- Co-owners used the Malnutrition Universal Scoring Tool (MUST) to assess each patient's nutrition and hydration needs. We saw accurately completed assessments in patient records and co-owners re-assessed each patient based on their need.
- Although the service did not have dedicated dietician input, a dietician was based in the community team and could assess high-risk patients and help nurses to use food charts to monitor nutrition. Each patient was also reviewed by the community dietician once they were discharged home.
- Patients we spoke with told us they liked the food and felt they had enough to eat and drink. Although patients and visitors had access to fresh water and juice, tea and coffee at all times, co-owners provided formal beverage rounds seven times each day. This helped patients to stay hydrated and provided them with an opportunity to interact with each other and socialise.
- Co-owners described the quality of food as variable and said occasional complaints were received about this. The food available at mealtimes did not match what was available at the time of our inspection. This was because the increase in beds had meant the catering department had to reorganise the planned menu. Co-owners said as a result of feedback and an annual catering survey, the service had improved. For example, portion sizes had been modified and co-owners said planned meals were now more appropriate such as the removal of rice from the Sunday roast option. Co-owners also said the presentation of food had improved, which had been an area of feedback from elderly patients.
- The hospital had a cook and chill service. This meant food was delivered in a chilled state and then reheated with safety checks made of food temperature before serving. Catering staff kept a log book of food temperatures, which were recorded consistently.
- Catering staff maintained an up to date record of special diets that were required for patients and told us they worked closely with the nursing team to ensure patients got the right diet.
- Food was available 24-hours, seven days a week. This meant patients who were admitted out of hours always had access to meals and snacks.

Good

Are services effective?

- The hospital had been awarded a maximum five star rating from the Food Standards Agency for food hygiene and safety, structural compliance and management.

Technology and telemedicine

- GPs were contactable by text message. This enabled clinical co-owners to securely send information out of hours and receive guidance on care and treatment. For example, when a patient had not received a check related to their anticoagulation time that meant nurses could not administered a scheduled dose of medicine, they were able to share images of the most recent test results with the GP by text message. This meant the GP could quickly make an assessment and decision for nurses in the patient's best interest. Nurses transcribed the GP's instructions onto the patient's medicine chart and the GP signed this the next day.
- The service had adopted an electronic reminiscence tool to support patients living with dementia although this was not yet operational at the time of our visit.

Patient outcomes

- The discharge coordinator monitored delayed transfers of care in line with NHS England guidance. This included liaison with adult social care services to reduce delays and plan complex care packages. Although they reported this, the coordinator did not receive feedback or analysis on it. In the 2015/16 national benchmarking of inpatient services delayed transfers of care were significantly better than the national average, at 4% compared with 10%.
- A clinical lead continence nurse conducted an audit in 2016 to assess standards of care related to catheter care. This followed a serious incident in community services and aimed to ensure co-owners on inpatient wards recorded the type of catheter in place in progress notes. The results for Dorking Hospital showed 33% of patient notes included the catheter route. As a result of the audit, co-owners were offered training from the clinical lead continence nurse and a catheter documentation information poster was provided to support staff. We spoke with nurses who said they had worked closely with a catheter specialist nurse to achieve their clinical competencies, which meant they undertook practically-assessed experience before they were able to practice themselves.
- In the 2015/16 national benchmarking of inpatient services, Dorking Hospital reported a two day average increase in the length of stay, at 23 days, which was still five days better than the national average. The unplanned readmission rate was 9%, which was slightly worse than the national average of 7%.
- The service used the Modified Barthel Index (MBI) to measure each patient's functional ability to complete activities of daily living and mobility between their admission and discharge. In 2015/16, Dorking Hospital demonstrated an average 20 point improvement in MBI score between admission and discharge. Co-owners used the functional independence measure (FIM) in patient notes as an additional assessment of mobility and to ensure patient's rehabilitation needs were being met.
- The physiotherapy team led an audit of the elderly mobility scale (EMS) in 2015 and repeated this in 2016 to monitor the change in EMS between admission and discharge. The EMS is a tool used to identify the level of assistance patients may need and the risk of falls. The latest audit results indicated that increase in staffing numbers in the team had led to more one-to-one therapy sessions and better EMS outcomes as a result, including a 62% increase in the patients who experienced a moderate improvement in EMS by the time they were discharged. The physiotherapy team identified actions from the audit, including the introduction of additional measures to future work to identify when physiotherapists felt patients had reached their target rehabilitation goals.

Competent staff

- New co-owners undertook a two-day corporate induction followed by a supernumerary period in which they were mentored by an experienced colleague. New temporary co-owners also undertook a supernumery shift and agency nurses were given an induction and orientation that included emergency procedures and escalation pathways. The service-specific induction included communication standards with patients and colleagues, a detailed briefing on local and organisational procedures and confirmation of their role and responsibilities. Agency staff undertook a dedicated induction that included practical coaching on the recognition of key risks to patients, including pressure ulcers and safeguarding. The senior co-owner on shift

also ensured agency staff could demonstrate suitable knowledge of medicines management, infection control and health and safety guidance. We looked at the completed checklists and documentation for recent agency staff, which showed they were completed. We spoke with co-owners who had joined the service in the previous six months, who told us the induction had been detailed enough to prepare them for their role.

- Laptop computers had been provided on the ward to enable staff to complete training while on nightshift or during protected time In response to feedback from co-owners. This reduced the need for them to complete training out of hours and at home.
- Therapies co-owners had completed competencies to enable them to carry out access visits and to safely use rehabilitation equipment, which was documented and kept up to date.
- The senior team encouraged co-owners to continue their professional development. For example, one co-owner received support to complete their masters programme and another co-owner was due to start this in 2017.
- Co-owners had undertaken dementia training using a virtual dementia tool. This enabled them to experience the sensory disruption people with dementia can experience as a method to understand how to provide effective care. In addition, co-owners had undertaken a simulation exercise that involved wearing modified shoes to help them understand the symptoms of peripheral neuropathy. Co-owners described simulated exercises as very useful in helping them understand pain and symptoms from a patient's perspective.
- Other specialist training included sepsis awareness and responding to deteriorating patients. In addition, co-owners had taken additional training to help them identify early risk factors for pressure ulcers. This was in addition to mandatory training and provided nurses with additional knowledge to help them assess how often patients should move to reduce pressure risks.
- In the 12 months prior to our inspection, 95% of co-owners had had a formal appraisal. The figures reflected a number of new starters, who were not required to complete a PDR in the first year of employment but who were counted in the co-owner complement. We looked at two PDRs and found them to be structured and focused on the achievements of each individual as well as identifying opportunities for development in the following year. PDRs were empowering for co-owners and the senior team used them to encourage individuals to challenge themselves. For example, objectives included building confidence to challenge inappropriate referrals and progressing with a leadership development pathway. Co-owners told us the PDR process enabled them to plan additional training needs and interests and that the senior team supported them with this. For example, one co-owner had asked for more intensive training in electrocardiograms as part of their PDR, which had been sourced by the ward manager.
- A clinical supervision audit had taken place in 2016 to establish the effectiveness of one-to-one and group specialist training amongst clinical co-owners, including nurses and therapists. Co-owners gave positive feedback about the standard, quality and usefulness of supervision and highlighted the need for more reliable protected time to avoid training being cancelled due to clinical short-staffing. The head of quality and nursing implemented an action plan as a result, which aimed to embed the clinical supervision process into each team and service to reduce the risk of short-term cancellations or missed sessions.
- Co-owners were given the opportunity to specialise in areas of care of interest to them. For example, the organisation held regular meetings organised by groups involved with falls prevention, dementia, palliative care and infection control. The ward manager worked with co-owners to enable them to attend the meetings and engage with colleagues in audits and practice development projects. This had resulted in improved practice and safety. For example, the falls group identified a lack of training amongst nurses in post-fall first aid, including in spinal injury assessment. To address this the group updated falls policies and included after-care in the falls pathway to help improve co-owner understanding and patient experience.
- Although the ward was equipped to provide palliative care, including syringe drivers for pain medicine, co-owners were at risk of losing their skills due to low

patient numbers. To address this, the ward manager arranged for co-owners to visit a local hospice and undertake periodic refresher training with district nurses to maintain their competencies.

- There was a clear focus on adapting established training tools to meet the needs of patients and co-owners. For example, the team had undertaken bladder scanning and urinalysis training and then developed their clinical competencies to make a training package suitable for healthcare assistants. Co-owners also adapted clinical competencies to help provide training and development opportunities for student nurses.
- Allied health professionals offered nurses and healthcare assistants (HCAs) opportunistic learning opportunities on the ward, such as how to complete log rolls. This enabled physiotherapists and nurses to work together in the completion of appropriate care plans. In addition, physiotherapists supported student nurses through an access experience that enabled them to spend time shadowing to gain initial basic skills.
- HCAs were supported to develop clinical and professional competencies. For example, two HCAs had successfully completed the national care certificate and another HCA had started their nurse training.

Multi-disciplinary working and coordinated care pathways

- We found multidisciplinary (MDT) relationships worked effectively to improve patient outcomes. For example, by liaising with a mental health nurse practitioner, one patient who developed depression during their admission was ultimately discharged with no on-going mental health needs. In another case, a mental health nurse practitioner worked with a Parkinson's nurse to coordinate their complex care needs and secure a discharge into the community with significantly reduced mental health concerns.
- We observed a daily operations meeting that involved a nurse, occupational therapist, physiotherapist and discharge coordinator. There was a clear focus on discharge planning and assessing patient safety in the context of this.
- Co-owners updated patient handover sheets regularly to ensure the nursing plan, discharge date and other relevant information remained relevant. Co-owners told us this helped to continually monitor the patient's condition.
- Speech and language therapists had recently been introduced to the service as a result of safety feedback and incidents.
- Patients did not have access to podiatry input until they were discharged from the hospital. To mitigate the risks associated with this, nurses had been trained to cut, trim and take care of patients' nails as part of their personal care.
- The hospital was part of a health improvement health and care alliance. This aimed to facilitate teams from the hospital, adult social care, community health services and GPs into a single-team ethos to review planned admissions and discharges with early interventions to improve their outcomes. This included weekly meetings with social workers, therapists and paramedics who contributed to the planning model. We looked at the minutes of three meetings and saw they were well-attended and worked to ensure a positive and timely admission and discharge process for patients.
- Other specialties available to patients on referral from a clinical co-owner included a tissue viability nurse, a mental health nurse practitioner and specialist Parkinson's disease nurses.

Referral, transfer, discharge and transition

- Senior co-owners worked with staff in acute hospital trust accident and emergency departments to reduce inappropriate transfers. This included where patients were transferred to the unit without complete paperwork or a full discharge review of their medical condition and needs. In addition, patients were sometimes transferred without a nurse with them, which meant co-owners did not receive a full nurse to nurse handover. In such circumstances co-owners followed an escalation pathway to the acute hospital site manager to obtain critical information needed for the patient. We saw evidence co-owners were proactive in submitting incident reports in relation to unsafe admissions. For example, one patient had been transferred from an acute hospital without full medicine information and co-owners could not confirm if the

patient had received their last dose of a prescribed medicine. The hospital was unable to confirm this information and co-owners escalated this to a GP, who provided an urgent review to keep the patient safe.

- A dedicated discharge coordinator supported patients with complex health and social care needs to leave the inpatient ward with an appropriate package of care in place. This individual coordinated with the multidisciplinary community team, GPs and nurse co-owners to plan discharge as part of the admissions process. This included assessing patients for NHS continuing care. The discharge coordinator used a continuing care checklist that included a decision support tool to ensure referrals were appropriate and in the best interests of patients.
- A weekly discharge meeting took place every Monday with the discharge coordinator, ward nurses and a GP. Families and patients were involved in discharge planning and were invited to join the meeting. We saw evidence of this in patient notes and in the minutes of meetings.
- A dedicated information display was in place to help patients plan for their discharge by identifying rehabilitation needs at home. For example, co-owners had supplied information on how to make home environments safer with advice such as securing carpets, taking a sight test and rearrange furniture to make moving around easier.
- The discharge coordinator planned each patient's discharge to be individualised and ensured they had everything in place to achieve a positive outcome after they left the hospital. This included taking away medicines, transport arrangements, appointments with a district nurse and community matron and risk assessments including for issues such as continence and mental capacity. Patients and their relatives were involved in discharge planning and co-owners used a discharge checklist to ensure that while each discharge was personalised, a standardised approach was taken to ensure each patient had the same safety and planning considerations.

Access to information

- Co-owners relied on hospitals discharging patients into their care to provide appropriate documentation as there was not a shared electronic records system. This had not always happened and senior co-owners had worked with the hospital to implement a standardised system that meant patients left hospital with a discharge summary and to take away medicine or prescriptions. Co-owners told us this had significantly improved the relationship and reliability of printed information.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw that clinical co-owners were aware of the need to obtain patient agreement and consent to deliver care and we observed this in practice. This meant that patients understood and participated in decisions about their care and treatment.
- There was an up to date Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) policy and all of the co-owners we spoke with were aware of it and how to access it for reference. The GP we spoke with was also aware of their responsibilities under the MCA and DoLS.
- All co-owners had up to date training in the completion of mental capacity assessments, DoLS awareness and caring for patients who demonstrated self-neglect.
- On the day of our inspection we looked at the care plan of one patient with a DoLS authorisation in place. A GP had conducted an appropriate best interests assessment and there was evidence of best interests input from the adult social care team. The hospital had submitted 10 DoLS applications, including two urgent applications, between April 2016 and September 2016. This was in line with the provider's admissions policy that patients who required seclusion or segregation were not normally accepted.
- Co-owners demonstrated knowledge of the Deprivation of Liberty Safeguards (DoLS) and used appropriate documentation and assessment methods for this. For example, specific care plans were in place for patients with a DoLS authorisation. This enabled staff to provide and document the specific care patients needed to meet their needs and keep them safe. There was evidence best interests decision meetings had taken place between appropriate professionals and mental capacity assessments. Co-owners used a DoLS decision-making tool to help them identify when an authorisation might be needed.

Good

Are services effective?

- Adults safeguarding advisors conducted a DoLS audit in 2016 to assess the knowledge and understanding of co-owners and the standard of mental capacity and consent processes on the ward. The audit identified areas of good practice in the completion of the mental capacity assessment process and liaising with the next of kin of patients. Amongst co-owners at this hospital,73% were able to explain what constituted a DoLS and 100% able to explain what they would do if they thought a DoLS was required.

Good

Are services caring?

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

Summary

Overall we judged caring at Dorking Community Hospital to be good.

- Patients we spoke with were consistently positive about their experience. Patients told us they were treated with kindness, respect and dignity. We were told of instances when co-owners had been especially thoughtful and of how patients felt they were treated as an individual and appreciated gaining back their independence
- During our visit we saw that clinical co-owners ensured that when administering care, it was done in a respectful way ensuring the patient's dignity was maintained.
- Patients told us they were included in discussions and decisions relating to their care and treatment, we saw that this was documented in the patient records. Patients understood and participated in decisions about their care and treatment. Relatives told us they appreciated the care they received and that their questions were answered.

Compassionate care

- During our inspection, we observed that patients were treated kindly and with respect. During conversations with each other, clinical co-owners talked positively and sensitively about patients and their circumstances.
- Dorking Community Hospital administered the NHS Friends and Family Test (FFT) which is a feedback tool that gives people who use NHS services the opportunity to provide feedback on their experience. We saw monthly results from November 2015 to November 2016 and the percentage of patients that would recommend ranged from 100% to 83 % with an average score of 94%. However caution is required in interpreting these results as often sample size was small.
- We saw FFT information displayed in the clinical areas and in the staff rest room and the co-owners we spoke to were aware of the process and results of gathering this information.
- Patients we spoke to were all very positive about the care they received and said they were treated with kindness, respect and dignity. They commented on how well they were looked after and how choices were given with regard to hygiene and diet. A number of patients commented on the good quality of the food and cleanliness of the ward.
- Patients commented on the care received from the physiotherapist and one patient described the team as "wonderful" and another patient commented that the physiotherapist "went above and beyond", what she expected of her treatment.
- Throughout our inspection we witnessed good interaction between co-owners and patients. We observed how the clinical co-owners assisted patients with patience and compassion. For example we saw a new patient arrived from an acute hospital we observed the patient being given a cup of tea and a blanket to ensure she was warm. We observed the clinical co-owners were caring, making the patient comfortable.
- One patient's relative said the care given to her parent was exceptional and the staff had cared for the family by giving time and clear explanation of treatments. Another relative praised the support she received in finding an appropriate care home for her family member.
- During the inspection one healthcare assistant (HCA) excused herself from speaking to the inspector to assist a patient she could see might need help which demonstrated a caring approach, putting the patient first. The clinical co-owner said they were very proud of their role, what they do and felt part of a good team.
- We reviewed 11 patient feedback cards all of which contained positive comments. The comments included the comment by one patent who said on arrival at the hospital, "I was greeted by all the staff and made to feel an individual again by their caring, kind, smiling, attitude and slowly regained confidence". Another patient described herself as lucky to be at this particular hospital and said, "The nurses are very caring, and help us in every way" and several patients commented on the happy atmosphere and the care from the physiotherapist team.

Good

Are services caring?

- We observed that intentional rounding was in place and all patients were checked on a regular basis to ensure their comfort and that they had sufficient drinks. On checking the patient records we evidenced consistent rounding with completion of records over a two-week period.
- There were no instances of mixed sex accommodation as male and female patients were looked after in single sex bays of six beds.
- Dorking Community Hospital achieved a score of 79% in the patient led assessments of the care environment (PLACE) 2016, for treating patients with privacy, dignity and wellbeing, which is above the organisational average of 76% but below the national average of 84%. We saw a corporate action plan that addressed all areas of non-compliance within the PLACE audit with local actions to be taken who was responsible and by when to be completed.

Understanding and involvement of patients and those close to them

- Patients told us they were included in discussions and decisions relating to their care and treatment. We saw that discussions concerning patient treatment plans were documented in their records. We saw that family meetings were encouraged and that access visits and home visits were done as required.
- We observed that during medicine administration patients were appropriately identified and were given an explanation of what their medicines were and where necessary help was given to take the medicines.
- When preparing for patient discharge we were told that patients could be discharged to either a nursing home or residential home for the day and were given the option to stay if they were comfortable. The patient was also given the option to return to the hospital if they were not happy, which enabled the patient to have an active part in the decision being made about discharge.
- We spoke to a patient's relative who praised the "excellent caring" and was pleased with how his relative was doing saying there was no need to bring anything in as, "Everything is provided, a phone is brought to the bedside if that is required". They also commented on convenient visiting times and easy free parking.
- Each patient had a personal goals and information plan. The multidisciplinary co-owner team used this to identify the patient's future goals and what they wanted to be able to do after discharge. The document was also used to record significant updates, explain the discharge process and explain the use of coloured wristbands.

Emotional support

- We reviewed patient records that showed that clinical co-owners provided emotional support to the patient and their families. Details of decisions taken and who was involved were recorded.
- At the multidisciplinary meeting we attended, co-owners discussed the emotional needs of the patient and how they would support them.
- We saw that patients had access to spiritual advisers and chaplaincy if requested and there was a monthly chapel service. Co-owners had details of how to contact appropriate chaplaincy support at any time.
- Co-owners demonstrated an acute awareness of the anxiety and stress a hospital admission could cause to patients. In addition to conflict awareness training, co-owners had developed skills in helping patients to be calm and ensuring they followed through on promises, which helped patients to feel more settled. An anxiety care plan was available and co-owners used this for appropriate patients.
- We were told that emotional support and counselling for co-owners could be arranged through the occupational health department. An example was given that following a recent patient death that support was made available.

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 rated responsive as good because:

- Services were planned and delivered to meet individual needs. This included a modified environment to ensure rehabilitation could take place safely and resources on the ward to help patients relax and take part in activities.
- Co-owners delivered care in line with NHS England Equality Delivery System guidance on equality and diversity in healthcare.
- Patients had exercise to a range of services and support to ensure they were comfortable and to support their rehabilitation. This included a breakfast club, exercise programme, a hairdresser service and personal goals planning.
- Co-owners supported patients living with dementia with the use of modified communication tools and the support of a dementia champion and dementia steering group.
- The complaints policy enabled all co-owners to take part in investigations and learning and there was evidence proactive improvements were made as a result.

Planning and delivering services which meet people's needs

- Physiotherapists and occupational therapists used a recreation room to provide rehabilitation to patients in domestic skills. For example, a microwave, oven and other kitchen equipment was available to help support patients to develop their motor skills. This facility was adjacent to the ward and could also be used as private environment for conversations or to complete cognitive assessments.
- The ward environment had been adapted to meet the social and rehabilitation needs of patients. For example, an open-plan seating area was available that provided social space for patients to meet. A television, piano and library were available and furniture had been adapted with support aids such as foot rests for chairs. A 'jumbo' remote control for the television was in place to help patients maintain some independence when they had reduced motor skills.
- Co-owners signposted patients and relatives to community groups, charities and organisations to support them with care and rehabilitation in addition to that provided by the hospital. This included two local patient representative and engagement groups.
- The ward had capacity to open an additional six beds during times of exceptional demand, such as during the winter pressures period. A standard operating procedure was in place for this and an additional twilight shift was added when the extra beds were open. This meant capacity could be increased safely.
- Co-owners provided appropriate patient information on the ward that was current and relevant for the elderly population. For example, about how to keep fit and prevent falls.

Equality and diversity

- The organisation had undertaken an equality and diversity project in September 2016 to identify how teams could recognise and use the diversity within them to their advantage. This had resulted in a diversity and inclusion action plan for 2016/17 which included 11 actions to ensure the team could achieve the reporting requirements of the NHS England Equality Delivery System.
- Cultural, religious and spiritual criteria were including in training for co-owners on care after death. This meant they could provide targeted support and guidance to relatives whilst maintaining respect and knowledge of their beliefs and circumstances.
- Patients had access to culturally appropriate food cultural food such as Kosher meals and Halal meals.

Meeting the needs of people in vulnerable circumstances

Good

Are services responsive to people's needs?

- The premises had level access from the car park to the ward, including hand rails to support people with limited mobility in the corridors. Wide-access bathrooms and showers were available for patients who used wheelchairs.
- Physiotherapists provided group training sessions to help patients engage in their rehabilitation plans whilst encouraging them to socialise together. Therapists and nurse co-owners had adapted rehabilitation plans to meet the changing needs of patients. For example, therapists told us the acuity of patients had gradually increased in the preceding three years and this meant they often needed to spend two days in bed to acclimatise before they could begin physical therapy.
- Nurses completed assessments of activities of daily living to assess each patient's independence and mobility as part of discharge planning, with support from occupational therapists.
- There was no formal activities or recreation programme although patients had access to audio visual entertainment, a library and board games. Healthcare Assistants (HCAs) were able to spend time with patients using these activities.
- The service recognised the needs of carers and provided signposting to local support services and organisations. Co-owners also provided information to carers on how to access health services and strategies to maintain their own health. In addition, a weekly self-help group for people experiencing depression was available as a method for individuals to discuss coping strategies.
- End of life care was provided in line with national standards. For example, co-owners maintained an end of life care register that helped them to allocate appropriate resources, support and multidisciplinary working to individual patients. Co-owners also supplied 'What to expect' leaflets to relatives and carers as part of their support.
- Services, processes and resources were in place to support patients living with dementia. For example, reminiscence materials were available on the ward and digital reminiscence software was due to be implemented. Co-owners had completed their training for this and were awaiting its delivery.
- Co-owners used the Alzheimer's Society 'This is me' tool to document patient's preferences and understand how they could provide individualised care. Although dementia training was not mandatory, staff had access to study days and development opportunities in this area. Co-owners had provided sunglasses for one patient who was light-sensitive and felt tip pens to help one patient who liked drawing to reduce anxiety. Volunteers could be provided for one-to-one care with patients .A dementia navigator was in post who helped co-owners, patients and carers to access specialist support.
- All clinical co-owners had undertaken dementia training. Four annual learning events had been offered in 2016 that included training for staff in communication, swallowing, nutrition and hydration and supporting carers.
- Co-owners screened each person on admission using the Mini-Cog screening tool for cognitive impairment in older adults. This was used to check each patient understood why they had been admitted. This formed part of a dementia care process that was used to identify any issues with cognition that could trigger a full MCA assessment or DoLS application. Nurses spoke positively about this tool and said the process could be further improved if it required to co-owners to complete it to provide broader initial input.
- Co-owners had access to several local support services and groups that they could use to support patients with reduced cognition and capacity or those who needed additional support to understand their care and treatment. This included mental health advocacy groups, Independent Mental Capacity Advocates and organisations with provision to support patients with specialist needs, including where they had sensory impairment.
- A multidisciplinary dementia steering group met quarterly to review policies and the care delivered to patients living with dementia. Although this group and co-owners on the ward could influence and adapt care, the physical environment was not conducive to providing appropriate care for patients living with dementia. For example, there was a lack of high-impact visual signs that could help patients to orientate themselves.

Good

Are services responsive to people's needs?

- A co-owner had recently taken on an additional role as dementia champion and attended a dedicated dementia hospital unit to identify how this service could adapt to the needs of patients. Their immediate plans were to implement pictorial menus, provide 'fiddle muffs' to help reduce anxiety and introduce work to decorate patient's individual walking frames so they could identify them more easily.
- Co-owners displayed pictorial easy-reference cards above each patient's bed, with consent, to identify specific needs. For example, if a patient had a food and fluid chart in place or if they needed to keep their feet elevated.
- There was evidence co-owners considered adjustments to the service to prepare for planned patient admissions. For example, bariatric equipment could be ordered in advance.

Access to the right care at the right time

- Between January 2016 and December 2016, the average bed occupancy was 93% and the average wait for a bed following referral was one day. This was better than the national average of comparable hospitals of 2.6 days.
- Patients accessed the service as a step-up unit from the community by referral from their GP or a community matron. Doctors could also transfer patients to the ward as a step-down from acute care. Admissions criteria enabled nurses to review each patient individually as part of a multidisciplinary team and accept those with complex needs, including rehabilitation needs. This broad approach to admission enabled the service to provide individualised care for patients that improved access to rehabilitation whilst reducing pressure on acute hospital beds and home carers.
- The provider did not collect information in relation to delayed discharges and planned to implement a process to do so from January 2017.

Learning from complaints and concerns

- The complaints policy was readily accessible and a copy was on display at the entrance to the ward. This meant patients and relatives knew how to complain because they had access to the information they needed. When a complaint was received, the ward manager responded immediately and led an investigation involving appropriate co-owners other health professionals if needed. For example, when a complaint was received about the attitude of a bank nurse, the ward manager interviewed all staff on the shift and worked with colleagues in the temporary staffing department to resolve the problem. Co-owners told us complaints were looked at and resolved from a team perspective and that learning was shared.
- Between October 2015 and October 2016, the inpatient ward received one formal complaint, which was partly upheld. As part of the investigation, the ward manager discussed with the complainant how the team could have improved communication with them during the period in question. This was used to ensure co-owners communicated openly and frequently with patients and relatives.
- The ward manager maintained a record of minor concerns or complaints and how these were addressed. For example, one patient was unhappy when they mislaid their false teeth and co-owners could not find them. In response the ward manager arranged for a dentist, manager and speech and language therapist to attend the ward.

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

We rated well led as good because:

- The leadership structure was clearly defined and supported a multidisciplinary approach to care and a service that enabled each individual co-owner to make a unique contribution. Co-owners spoke positively of the leadership structure and said members of the senior team were visible and readily available.
- The organisation was accredited by the Institution of Leadership and Management to provide leadership training and a diploma-level development pathway and co-owners were supported to develop their leadership skills.
- Co-owners spoke positively of the vision and work ethos of the organisation and said they felt valued and respected.
- The organisation used a range of tools to ensure co-owners were engaged and to achieve quality assurance. This included a monthly core brief, regular walkarounds by the senior team, whole-team meetings and activities and a staff survey.
- The Clinical Commissioning Group conducted a quality assurance visit in November 2016. This found coherent and clearly functioning leadership and a team responsive to the needs of patients, including in identifying strategies to reduce risks.
- Co-owner engagement in the 2016 co-owner survey was high. Results overall were in line with or better than the organisation as a whole.
- Feedback from patients and visitors was actively sought and used to make improvements in care and the service.

Leadership of this service

- The head of the community hub led inpatient services with day-to-day clinical practice and the operation of the ward led by a ward manager and both co-owners reported to an senior manager, the Head of Community Hub. This manager reported to the Director of Clinical Services who managed all of the organisation's hospitals, hubs and community integrated teams.
- Co-owners spoke positively of the leadership structure and said members of the senior team were visible and readily available. For example, the Head of Community Hub visited the ward at least one day per week and co-owners said the human resources and IT directors were easy to reach and responsive with problem-solving. The Lead Matron for the Hub provided additional support if the head was unavailable. One clinical co-owner said, "I think our ward manager is inspirational in keeping us motivated, holding us to account and helping us learn from our mistakes."
- A leadership development pathway was available to nurse co-owners that involved additional training and mentoring from senior colleagues. This enabled them to lead shifts with supervision to help them progress their leadership skills.
- The head of the community hub used a daily walkaround of the unit as a quality assurance strategy to ensure the smooth running of the ward. Co-owners we spoke with said they used this time to be available for co-owners to discuss any issues, concerns or ideas.
- Ward managers were supported by the senior team with mandatory clinical supervision, support meetings from the community hub manager, one-to-one coaching and leadership training modules. In addition the organisation was accredited by the Institution of Leadership and Management to provide leadership training and a diploma-level development pathway.
- Co-owner meetings took place monthly and were offered twice on the same day to maximise the number of co-owners able to attend. Three clinical co-owners we spoke with described meetings positively and said they were a forum to be open and discuss new ideas, learn from mutual experiences and escalate concerns.

Service vision and strategy

Good

Are services well-led?

- Employees in the organisation were named 'co-owners' as part of the overall social enterprise approach and co-ownership model of operation. This model also acted as a strategy to foster strong team cohesion and commitment amongst nurses, therapists and other employees. All of the co-owners we spoke with were positive about this designation. One individual said it helped to foster a team spirit and others said it made them feel more a part of the organisation rather than just an employee. In addition, 91% of respondents to the 2016 internal survey said they valued working for an organisation with a co-ownership model.
- Co-owners told us they felt involved in the vision and strategy of the organisation and understood how they could contribute to it, including in relation to the four core values shared by each individual. This included through six monthly director's brief meetings and discussions of the organisational business plan.
- Professional development records (PDRs) held by staff and which we saw, were linked with the organisation's values of putting people first and behaviours including integrity and exceptional delivery.
- Co-owners had the opportunity to adapt the corporate strategy to the local work, needs and development of their unit. For example, each co-owner had the opportunity to suggest contributions to the ward including the potential impact and the resources they would need. The ward manager then supported them to prepare a business case.

Governance, risk management and quality measurement

- Clinical governance was centralised in the organisation with oversight and support provided to wards by a quality and clinical governance committee (QCGC). Seventeen distinct committees and forums informed the QCGC on an organisation-wide basis that helped maintained an understanding of performance, quality and safety at each hospital. Groups included a medical devices group, a privacy and dignity group, a diabetes forum and a falls prevention group. The QCGC met every two months and reviewed the unit's quality assurance report for clinical services report, which included safety and risk governance such as the number of falls, pressure ulcers and multidisciplinary availability. A co-owner's council monitored, reviewed and discussed the work of the QCGC and held it to account.
- The Clinical Commissioning Group conducted a quality assurance visit in November 2016. The report found coherent and clearly functioning leadership and a team responsive to the needs of patients, including in identifying strategies to reduce risks such as for falls.
- The ward manager attended a monthly core brief for all community inpatient wards with their counterparts from the Molesey and Epsom sites. This was a multidisciplinary clinical governance meeting and included the physiotherapy, occupational therapy and heart failure leads. We looked at the minutes of three meetings and saw they were well-attended with clear actions followed up afterwards.
- We saw that there were systems to identify, monitor and manage risks to patients. Risks were identified and recorded on a risk register. Co-owners were aware of the risk register and could identify those risks relevant for their area of work.
- The senior team used a risk register to identify and monitor risks to the service. The ward manager and head of the community hub held responsibility for each risk and assessed each item on a quarterly basis, or more regularly if indicated by the severity. There were seven risks on the risk register for this hospital, including one major risk, four high risks and one moderate risk. Major risks were also included on the corporate risk register and reviewed by the senior leadership team as part of overall risk management. The major risk related to the risk of falls. High risks related to the lack of site security out of hours, recruitment of qualified nurses, completion of mandatory training and unreliable IT and phone systems. Moderate risks related to estates problems and the risk that closed beds could be reopened at short notice without sufficient planning for staff levels. Although the team had completed substantial work in reducing the risk of falls, the risk would only be removed from the risk register when there was evidence of positive impact.
- The ward manager engaged with other community hospitals to implement changes to practice following safety alerts from the National Patient Safety Agency.

For example, the ward manager worked with colleagues to consider how to adapt the National Early Warning Scores tool to the community hospital setting to enable co-owners to identify chronic problems.

Culture within this service

- Co-owners planned and evaluated their work using a quality model they had developed called the 'house of quality'. This was supported by results from the 2016 survey that indicated 96% of co-owners said they believed the organisation was genuinely committed to delivering high quality services
- We saw there was a strong ethos of promoting independence and rehabilitation and all patients were encouraged to be up and dressed out of bed for meals. We saw that clinical co-owners took time to ensure the patient was ready for their meal times and there was no rushing but we saw co-owners being kind and thoughtful in their approach.
- Co-owners told us the local management team were very approachable and they had felt supported during recent changes in leadership structure. One co-owner described how the culture had improved over the last two years and they felt opportunities were better.
- Two co-owners said they felt everyone had an investment in the business and a sense of belonging. Co-owners were encouraged to believe that they could make a difference and make changes.
- As part of the organisation's approach to inclusivity for the co-owner team, including empowering each individual to contribute to the development and improvement of the organisation, monthly wellbeing events were offered. Recent events included cholesterol checks, massages, back care clinics and Pilates.
- Co-owners spoke positively about the culture of the organisation and the support they had access too. One nurse said, "The occupational health team are very supportive and accessible. They offer same-day appointments and I feel that they really care about our health." Another co-owner said, "Our relationship with the physiotherapists is brilliant. Anything we need they'll help us with and take the time to teach us new skills." All of the co-owners we spoke with said they felt their contribution was valued by the senior team.

Public engagement

- Co-owners sought feedback from relatives and visitors and used this to improve services. For example, following patient feedback, co-owners introduced a washing and dressing care form that enabled them to identify how each patient wanted to be supported with personal care and ensure this was reflected in the care they received.
- We were made aware and met a voluntary representative who was part of the staff managing a shop on site and raising funds for the hospital. We were told they see their role as supporting co-owners and patients and an example was given of their participation in organising gifts for patients at Christmas.
- We were told that another voluntary group attends six times a year and provides musical events for the patients.

Staff engagement

- A number of regular activities took place to engage co-owners with the organisation and executive team. This included a monthly 'walkabout' by board members of the hospital, publication of a monthly electronic magazine, a bimonthly leadership team day and a monthly 'spirit award' that recognised individual contribution.
- Co-owner engagement in the 2016 survey was high, with 98% of the team contributing. Results overall were in line with or better than the organisation as a whole. For example, 100% of co-owners said they had a good working relationship with the rest of their team and 100% said they felt the relationships between them and the leadership team were positive.
- The organisation placed value on feedback and open communication with co-owners and visiting health professionals. For example, there was a comments box at the nurse station for co-owners to give feedback on shifts and teams they worked in. One recent comment related to how pleased a co-owner was with the teamwork they had experienced during a challenging shift. One co-owner told us they felt there were plenty of opportunities for updating, reporting and sharing good practice and experiences.
- We saw there was a service award recognition scheme and the ward had won 'team of the year award'. The ward manager said they were proud of this achievement

having previously won an individual leadership award. The team had also been recognised with a quality prize for their work in a falls project. Co-owners commented that they really appreciated the team award and it was a contributing factor in their morale and work satisfaction.

- Co-owner teams were assigned a representative as part of the organisation's "The Voice" programme of engagement for staff. This was part of a strategy to encourage each individual to participate in the delivery, development and evaluation of the service as well as empowering them to speak up when they had concerns or issues. The last co-owner survey identified room for improvement in the visibility of voice representatives and this was reflected in our discussions with co-owners, who did not always know about this.
- Co-owners told us this identity meant they had accountability for the standard of their work and the experience of their patients. One co-owner told us it meant they approached problems collectively instead of passing it to someone with a different level of responsibility.

Innovation, improvement and sustainability

- Co-owners used an innovative 'blue moon' project for patients with cognitive impairment. This scheme used blue wristbands to help identify patients who needed assistance in areas such as memory and communication.
- Newly qualified nurses were offered a two year rotational post with the district nursing team that enabled them to achieve an MSc masters qualification. This motivated new nurses to develop their professional career in community services while spending time in different environments to develop their competencies.
- Co-owners were encouraged to submit improvement plans and ideas and the organisation supported implementation. For example a co-owner had identified the need for improved catheter care. To achieve this they completed research on existing assessment and care tools and produced a new catheter care competency assessment for colleagues. Another co-owner had produced a new starter pack for agency and bank staff to standardise the induction and introductory process. This member of the team had been recognised with a 'rising star 2015' award as a result of their work.
- The leadership team held a quarterly afternoon tea with student nurses. This event was used to understand the student experience and encourage them to continue their development to become registered nurses. The hospital team used placement feedback from student nurses to improve the experience of future students and to ensure the programme contributed to the future sustainability of the service. For example, an additional co-owner had been trained as a clinical mentor as a result of feedback and three student nurses had joined the organisation's central bank as nurses following their positive experiences as students.
- As a strategy to recruit highly skilled co-owners, the ward manager had introduced a more detailed interview and selection process. This included observations of applicants conducting a blood pressure test on a co-owner and checks to ensure the applicant could recognise the signs of sepsis. Applicants also had to demonstrate their skills in the aseptic non-touch technique.