Humber NHS Foundation Trust

RV9

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RV9HE	East Riding Community Hospital	East Riding Community Hospital	HU17 0FA
RV9X8	Whitby Hospital	Whitby Hospital	YO21 1DP
RV913	Withernsea Community Hospital	Withernsea Community Hospital	HU19 2QB

This report describes our judgement of the quality of care provided within this core service by Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Humber NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service: Good

We rated community inpatient services as good because:

- Patients were positive about the care they received. We saw staff being respectful towards patients, and making sure that they were treated with dignity. Patients were involved in decisions about their care where possible.
- There was evidence to show that staff recorded and reported incidents, and completed risk assessment and risk management plans. Staff were familiar with the systems in place to report incidents that may affect the safety, health and welfare of patients and with the reporting system. Regular meetings to discuss lessons learned from incidents took place.
- Patient risks were assessed and plans developed to reduce them. Patients with individual needs were given the support they required. In addition, members of staff were identified as leads in learning disabilities and dementia.
- Staff were trained in safeguarding and mental capacity procedures, and were able to apply and discuss these appropriately.
- Complaints were handled in line with the trust's policy.
- Information was displayed information about the trust's vision and values and staff demonstrated they understood and put these in to practice.
- Services at Whitby Hospital had recently transferred to the trust (April 2016) and staff told us they had been communicated to well and kept informed of developments affecting the service. Performance information for this ward was not yet available through the trust.
- There were temporary arrangements in place at Withernsea Community Hospital to provide medical cover for the ward and the trust had advertised a tender to contract medical cover for the ward.
- However, although wards worked well together as a multidisciplinary team, there was limited access to therapy support at Withernsea Community Hospital. This affected the discharge of some patients.
- There were also problems with accessing medicines through the local pharmacy services out of hours.

Background to the service

Information about the service

We inspected the community inpatient wards at East Riding, Whitby and Withernsea Community Hospitals.

These provided diagnostic and screening services, and care for people with long-term conditions through rehabilitation beds, overnight beds and day care beds (for planned treatment, falls and for palliative care patients). Patients were referred from General Practitioners or local trust hospitals for rehabilitation before discharge to home.

Our inspection team

Our inspection team was led by:

Chair: Dr Paul Gilluley, Head of Forensic services at East London Foundation Trust and CQC National Professional Adviser

Head of Inspection: Jenny Wilkes, Care Quality Commission.

Team Leader: Patti Boden, Inspection Manager (Mental Health) Care Quality Commission.

Cathy Winn, Inspection Manager (Acute) Care Quality Commission

The team included CQC inspectors and specialists advisors: Iris Fitzgibbon (Nurse Team Leader -Community Health Services – Adults), John Pope (Occupational Therapist) and Jacqui Watson (Expert by Experience).

Why we carried out this inspection

We inspected this core service as part of our comprehensive mental 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?

For example:

'Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit between 11 and 15 April 2016.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who used services. We observed how people were being cared for and talked with carers and/or family members and reviewed care and treatment records of people who used services. We met with people who used services and carers, who shared their views and experiences of the core service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust should:

- The Trust should review access to therapy support within Withernsea Community Hospital**;**
- The Trust should review the arrangements within community inpatients services for obtaining medication outside designated delivery times.

Humber NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found that care on the community inpatient wards was safe because:

- There was evidence to show that staff recorded and reported incidents, and completed risk assessment and risk management plans. Patient risks were assessed and plans were developed to reduce them. There were daily multidisciplinary review of patient risks and progress, to ensure planned care was relevant to progress.
- Infection control policies were available and we saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistently good and we observed signage for isolation of patients in single rooms that was clear.
- The trust had formal nurse staffing review processes in place and these ensured safe staffing levels based on relevant national guidance and acuity information.
- The trust provided clinical skills training for staff, as well as additional managerial support. There were systems in place to report incidents that may affect the safety, health and welfare of patients and staff were familiar with the reporting system and could give examples of what they would report.
- There were temporary arrangements in place at Withernsea Community Hospital to provide medical cover for the ward. The trust had advertised a tender to contract medical cover for the ward.
- The matrons told us about regular meetings to discuss lessons learned from incidents and staff confirmed they had received feedback about learning from incidents through supervision, shift handovers and team meetings. Staff had taken steps to reduce the recurrence of incidents, including the development of comprehensive patient assessments.

Incident reporting, learning and improvement

- The trust reported no never events within community inpatient wards within the previous twelve months.
- Data provided on the wards showed very few incidents had been reported (e.g. three hospital acquired pressure

ulcers, two falls and three urine infections associated with catheter insertion at Withernsea Community Hospital between October 2015 and February 2016), no medication errors were reported.

- Staff within community hospitals understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff were fully supported and attended regular meetings where feedback and learning was encouraged.
- Staff reported incidents through the electronic system and learning was shared through meetings, communication books, one-to-one and team briefings.
- We saw evidence of this approach displayed in staff and patient areas and saw minutes of clinical governance meetings, including monthly ward meetings.
- Ward managers had an overview of every incident, complaint and concern and operated an effective system of response and feedback to patients and staff. Staff understood their responsibilities in reporting and learning from events.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Although there had not been a requirement to notify patients (or other relevant persons) of incidentscovered by this regulatory duty andprovide support in these circumstances, staff were aware of the procedures and processes to follow.
- Staff were able to describe the actions they would take and the support they would give to support patients and family members.

Safety

- All inpatient wards participated in the NHS safety thermometer approach to display consistent data to assure people using the service that the ward was improving practice based on experience and information. This was easy to understand and assured people using the service that the ward was improving practice based on experience and information.
- Information was displayed in ward entrances and staff had knowledge of the displayed information and ward performance.
- This tool was used to measure, monitor and analyse patient 'harm free' care and was displayed in ward entrances and was easy to understand; staff had knowledge of the displayed information and ward performance.
- For example, information displayed showed low incidence of hospital acquired pressure ulcers (two), patient falls (one), urine infections associated with catheter insertion (one) and the venous thrombosis embolism (none) in those patients assessed as being at risk (Whitby Hospital, December 2015 – February 2016).
- The National Early Warning System (NEWS) was used to monitor and record patient observations. The Glasgow Coma Scale (GCS) was used to observe patients and escalation processes were in place for all patients.

Safeguarding

- The trust had a clear safeguarding strategy and held regular safeguarding board meetings. Minutes and action plans were clear and these meetings are well attended by senior staff from across the trust. This provided a forum for staff to discuss safeguarding concerns and share learning across the trust.
- Staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust and were aware of who to contact, where to seek advice and what initial actions to takes.
- Qualified staff were trained to an appropriate level for their role, for example level three for adults and children.
- We spoke with members of the multidisciplinary team and they were confident staff knew how to respond to allegations or signs of abuse. Staff we spoke with were all aware of the phone numbers and procedure for escalating concerns. There had not been any safeguarding alerts raised by the wards in the last 12 months.
- Information was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.

Medicines

- There were effective arrangements for safely managing medicines, including medicines prescribed 'as required'

and controlled drugs. We saw that patients' care plans included details of when 'as required' medicines should be offered to patients. Medicines were stored securely and were administered by qualified nurses.

- We looked at the records of administration of medicines for 35 patients and found these were completed correctly.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors. Medication rounds were conducted with good practice principles and wards had dedicated support from pharmacy.
- The storage of medication in refrigerated units was monitored and daily temperature checks recorded, these were within the correct limits on all wards.
- Pharmacists liaised with the ward team regularly. We found allergies clearly documented.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics and liaised with pharmacy prior to prescribing for MRSA and C. difficile.
- Staff were required to attend mandatory updates on storage and recording of controlled drugs. Newly qualified staff were required to attend training and complete the safe medication training before being able to administer. Ward managers ensured training was in place to achieve trust targets.

Environment and equipment

- All inpatient wards were bright and well organised, staff and patients spoke positively about the facilities and environment.
- The standard of fixtures and fittings in ward kitchens was high and improved the service to patients.
- We inspected resuscitation trolleys and suction equipment on wards and found all appropriately tested, clean, stocked and checked as determined by policy.
- Risks to the safety and welfare of patients were identified and managed. This included environmental risks, such as fire safety risks on wards. Risks were monitored by regular checking and review.
- We saw appropriate equipment to ensure effective care was available. Portable appliance testing was current on all equipment inspected.

Quality of records

- We looked at 35 sets of medical and nursing records on the wards and we saw they were complete, legible and organised consistently.
- On inpatient wards, patient medical notes were stored in lockable trolleys and patient care charts were kept at the bedside for ease of access to staff. We did not observe a breach in confidentiality during inspection.
- Daily entries of care and treatment plans were clearly documented. Care plans and charts we reviewed had completed patient assessment, observation charts and evaluations and records examined included a pain score and allergies documented.
- We saw thorough completion of observation and monitoring charts including the national early warning score (NEWS) observation chart. Audits showed NEWS charts were completed in full for each set of observations and for actions taken based on escalation plans.
- We reviewed handover meetings and sheets used by ward staff and the escalation documentation which was effective in communication and decision making for those patients at risk of deterioration.
- Admission procedures included comprehensive assessment of key areas of health needs including tissue viability and nutrition screening, assessment of personal care needs included infection and continence and risk assessments for falls and venous thromboembolism.

Cleanliness, infection control and hygiene

- Infection control policies were available as paper copies, with review dates, and on the trust internet. Monthly reports were generated and reported for clostridium difficile infection (C difficile), and Methicillin resistant Staphylococcus Aureus. (MRSA).
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistently good and we observed signage for isolation of patients in single rooms that was clear.
- Wards had daily, weekly and monthly cleaning schedules in place for domestic and nursing staff. We observed clean equipment throughout surgical areas and staff completed cleaning records, domestic cleaning schedules and identified clean equipment.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and showed 100% compliance with trust procedures.

Good

Are services safe?

- We observed staff washing their hands and all patients we spoke with told us that this was done without exception. Hand gel was available at the point of care and staff used personal protective equipment (PPE) compliant with policy.
- Wards had appropriately equipped treatment rooms for aseptic technique and dressing changes. Nurse assessment of aseptic technique competence took place annually.
- Clinical and domestic waste disposal and signage was good and staff were observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.

Mandatory training

- At the time of inspection the training compliance rate for community inpatient services was 75%. The inpatient ward at East Riding Community Hospital had the highest percentage of trained staff with an overall training rate of 77%. Overall training rates were 58% for the integrated hospital team and 64% for the inpatient ward at Withernsea Community Hospital.
- Infection Control had the highest rate of completion with 91%, followed by moving and handling (84%). Equality & Diversity training had the lowest completion rate of 33%. Inpatient services had identified actions at a local level to achieve compliance with mandatory training targets and attendance at mandatory training programmes for all staff.
- All staff reported they had received mandatory training in areas such as infection prevention and control, moving and handling, and health and safety. The mandatory training matrix displayed on the wards confirmed staff had attended or were planned to attend required mandatory training. However, this was inconsistent across wards.
- Staff accessed mandatory training in a number of ways, such as online modules and e-Learning, workbooks and trainer delivered sessions. Staff said they were supported with professional development through education where possible.
- We spoke with 33 staff and they told us they were up to date with mandatory training, the access to the training system online was good and they felt supported to attend training and mandatory update sessions.

Assessing and responding to patient risk

- We saw appropriate risk assessments were completed when patients were admitted. This included the risk of falls and developing pressure ulcers. We saw that risk assessments were regularly reviewed according to the level of risk. Appropriate action was taken in response to the risks identified.
- We saw patients were monitored throughout their stay through the use of a range of tools, such as the early warning score. The strategy and processes for recognition and treatment of the deteriorating patient were embedded and included the transfer of deteriorating patients to hospital where appropriate. Staff gave examples where escalating a sick patient had worked well.
- There were regular (daily) multidisciplinary reviews of patient risks and their progress, to make sure that planned care was still relevant and that patients were making suitable progress.
- This allowed staff on the ward to record observations, with trigger levels to generate alerts, which identified acutely unwell patients. We saw full completion of NEWS risk assessments and sepsis screening tools and staff were aware of escalation procedures.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patients' nutritional needs. Pain scores and diaries for patients were available.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example one to one nurse patient ratio, close observation, safety rails on beds, falls stockings, stickers to identify risk on display boards and nurse call system in reach.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.

Staffing levels and caseload

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.

Good

Are services safe?

- The trust had formal nurse staffing review processes in place and had a staffing establishment based upon agreed methodology and professional judgment triangulated through benchmarking, relevant national guidance and acuity information.
- Senior nursing staff had daily responsibility for ensuring safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours by senior nurses with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances. On all inpatient wards, actual staffing levels were in line with those planned. Variations were appropriately made to meet activity and patient acuity and nurse staffing levels were managed day to day.
- Nurse sickness rates were between 8.4% and 8.9%, vacancy rates were 0% and the average 'fill rate' was 101% for nursing staff and 96% for health care assistants (February 2016).
- The trust had an established staff 'bank', which provided cover for short notice absences.
- Consultants and doctors were available for handovers, ward rounds and MDTs, staff had good relationships with medical staff and out of hours cover was provided and included access to consultant review for patient care when required.
- The model of care at Withernsea Community Hospital was medically led with a Responsible Medical Officer (RMO), a consultant physician, working jointly with a non-training grade doctor. They designed, coordinated and oversaw patients care plans and ensured these provided an efficient patient flow through the unit whilst providing clinical care.
- Cover was provided Monday to Fridays 0800-1800 (either in the form of face to face or telephone contact) and Sunday mornings, with out of hours care provided on the same basis for the remaining weekly hours. Patients were reviewed each morning, with completion of relevant clinically administrative duties and new admissions clerked where necessary.
- At the time of inspection the trust was seeking bids for the provision of medical cover to inpatients admitted and cared for in the East Riding Community Hospital at Beverley, Withernsea Community Hospital and the Macmillan Wolds Unit at Bridlington Hospital. This contract was to start in May 2016.

Managing anticipated risks or incident awareness and training

- The trust had major incident and business continuity plans in place that included protocols that were reviewed and updated annually. Staff received mandatory training in fire safety and health and safety. There were clear instructions in place for staff to follow in the event of a fire or other major incident.
- A review is undertaken to assess nature, size and type of incident and immediate staff available to manage admissions. Processes are in place for monitoring compliance with the policy.
- Potential risks were taken into account when planning services and consideration given to seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Action plans were discussed and implemented as necessary.

Good

Are services effective?

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

Summary

We found that care on the community inpatient wards was effective because:

- We saw that regular audits were undertaken and that issues identified were addressed or escalated. Staff completed assessments for all patients and recorded the outcomes in their care records.
- Wards worked well together as a multidisciplinary team, but there was limited access to therapy support at Withernsea Community Hospital. This affected the discharge of some patients.
- However, there were also problems with accessing medicines through the local pharmacy services out of hours.
- Although, not all training and awareness was meeting trust targets, local plans were in place to ensure compliance.

Evidence-based care and treatment

- Staff had access to the trust's policies and procedures in both paper form and electronically and local policies were written in line with this and were updated every two years or if national guidance changed. Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE).
- Matrons at community hospitals undertook regular audits (for example, hand hygiene, records and falls). We saw that action was taken where issues were identified, for example increased staffing and introducing link roles.
- Patients were assessed on admission to the impatient wards using recognised assessment tools. Staff carried out risk assessments in order to identify patients at risk of harm at the time of their admission and these included venous thromboembolism (VTE), pressure ulcers, falls and infection control risks.
- Care pathways and care plans were in place for those patients identified to be at high risk, to ensure they received the right level of care through the care pathways and ensured each patient received continuing care.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- We saw nurses administered pain relief as required in accordance with pain assessments and all patients reported their pain management needs had been met in a timely manner.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients.
- Each ward had identified a pain link nurse and pre-planned pain relief was administered for patients on recovery pathways.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.

Nutrition and hydration

- Nutrition and hydration assessments were completed on all appropriate patients in the care records reviewed. These assessments were detailed and used the Malnutrition Universal Screening Tool (MUST). Care pathways for nutrition and hydration were in place and had been comprehensively completed.
- Patients were able to access suitable nutrition and hydration including special diets. Dietician advice and support was available if a patient was at risk of malnutrition.
- Protected patient mealtimes were complied with and showed practice was in line with trust nutrition policy, protected mealtimes policy, and clinical management of complex feeding problems in adults with cognitive impairment guidance.

Good

Are services effective?

- Patients reported their meals to be good, with a hot breakfast, choice and staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients before and after surgical procedures.
- We saw a range of food choice, meals and snacks, safe storage and supplies of crockery and cutlery for patients with specific needs.
- A system was in place to identify patients who required nutritional support to the catering staff. Details of dietary needs for individual patients were clearly identified on displays in the kitchen.
- We reviewed 35 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the dietetic department and meal charts were completed comprehensively and reviewed.

Patient outcomes

- Assessments were undertaken at admission and discharge and evaluation completed on the clinical effectiveness of health initiatives and support provided during inpatient treatments.
- We reviewed records from the therapy teams that considered health assessments from GPs and nurses on the ward, including timescales and plans for treatment or discharge which were linked to the frequency and intensity of therapy offered.
- Daily multidisciplinary team meetings ensured practice was shared and patient care was discussed and reviewed as required.
- There had been 4 readmissions within 30 days at Withernsea Community Hospital and 5 readmissions within 30 days at East Riding Community Hospital between June and November 2015.

Competent staff

- Staff were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff told us they were supported by their managers to attend training days and to complete online training. Staff said the training they had received was appropriate and relevant to
- their work role.
- Staff said they had a good induction and preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.
- Nursing staff had received appraisals within the last twelve months which included discussion of their personal development and training needs. For example, at the time of inspection 68% of staff had received an appraisal at Withernsea Community Hospital. Local plans were in place to ensure compliance with trust targets.
- Revalidation processes for nursing and medical staff were in place and up to date.
- Staff told us they had regular clinical supervision described as protected time for staff to reflect on their practice in order to learn from experience, develop and maintain competence. There were also informal one to one meetings for staff should they request these. Monthly governance and staff meetings were taking place.
- Staff felt supported with their training and in maintaining competence. We found staff were encouraged to undertake additional learning when time allowed.
- Ward managers were clear during discussion that new members of staff were mentored and supported until they gained the necessary skills, knowledge and experience to do their job when they started their employment.
- Experienced members of staff were gradually encouraged to take on additional role and responsibilities once it had deemed appropriate.

Multidisciplinary working

- Inpatient wards had developed multidisciplinary team (MDT) working that allowed shared decision making on the most appropriate care and treatment for patients. Daily MDT meetings were held where each patients care was discussed.
- We observed MDT meetings and saw the MDT had agreed a shared way of working based on each member's professional and clinical background. The MDT meetings served to address issues as they arose. Consultant led ward rounds, including weekends, involved the multidisciplinary team.
- Delays in discharge were discussed and problems addressed (15% delayed discharges at Beverley Community Hospital inpatient ward and 14% delayed discharges at Withernsea Community Hospital inpatient ward (September 2015 – April 2016))
- All patient care was reviewed within the multidisciplinary team (MDT) meetings. The MDT meetings resulted in a joint plan of care for each patient.

Good

Are services effective?

- All members of the team remained clear when discharge was expected and additional support required from any specific team was actioned. This included an assessment for equipment, continuing health care or access to additional support networks.
- The team worked together to ensure the patient was only discharged when their needs for discharge were met. Staff worked closely with the patient, their family, allied professionals and the local authority when planning discharge of patients to ensure relevant care was in place and that discharge timings were appropriate.
- Nursing documentation was completed appropriately. Handovers were carried out with members of the multidisciplinary team and referrals were made to the dietician, diabetes nurse, or speech and language team when needed.
- Staff at Withernsea Community Hospital told us it was difficult to obtain therapists input at times and this affected the discharge of patients (16% delayed transfer of care, February 2016). Therapists worked closely with the nursing teams on the ward where appropriate but were often prioritised to work with patients within the community setting.
- Although there was pharmacy input on the wards during weekdays and weekends, staff at Withernsea Community Hospital told us arrangements with local pharmacy services caused difficulties obtaining medication outside designated delivery times. We were told staff had to take prescriptions and collect medications themselves from pharmacies outside delivery times. This had not changed since the previous inspection in 2014.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and planning started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff. Staff told us systems were in place to ensure effective communication of information when transferring a patient.
- All staff had access to policies, procedures and NICE guidelines on the trust intranet site. Staff we spoke to stated they were competent using the intranet to obtain information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies in place to inform and guide practice around the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) although these had not been regularly updated.
- Information and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.
- Staff we spoke with were confident in identifying issues in regard to mental capacity and knew how to escalate concerns in accordance with trust guidance.
- Patient records showed consent had been gained before treatment or support was given.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and DoLS were referred to the trusts safeguarding team. The trust made 24 Deprivation of Liberty Safeguards (DoLS) applications June 2015 to October 2015. None of 24 DoLS applications related to community health inpatient services. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Consent, MCA and DoLS training was delivered as part of staff induction. The overall compliance rate for Mental Capacity training across community inpatient services was 29% (trust 39%). Local plans were in place to ensure compliance with trust targets.
- We looked at 35 records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.

Good

Are services caring?

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

Summary

We found that care on the community inpatient wards was caring because:

- Patients and their relatives were all positive about the care they or their relative received. We saw staff being respectful towards patients, and making sure that they were treated with dignity.
- The NHS Friends and Family Test showed patients were either extremely likely or likely to recommend the service to others requiring similar treatment.
- Patients were involved in decisions about their care where possible, for example, taking part in the multidisciplinary team meetings. We saw staff taking families' needs into consideration.

Compassionate care

- Throughout our inspection we observed patients were treated with compassion, dignity and respect. Patients were spoken and listened to promptly. We received universally positive comments from patients regarding their care and treatment. We observed staff treating patients with kindness and respect.
- Staff took time to introduce themselves to patients and give explanations for the treatment and care provided.
- The NHS Friends and Family Test showed between 88% and 100% of patients were either extremely likely or likely to recommend the service to others requiring similar treatment (December 2015 – February 2016).
- We spoke to 33 members of staff and it was clear that the demonstration of a caring approach was a high priority. Staff spoke to patients as individuals and demonstrated knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.
- Patients told us staff responded promptly to the call bell system and that they asked about pain control. Pain relief was given as required.
- Staff understood and respected people's personal, cultural, social and religious needs, and considered these when delivering care and planning discharge. We observed staff take time to interact with patients and relatives in a respectful and considerate manner.
- Staff showed empathy and were supportive to people in their care. People's privacy and dignity was respected when assisting with physical or intimate care.
- We saw staff give emotional support to patients who needed reassurance in a calm, friendly and patient manner.
- Staff promoted independence and encouraged those in bed to take part in personal care, to mobilise within their limits and positively encourage those patients who were having difficulty.

Understanding and involvement of patients and those close to them

- Patients we spoke with all said they felt they were involved with their care and attended MDT meetings where possible. This resulted in a joint plan of care for each patient. The plan was agreed or amended in discussion with the patient.
- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the nurses and doctors looking after them.
- Matrons were visible on inpatient wards so that relatives and patients could speak with them. Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- Patient care was personalised in line with patient preferences, individual and cultural needs and engagement with the local population took place when planning new services. This ensured flexibility, choice and continuity of care.
- We observed patients being kept informed throughout their time on the wards and saw all staff introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- We observed staff interacting with patients in a respectful, caring and empathetic way designed to encourage them to engage with staff and other patients, particularly at meal times.

Good

Are services caring?

- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan and felt involved in their care. Regular ward rounds gave patients the opportunity to ask questions and have their treatment explained to them.
- Consultant led ward rounds, including weekends, involved the multidisciplinary team.

Emotional support

- We spoke with patients and relatives (27) and were told they had been involved with the support they had received. We were told they felt their needs had also been assessed when the wards decided on the support their family members needed when they got home.
- Wards had the facilities for relatives to stay with patients prior to discharge to assess particular needs.
- All patients said that staff made sure they had everything they needed, e.g. call bell, drinks, glasses (Patient Safety Rounds, March 2016), staff came to see them regularly through the night and that they had enough contact to feel safe, relaxed and confident.
- Patients said that the felt able to talk to ward staff about concerns they had either about their care or in general. There was information within the care plans to highlight whether people had emotional or mental health issues. We saw patients were able to access counselling services, psychologists and the mental health team if appropriate.
- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially and care plans highlighted the assessment of patients emotional, spiritual and mental health needs.

Good

Are services responsive to people's needs?

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

Summary

We found that care on community inpatient wards was responsive because:

- Patients with individual needs were given the support they required. In addition, members of staff were identified as leads, for example, in learning disabilities and dementia. Staff were trained in safeguarding and mental capacity procedures, and were able to apply and discuss these appropriately.
- Patients were able to access services at the right time through dedicated referral routes for continuation of specific support and effective discharge planning.
- Discharge was discussed with patients on their admission. Staff informed patients if their discharge was going to be delayed and the reasons for this.
- Complaints were handled in line with the trust's policy.

Planning and delivering services which meet people's needs

- Multidisciplinary teams (MDT) were committed to meeting the needs of the people who used the wards. Support was available to meet the needs of different people, for example patients living with a dementia and learning disabilities.
- There had been four readmissions within 30 days at Withernsea Community Hospital and five readmissions within 30 days at East Riding Community Hospital between June and November 2015.
- Comprehensive assessments were completed by each member of the MDT and progress was discussed within the daily MDT meetings and communicated in a timely manner with the patient and

their family.

- Facilities and premises were appropriate for the access and availability to disabled people who accessed and used services.
- We saw a range of food choice, meals and snacks, safe storage and supplies of crockery and cutlery for patients with specific needs.
- A system was in place to identify patients who required nutritional support to the catering staff. Details of dietary needs for individual patients were clearly identified on displays in the kitchen.

Equality and diversity

- We checked 35 patient records and found all had a completed learning disabilities assessment and mental capacity assessment, where appropriate. This meant care and treatment planned accounted for the individual needs of patients.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing care. These were available in languages other than English on request. Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- Information leaflets were available on each ward covering various conditions and surgical procedures to enable patients and family members to find further information. Nursing staff and specialist nurses were available to ask questions about care and treatment at any time.
- Leaflets included complaints guidance from the Patient Advice and Liaison Service, nutrition guidance, stop smoking support, friends and family test data, infection prevention and control guidance, hand hygiene data, and the Forget-me-not booklet.
- Wards had access to interpreters both in person and on the telephone, Requests for interpreter services were also identified at the pre-assessment meeting.
- A translation service was in place and advertised throughout the hospitals and policies were in place to ensure patients following different religions were treated with dignity and respect.
- During the inspection at the hospitals and across the trust we saw consistent examples of patient's individual needs and preferences being central to the planning of services and care.
- We observed effective access and facilities for wheelchair users and disabled bathrooms and toilet access.

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- There were systems in place for open and individual visiting for relatives and friends of patients. Staff said single room accommodation allowed a greater degree of privacy and facilitated open visiting.

Meeting the needs of people in vulnerable circumstances

- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.
- The inpatient wards completed a dementia assessment with every new patient. The assessment gave staff the information they needed to refer the patient onto specific support services.
- Patients on the wards who lacked capacity were supported appropriately through best interest assessments and decisions. Senior staff were trained to undertake best interest assessments.
- Wards had dementia and learning disability champions designated, responsible for ensuring staff were aware of the needs of individual patients.
- A dementia strategy was in place which identified the trust's aims and objectives in the care of people who have a dementia and their families and carers. This applied to all adults accessing community services. East Riding Community Hospital had designed facilities incorporating dementia friendly initiatives.
- Staff provided engagement, socialisation, companionship, cognitive and physical support for patients with a dementia.

Access to the right care at the right time

- Patients were able to access a bed at the right time as bed occupancy varied in the inpatient wards in the six months before inspection (for example 72% at Withernsea Community Hospital and 95% at East Riding Community Hospital).
- Average lengths of stay for discharged community inpatients varied from 18 days at Withernsea Community Hospital and 26 days at East Riding Community Hospital.
- Each team had dedicated referral routes for continuation of specific support as required. This included the inpatient hospital team, extended therapy or rehabilitation and adult social care support provided by the local authority.
- Each ward had identified staff to undertake discharge planning and this was begun as soon as patients were admitted. Discharge was discussed with patients on admission; this gave patients and staff ideas about expectations and anxieties.
- Patients said the discharge process was fully explained and helped to give them extra confidence to remain independent. The discharge planning process commenced at the admission stage. Services, equipment and community packages of care were all in place for the patient when they returned home.
- Access to equipment was arranged during inpatient provision and the inpatient hospital team ensured everything was set up and understood by the patient on discharge.
- Discharge processes helped ensure a smooth transition from inpatient unit to independent living. A discharge summary was sent to the GP on discharge from the wards. This detailed the reason for admission and any investigation results and treatment undertaken.
- Delayed discharges were 9% at Withernsea Community Hospital and 12% at East Riding Community Hospital between June and November 2015. We discussed discharge arrangements with patients on the wards and all said they had no concerns about their discharge; they said they were kept informed of any delay and understood the reasons.

Learning from complaints and concerns

- The trust had a Patient Advice and Liaison Service in place and information was available for patients and their families about how to make a complaint or raise concerns, including an easy to read format. Patients told us they would go to the ward staff if they were unhappy about anything.
- Inpatient wards also sought patient feedback within ward rounds and daily discussions. Six complaints had been received about community hospital services between January and December 2016. These were mainly about discharge arrangements and patient transport. The complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the matron.
- Staff described the complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS)

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and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospitals and wards informing patients and relatives about this process.

- Themes from both formal and informal complaints were collected and discussed in staff meetings, when appropriate.
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were visible in the wards.

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 found that care on the community inpatient wards was well led because:

- The community hospitals displayed information about the trust's vision and values and staff demonstrated they understood and put these in to practice. Risk registers were in place, actioned and completed at both local and trust level.
- Staff were aware of the structure of the organisation and said they were supported by their matrons, senior staff and the service manager.
- Services at Whitby Hospital had recently transferred to the trust and staff told us they had been communicated to well and kept informed of developments affecting the service.

Service vision and strategy

- We met with senior managers who had a clear vision and strategy for community inpatient services and identified actions for addressing issues. The strategy identified the vision, behaviours and goals for the division.
- Specific objectives had been set for improving patient care, maintaining safety, developing a workforce for the future and financial sustainability.
- The vision and strategy had been communicated throughout inpatient services and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust vision and strategy was displayed in wards and staff were able to articulate to us the trust's values and objectives across inpatient services.
- We were told the trust had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection.

Guidance, risk management and quality measurement

- Clear governance procedures and structures were in place and these included a local governance framework, quality circle and clinical network supported by local management teams, business management teams, governance and compliance committees, organisational risk committee and the trust board.
- Minutes of these committees showed regular discussion and action took place regarding audit,
- patient experience, management and quality dashboards, incident management and risk. In focus groups and individual discussions, staff were able to express the same concerns as those in more senior positions within the wards.
- Matrons told us they had overall responsibility for monitoring and managing risks, though this was shared by delegation to specific members of staff.
- Risk registers were in place for inpatient services. Risks, impact, controls, gaps in control, assurance, gaps in assurance and mitigating actions had been identified, although it was difficult to identify when these had been updated.
- Risks at ward level were identified and monitored. This included risks specific to individual patients, such as moving and handling and self-harm. Environmental risks were included, such as fire safety, infection control and security.
- We saw action plans were monitored and implemented across inpatient services and the risk register was updated with progress or new risks.
- Complaints, incidents, audits and quality improvement projects were discussed at regular staff meetings and we saw 'quality' boards displayed throughout the wards. Feedback from these meetings was given to matrons.
- Wards used a quality dashboard and safety thermometer to measure their performance against key indicators.

Leadership of service

- Staff said matrons and service managers were available, visible within inpatient services and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level.

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- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.

Culture within the service

- Staff said that the matrons and senior staff were approachable and there was good team working. Every staff member expressed commitment to their role and the care of the patients using the service.
- Staff spoke positively about the service they provided for patients and emphasised the patient experience was a priority. We saw staff worked well together and there was respect between disciplines. We saw good team working on the wards between staff of different disciplines and grades.
- Staff we spoke with felt that they received appropriate support from management to allow them to perform their roles effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Ward managers told us that they had appropriate access to senior staff members. This included being able to access support and courses to help them in leading their services.

Public and staff engagement

- Patients and relatives were positive about the care and treatment provided by inpatient services. Patients and their families were provided with opportunities to raise concerns or complaints and told they would speak to staff if they were unhappy.
- Patient views on their experience were sought at ward level and used to inform changes and improve care.
- Staff were able to share ideas and raise concerns through team meetings, supervision, shift handovers, and informally with their managers. Staff told us they were asked for their opinions on new ideas.
- Staff were clear about their roles and responsibilities, patient focused and worked well together to engage patients and families.
- The NHS Friends and Family Test showed between 88% and 100% of patients were either extremely likely or likely to recommend the service to others requiring similar treatment (December 2015 – February 2016).
- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, and the Patient Advice and Liaison Service were available on all wards.
- Discussions with patients and families regarding decision making was recorded in patient notes.
- Results from the 2015 NHS Staff Survey identified the key findings for the trust that compared most favourably with other similar trusts in England.
- These were the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, percentage of staff reporting errors, near misses or incidents witnessed in the last month, percentage of staff witnessing potentially harmful errors, near misses or
- incidents in last month, percentage of staff and colleagues reporting most recent experience of harassment, bullying or abuse and the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
- The survey also identified the key findings for which the trust compared least favourably with other acute trusts in England.
- These were the support from immediate managers, effective team working, recognition and value of staff by managers and the organisation, effective use of patient/service user feedback and the percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell.

Innovation, improvement and sustainability

- Matrons, service managers and staff told us they were supported to try new ways of working to improve the effectiveness and efficiency of the wards. Notice boards on the wards displayed patient experience data, safety and staff welfare.
- Staff meetings identified good practice and were held regularly. The quality dashboard had been developed and had been rolled out across other services.
- During the inspection it was clear that there was a culture that supported innovative practice and improvement.