Hounslow and Richmond Community Healthcare NHS Trust

RY9

Community health inpatient services

Quality Report

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Date of inspection visit: 25 January 2017 and 6 February 2017
Date of publication: 27/04/2017

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)
RY902	Teddington Memorial Hospital	Community inpatient unit	TW11 0JL

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of Hospitals

We undertook a follow up inspection of the inpatient unit run by Hounslow and Richmond Community Healthcare NHS Trust at Teddington Memorial Hospital on 25 January and 6 February 2017. It was a focussed inspection to follow up on concerns, particularly looking at the safe and caring domains which CQC had judged inadequate in its inspection of March 2016 (published 6 September 2016.) The unannounced inspection reviewed the action taken in response to the requirement notices issued under The Health and Social Care Act (Regulated Activity) Regulations 2014. These had related to dignity and respect, governance processes in relation to monitoring the quality of the service and numbers and training of staff.

Following the March 2016 inspection the provider sent us an action plan detailing how they would improve the areas of concern in the inpatient unit. The unit is now focused on rehabilitation, rather than being a general elderly care step down ward, so the service now provided is quite different from that we inspected in March 2016. We therefore also reviewed the inpatient unit's performance in the domains of effective, responsive and safe as well. These had formerly been judged as requiring improvement.

We inspected the inpatient unit because we were aware that the provider had made significant changes since the last inspection in March 2016. The inpatient unit was now meeting the regulations that had previously been breached and was providing a good service in all areas. We rated inpatient unit is as good overall.

Our key findings were as follows:

- There was a cohesive strategy for the inpatient unit which the trust had restored to its intended function as a bedded rehabilitation unit. The key elements of the transformation had been in place since September 2016. Work was continuing with staff and external partners on further changes over time.
- There was regular oversight of the inpatient unit by members of the executive team. New managers were in place on the unit and a small transformation team had been working with staff to ensure they owned and understood the benefits of the changes in practice.
- All day shifts were filled 100% by permanent staff and night shifts by 95% permanent staff. Nursing staff were delivering care in line with current national guidelines.
- The inpatient unit environment was visibly clean and was quiet and calm. Our visits were unannounced and we found patients were up and dressed early in the day, most of them ate their midday meal in the day room and on our evening visit we found the inpatient unit was quiet by 10pm so patients could sleep.
- Staff had received additional training in areas that had been identified as weak at the previous inspection: consent, the mental capacity act, infection control. All health care assistants had obtained the care certificate.
- Patient admissions and discharges were appropriately planned and managed.
- We found no issues associated with privacy and dignity in the accommodation, and we observed staff seeking patients' consent for treatment, including for daily activities such as washing and dressing.
- Rehabilitation patients achieved good outcomes, 97% improving their functional scores by the time of discharge.
- There was a good culture of incident reporting.
- Processes for safe administration of medication were in place.
- We spoke with patients and visitors and all the feedback we received was positive. All patients we spoke with were complimentary about their care and treatment and of the kindness of staff.
- There was resuscitation equipment on the inpatient unit which had not been readily available on the previous inspection, and staff were confident in how to use it.
- The average referral to admission time was 1.8 days which was less than the NHS average of 2.6 days.

An area of outstanding practice was:

- The rapid response and rehabilitation team acted as a single point of access for admissions and was also involved in discharge ensuring that patients were supported to continue their rehabilitation after discharge home.

However, the provider should ensure that:

Summary of findings

- All members of staff understand where to locate the originals of DNAR forms and know the process for managing active DNAR orders
- Hand hygiene audits improve to meet the trust target of 95%.

The new ratings impact on some of the trust ratings, although the overall rating remains requires improvement.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Background to the service

Hounslow and Richmond Community Healthcare NHS Trust provides a range of community services across the London borough of Richmond in south west London and the London borough of Hounslow in north west London. Services are provided to a population of 500,000 people living across the two London boroughs. It provides the following core se : inpatient rehabilitation services; community district nursing; health visiting; physiotherapy; nutrition and dietetics; health promotion, speech and language therapies and occupational therapy.

The trust also provides some specialist services such as audiology, neuro-rehabilitation, continence services, diabetes, respiratory, cardiac rehabilitiation, dementia care, continuing care and care for people with learning disabilities.

Hounslow and Richmond Community Healthcare NHS Trust has a total of 3 registered locations, including the hospital inpatient unit. The inpatient unit at Teddington Memorial Hospital.is in the London borough of Richmond and provides care for those registered with a Richmond GP.

Hounslow and Richmond Community Healthcare NHS Trust was formed on 1 April 2011 following the merger of community health services in Hounslow and Richmond. These services were previously run by NHS Hounslow and NHS Richmond. The organisation now provides services from more than 16 locations with an income of about £69 million, and employs more than 1120 staff.

Hounslow and Richmond Community Healthcare NHS Trust has been inspected 6 times since registration. We issued 3 requirement notices against regulations 10,17 and 18 of the HSCA (RA) Regulations 2014 . These related to the provider's failure to ensure privacy and dignity was maintained, good governance because of the lack of systems and processes to assess, monitor and improve the quality and safety of the services and the failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff. The provider took steps to respond to this positively.

Hounslow and Richmond Community Healthcare NHS Trust provides a community inpatient inpatient unit at Teddington Memorial Hospital for patients with a GP in the borough of Richmond. The inpatient unit provides 29 inpatient beds in a single inpatient unit, Pamela Bryant inpatient unit, with separate bays for male and female patients. 22 beds are allocated for rehabilitation with 7 beds available for continuing care and end of life patients, but which can be used for rehabilitation if not otherwise used. It is a nurse led unit with GP cover both during the day and out of hours, and regular involvement of a consultant geriatrician.

The mainly elderly patients were those assessed as able to benefit from inpatient rehabilitation after acute illness or injury or to prevent hospital admission. The aim was to enable patients to return to their homes or other suitable accommodation within the community.

Our inspection team

The team included two CQC inspectors supported by a specialist nurse.

Why we carried out this inspection

In March 2016, we had concerns about a number of aspects of the community inpatient services at the trust. Following the inspection the provider sent us an action plan detailing how they would improve the areas of concern. We carried out a focussed inspection at Teddington Memorial Hospital in January and February 2017 to follow up on concerns, particularly with the safety and caring domains which CQC had judged inadequate in March 2016. However as the service was now almost solely focused on rehabilitation which was very different

Summary of findings

from the service inspected in March 2016 we reviewed the inpatient unit's performance in the domains of effective, responsive and well led, which had formerly been judged as requires improvement.

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?

We carried out unannounced visits during the day on 25 January 2017 and in the evening on 6 February 2017. Before visiting we reviewed information about the changes in the service in board papers and the action plan. During the visit we looked at documents on site, such as care records and minutes of meetings and also reviewed further information sent to us by the trust after the inspection. We observed how people were being cared for on the inpatient unit and talked with carers and family. We also reviewed policies, protocols and training and monitoring records. We spoke with 15 staff from a variety of professional backgrounds and grades including physiotherapists, occupational therapists, administrators, nurses, doctors, pharmacists, the transformation leads and cleaners. We also spoke with 13 patients and two relatives.

Good practice

- The rapid response and rehabilitation team acted as a single point of access for admissions and was also involved in discharge ensuring that patients were supported to continue their rehabilitation after discharge home.

Areas for improvement

Action the provider COULD take to improve

- All members of staff understand where to locate the originals of DNAR forms and know the process for managing active DNACPR orders
- Hand hygiene audits improve to meet the trust target of 95%.

Hounslow and Richmond Community Healthcare NHS Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

In the March 2016 inspection we had rated safe as inadequate because there had been no resuscitation equipment or medicines for basic medical emergencies on the ward, there had been high levels of agency nurses and we had found substantial gaps in recording patient observations, documenting scores in the early warning system and a lack of appropriate action when changes in patients' observations were observed.

On this inspection we rated safe as good because;

- There was a good culture for reporting incidents and patients were protected from avoidable harm.
- Safeguarding had a good profile and enabled the identification of possible abuse.
- The inpatient unit was quiet and calm.
- There was resuscitation equipment on the inpatient unit.
- The quality of documentation was good and staff completed assessments for each patient.
- The inpatient unit was clean and well maintained, and staff were trained in infection prevention and control.
- The inpatient unit was fully staffed and most staff were permanent employees.

However

- Recent hand hygiene audit results were below the trust target of 95%.
- Not all staff had a clear understanding of the process for managing (Do not attempt resuscitation) DNAR authorisation orders. The trust responded immediately to this by amending their procedures and setting up a process to ensure that old copies of DNAR forms were destroyed when patients left the ward.

Our findings

Safety performance

- The trust participated in the National Safety Thermometer scheme to measure and monitor avoidable patient harm. This is a national tool that is a

Good

Are services safe?

way for trusts to measure and compare their performance in four key areas of safety; falls, pressure ulcers, venous thrombo-embolism (VTE) and urinary tract infections (UTIs) in patients with catheters.
- Safety thermometer results were displayed at the entrance to the inpatient unit, calendar-style, highlighting days that were harm free in green.
- The trust target was 95% harm free care and had achieved 100% in December 2016. Since April 2016, there had been no falls with harm and no new thromboembolisms. There were two reported incidents of pressure ulcers and two UTIs in patients with catheters during that nine month period.

Incident reporting, learning and improvement

- Patient safety incidents were reported through the National Reporting and Learning System (NRLS). All but four reported incidents were low or no harm.
- We found that there was an effective incident reporting and recording process using the trust intranet which alerted managers when an incident had occurred. All clinical and non-clinical staff we spoke with knew how to report an incident and gave us examples of what they would report. The inpatient unit sister reviewed incidents weekly. There was an expectation that staff would learn from incidents.
- There had been one serious incident in the six months prior to the inspection (an alleged assault). In the 12 months preceding the previous inspection (from February 2015 to February 2016) there were 12 serious incidents.
- There had been 246 incidents reported since September 2016 of which 58 were medication incidents. Most incidents were no harm. Four incidents required the patient to have further treatment: two pressures ulcers acquired elsewhere, a fall and an alleged assault. 21% of incidents were attributable to another organisation, mainly other hospitals. Incidents were discussed at six weekly staff meetings and at the weekly safety 'Flash' meeting, as well as through the minutes of the quality and safety committee, and the clinical excellence newsletter. A notice board in the nurses' office displayed current and relevant information including recent meeting notes.
- We saw an example of learning from a previous incident. Staff told us there had been an incident when a patient admitted to the inpatient unit from elsewhere did not have a completed drug chart. During our inspection, a patient returned from an acute hospital with no evidence that their regular medicine had been administered before the ambulance collected them. A nurse persevered in telephoning the acute hospital to obtain correct information to avoid the patient missing a dose.

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. Staff we spoke with were able to tell us when they would apply the duty of candour by being open and transparent with a patient, or relatives of a patient, about a safety incident.

Safeguarding

- The safeguarding policy was on the intranet and all staff were trained in adult and child safeguarding training as part of mandatory training. Staff knew who the safeguarding leads were.
- Safeguarding had a sufficient profile and staff were able to identify possible abuse and to whom they should escalate safeguarding concerns.
- Knowledge among staff about restraint was generally good. The staff we spoke with could identify the situations that could be considered restraint and they all correctly identified physical, verbal restraint and the nurses correctly spoke about restraint using medication and covert administration of tablets.
- Staff were able to identify the potential signs of abuse in the elderly patient and also the different types of abuse (physical, emotional, financial, sexual and verbal control).
- Healthcare assistants (HCAs) told us they had a duty of care to escalate suspected abuse to a nurse even if the patient asked them not to report.
- There had been two safeguarding incidents in the nine months to February 2017. One had occurred several months before our inspection and had been reported to CQC. Staff had followed the correct procedures. A second safeguarding concern was under investigation as a serious incident.
- Safeguarding concerns were on the agenda of the weekly multidisciplinary meetings.

Good

Are services safe?

Medicines

- The inpatient unit had medicines management policies and protocols for procedures not always available in community hospitals, such as the intravenous administration of antibiotics, which were used occasionally for otherwise stable patients.
- The inpatient unit had five day/week pharmacist cover. We spoke to the pharmacist employed by the trust who worked three days a week. Another pharmacist covered the other two days. The inpatient unit pharmacist told us that medicines reconciliation (to check that the list of medicines prescribed was compete and correct) was carried out within 24 hours of admission or within 72 hours at a weekend.
- There was evidence of pharmacy input on all medicines charts we looked at.
- We checked 20 patients and all had wristbands. Patient allergies had been written on the wristbands and the allergies correctly corresponded with the patient records of the six patients we cross checked.
- Medicines were supplied, stored and disposed of securely and appropriately including patients own medicines. We observed two nurses administering medicines on two occasions and saw they correctly checked the patients' identities and were not interrupted. Medicines were kept tidily in drug trolleys that were locked and secured to the walls when not in use.
- Staff we spoke with knew how to report medicines-related incidents. 58 medicine incidents had been reported since September 2016. All were low or no harm.
- We checked the medicine administration charts (MAR) of seven patients and although the majority were correct, two omissions of medicines had not been documented. Also some medicines had been crossed off without these being signed for.
- There used to be an onsite pharmacy but now an external pharmacy, some distance away supplied medication. The trust was moving to e-prescribing which would involve staff training. In the interim pharmacists were using a transcription sheet which was time consuming. GPs prescribed the medicines.
- Controlled drugs were safely stored in a metal cabinet fixed to the wall and locked with a key. The cabinet should be made of metal and fixed to the wall, and checked every day in accordance with national guidelines. The register for the stock level of controlled drugs showed the correct amount of stock.
- Staff made daily recordings of the medicine fridge temperature. There were no omissions in the list; the temperature was always within the recommended range of 2-8°C.
- We saw evidence that medicine incidents were analysed for learning to avoid repetition, and regular audits were carried out.
- The evening medication round which had, on the previous inspection started at 10pm now took place earlier to ensure the bays were quiet by 10pm.

Environment and equipment

- The premises were well maintained and managed. The inpatient unit was on the ground floor with access to a garden. Inpatient unit areas, corridors, the day room and treatment room were clean and tidy. Storage areas were also clean and arranged in an orderly manner. Entrance to the inpatient unit was secure via an intercom for visitors.
- The inpatient unit environment was quiet and calm. Our visit was unannounced and we found patients were up and dressed early in the day, most of them ate their midday meal in the day room and on the evening visit the inpatient unit was quiet by 10pm so patients could sleep. This had not been the case on the inspection in March 2016.
- The Patient-Led Assessments of the Care Environment (PLACE) scores were at or better than the national averages in most areas, for example : 94% for condition, appearance and maintenance (average 93.5); 92% for privacy and dignity (average 84%); dementia 88% (average 75%) and 87% for disability (average 79%).
- On the previous inspection, the inpatient unit had been found to be noisy at night. In response, staff had introduced a standard that the inpatient unit environment should be suitable for rest by 10pm. It was calm and quiet on our unannounced evening inspection. Any patient wanting to watch television used headphones. The medication round now took place earlier in the evening to avoid disturbing patients.
- There was sufficient space for therapeutic activity.
- Visitors and patients had free use of the day room which contained books and games for patients.

Good

Are services safe?

- A concern on the previous inspection was that male patients needing to walk through female areas. Male patients were now in accommodation which had access to the bathroom directly without walking through female areas and vice-versa. Our observation and patients comments confirmed this was not an issue. Since the last inspection staff had put privacy transfers on the glass partitions on the bays to make them feel more private, while still allowing nurses to observe patients from a distance.
- The inpatient unit had adequate stocks of manual handling equipment including hoists, sliding sheets and standing frames. This equipment was clean and had in-date service stickers in place.
- All patients had call alarms which were working, and within reach. The call alarm system indicated to nurses which room or bed the call came from.
- Bed frames were clean and all patients were nursed on air mattresses which were owned and serviced by the trust. All mattresses had in-date service stickers.
- Commodes and seating chairs were clean and well maintained. Staff said the estates department responded promptly to requests for repairs or replacements which was evidenced through the housekeeper diary used to report broken equipment or the need for a deep clean.
- The vital signs machine was used for multiple patients and had 2 sizes of blood pressure cuff. The cuffs were visibly clean.
- We checked the records of four blood glucose machines. Staff documented the checks daily.
- Oxygen was securely stored.
- The inpatient unit and the gardens outside which patients could use in summer were accessible to people who used wheelchairs and walking frames.
- We had felt the inpatient unit was warm on the second occasion we visited. In response to our concern the temperatures were immediately checked and were found to be within the recommended range. Inpatient unit staff told us they could easily report any temperature issues and said that estates staff were responsive and made minor adjustments to suit patient and staff requirements.
- Trust policy was to test the fire alarm system each week, which was strictly adhered to. Each call point throughout the trust was checked on a rotating weekly schedule. Fire equipment checks were in date.

Quality of records

- The overall standard of documentation we reviewed was good. We found risk assessments for patients were completed. We looked at electronic records of six patients. The assessments of the patients were based on national guidelines. These included falls assessments, the simplified mini-mental test, the Barthel Index of Activities of Daily Living, and the manual handling assessment undertaken by the physiotherapist. The 'Malnutrition Universal Screening Tool' (MUST), Venous thromboembolism(VTE) risk assessment and Waterlow score (pressure ulcer prevention) were recorded, as was the use of the nationally recognised five step model for pressure ulcer prevention (known as SSKIN). These had been completed and reviewed weekly in the patient notes we looked at.
- Patient records were part paper, part electronic using Systm1, which was used throughout the trust. Care plans and risk assessments were paper based so that assessments could be done at the bedside. The records we looked at were up to date, written legibly and signed.
- Therapy notes were clear, legible, dated and signed, with consent documented.
- Most records were stored securely. However, we saw nursing notes for patients in two of the side rooms were left outside patient rooms. This did not ensure the privacy of those patients' records.
- We noted that for a diabetic patient, the electronic record contained an individualised assessment of methods to manage his diabetes. The bed side record contained evidence of regular blood sugar checks and showed no extremes of blood sugar.
- Because documentation systems were part paper, part electronic, the inpatient unit clerk had to scan large numbers of patient records into the system. There was a back log of nearly a box full of patient documentation waiting to be scanned in the office on our first visit. This could present a risk in terms of delaying responding to alterations in patient conditions or a missed opportunity. However, when we returned for a second time, all the records had been scanned.
- Do not attempt cardio-pulmonary resuscitation (DNAR) information was recorded on the electronic system and emergency copies of forms were held in a folder in the nurses' office. During the inspection, one patient was listed on the handover sheet as having a DNAR form but

neither we, nor the nurse we asked, could find the authorisation form. The DNAR forms we looked at were completed appropriately with the families' views documented and some evidence of MDT input.
- On inspection we came across some copies of DNAR forms relating to patients no longer on the inpatient unit. The provider took immediate action to audit DNAR authorisation forms and to introduce a daily check to ensure that forms did not remain in the folder when a patient was discharged.

Cleanliness, infection control and hygiene

- There was an infection prevention and control nurse. Staff told us, and the infection prevention and control (IPC) nurse confirmed that they made a weekly check on patients in isolation rooms including the IPC notices and nursing documentation to check pathways for MRSA or diarrhoea. The IPC team responded regularly to queries by staff on the inpatient unit; there was a record of 14 telephone queries made by staff on the inpatient unit during January 2017. The IPC team had made recommendations for action in an earlier inspection and trained staff in infection control.
- The IPC team had carried out an infection control audit of the isolation rooms on 18 and 20 January 2017. The inpatient unit had not received the isolation audit report at the time of the inspection.
- IPC policies were available to all staff on the intranet.
- All doors on side rooms used to isolate infectious patients, or those who presented an infection control risk, were closed. A notice identified the precautions staff and visitors should take before entry. We observed staff and relatives taking appropriate precautions in using personal protective equipment (PPE) when entering the room and discarding this on departure. There were adequate supplies of PPE.
- We observed staff washing their hands frequently with soap and water, although their technique varied. There were alcohol hand gel containers outside each bay and side room. Staff carried hand gel containers in their pockets. The trust had carried out a risk assessment about leaving hand gel at the point of care in an elderly care inpatient unit. The infection prevention and control committee had decided that staff would carry personal hand gel in line with National Patient Safety Agency (NPSA) guidance, for patients for whom permanently-sited dispensers may pose a risk. A few staff were uncertain about when to use gel and when to use soap and water. Hand hygiene audits in January and February 2017 were showing scores of 85-90% against a target of 95%.
- All staff we saw adhered to the 'bare below the elbows' policy.
- A cleaner was on duty at the time of inspection whose trolley contained the correct type of cleaning materials. The cleaner wore correct personal protective equipment. Colour-coded cleaning equipment was used to avoid cross contamination and the cleaner had a good understanding of infection control and hygiene practices.
- Patients we spoke with said the inpatient unit was always clean.
- Patients' bed side curtains were disposable and every bed had a change date documented. All curtains were within date.
- Clinical and non-clinical waste was separated and waste bins were covered and operated by pedal. Waste outside the building awaiting collection was stored in locked bins.
- Staff screened patients for MRSA within 48 hours of admission.
- We saw one staff member emptying patients' used water after they had a wash into the sink staff used for handwashing rather than in the sluice room. This significantly increased the risk of contamination of the environment and hands through bacteria splashing onto hands and the environment. There was no dedicated sink for disposal of used washing water in the bay.
- We observed patients at lunch time who were having a meal in the dining room. Each tray had a hand hygiene wipe placed on it. However, none of the patients were encouraged or assisted to use the wipes.
- In the nurses station we saw a few pieces of old Blu-tack and peeling sellotape on the walls and furniture which was a potential infection risk. This was not seen on the inpatient units.

Mandatory training

- The trust's mandatory training completion target was 85%. The actual completion rate of inpatient unit staff at the time of the inspection was 88%.
- Mandatory and statutory training included topics such as moving and handling, conflict resolution, blood transfusion, equality diversity and human rights, fire

safety, health and safety, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), infection control, resuscitation, and safeguarding adults and children. Training was both face to face and online. Bank staff were also required to complete mandatory training.
- All new staff members, including bank staff, followed an induction program. We saw induction packs for student nurses and for agency staff on the inpatient unit. A database recorded staff that had undergone induction and when.

Assessing and responding to patient risk

- The trust had a policy for managing deteriorating patients. Staff used the Modified Early Warning Score to assess potential deterioration. We checked the MEWS charts on 10 patient records and there were no omissions. All patients had MEWS scores of between 1 and 2 (normal). The acuity of patients was low during our inspection and none of the patients caused concern regarding immediate deterioration.
- Staff had a good understanding of how to use the MEWS charts and how to identify deteriorating patients.
- There was a resuscitation trolley on the inpatient unit in an easily accessible recess. This had not been present at the previous inspection when we had remarked on the absence of resuscitation equipment. Equipment on the trolley included a working automated external defibrillator (AED) oxygen, suction, bag valve mask, razor, electrocardiogram (ECG) sensors and airway equipment. All equipment was in date and had been checked and signed for by staff weekly. Staff had been trained in use of the resuscitation equipment so they could respond to foreseeable emergencies until an ambulance arrived.
- The inpatient unit did not provide acute care for patients, nor fluid resuscitation, so the nurse in charge would escalate patients requiring acute care to 999 ambulance services or the on- call GP. This did not happen often. Staff told us the response time from the London ambulance service and of the out of hours GP was very good.
- Because the inpatient unit did not provide acute care and did not have an intensive care unit on site, no staff had received advanced life support training. The inpatient unit did not keep life support drugs. There were two mini jets of intramuscular adrenalin to be used case of anaphylaxis on the trolley and these were in date.
- Staff completed risk assessments when patients were admitted and care plans were based on the risk assessment. These included nutrition, hydration, skin integrity and mobility. Staff we spoke with showed awareness of the key risks to the mainly elderly patients on the rehabilitation inpatient unit such as falls and pressure ulcer damage.
- We observed handover. We saw that each patient report started with their MEWS score and the action needed, if any. We saw staff highlighted specific concerns for example, about more vulnerable patients who required one to one supervision, infection risks, any tests carried out and care plans for any pressure sores.
- There was one to one care for patients with challenging behaviour.
- We asked 10 patients if they felt safe on the inpatient unit and all affirmed they did.

Staffing levels and caseload

- Staffing had been a concern at the previous inspection because of the high proportion of agency staff due to vacancies. Agency staff were now rarely used and the inpatient unit manager said staffing was no longer a concern. The reduction in agency staff had been achieved by reducing the number of beds.
- Five registered nurses were on duty on the daytime inspection. The ratio of nurse to patients was 1:6. Four nurses were permanent staff and one a member of the bank staff. There were no agency staff in the daytime. There were four health care assistants (HCAs) on duty all of whom were permanent. Four nurses and four HCAs covered the afternoon shift. Three nurses (one of whom was bank) covered the night shift, with three HCAs. Staff worked eight hour shifts. The manager had reviewed the ratio of registered to unregistered staff and proposed a new skill mix agreed in principle. Additional HCA training had been rolled out. On our unannounced inspection there was one regular agency nurse on the night shift.
- Staff did not appear under pressure and we observed them spending time with patients. HCAs accompanied nurses to care for patients.
- A band 6 staff member was rostered on an evening shift until 10pm to help to support staff and assure care quality, ensuring changes to practice were leading to improvements.

Good

Are services safe?

- Records showed that safe staffing had been met every month since September 2016. Staff were aware of the escalation policy and process around staffing and were assured that staff knew how to escalate staffing and or clinical concerns.
- The small vacancy rate for trained staff (9%) was covered by bank staff. There were no other vacancies within the team.
- Agency staff when used were generally for 1:1 care.
- The inpatient unit had five hours a day medical cover by the GPs from a GP consortium. The local out of hours GP service, in the same building, provided medical cover outside working hours.
- The inpatient unit had cover from a psycho-geriatrician who saw patients living with a cognitive or mental health disorder.
- Other members of the MDT visited patients on the inpatient unit regularly including a dietitian, who visited weekly and tissue viability nurses. Patients had access to speech and language therapy as needed.

Managing anticipated risks

- The service manager told us the inpatient unit had tightened up its admission processes since the previous CQC inspection. The inpatient unit admitted patients who had mild cognitive disorders but not patients with severe dementia or delirium. In-reach workers, occupational therapists and physiotherapists received referrals from the local acute trusts and assessed patients for suitability for admission. Community matrons also referred patients from their catchment area. This meant the inpatient unit had a cohort of patients with similar needs and potential for rehabilitation.
- Staff carried out a daily check of all patients on the inpatient unit to check that medications had been given, MEWS charts were completed, comfort rounds had been done and fluid balances had been completed. This gave the nurse in charge a good overview of patient care being provided and comment on any issues. We reviewed these lists and saw they evidenced safe and effective care. These were the basis of an assurance report weekly to allow senior managers to be aware of the level of care.
- The service had managed to resist pressures from acute hospitals to take inappropriate patients due to winter pressures.

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

In the March 2016 inspection we had rated effective as requires improvement because staff did not always ask patient's consent before undertaking daily living tasks, we did not see evidence of pain evaluation following the administration of analgesia and saw staff ignore patients asking for pain relief, not all agency staff had an induction to the ward and Deprivation of Liberty safeguards had not been up to date.

In this inspection we rated effective as good because;

- The inpatient unit used current best practice guidelines to support patient treatment and care.
- Patients had comprehensive assessments that followed national guidelines.
- Patients received appropriate pain relief and were checked to ensure their pain was managed.
- Staff understood the importance of nutrition and hydration and patients received assistance to eat and drink.
- There were arrangements for supervision and appraisal and staff were supported with revalidation with professional bodies.
- Rehabilitation patients achieved good outcomes.
- We saw good examples of multidisciplinary planning. Patient discharge was managed to ensure effective transition to community services.

However

- We observed limited cross-working between nursing and therapy staff, although nurses said that at weekends nurses supported patients to follow their therapy care plans, however we saw that plans were in place to introduce more integrated working.

Our findings

Evidence based care and treatment

- The service used National Institute for Health and Care Excellence (NICE), Royal College of Nursing (RCN), College of Occupational Therapists and the Chartered Society of Physiotherapy policies and best practice guidelines to support patient treatment. We saw these were referenced in trust policies. Staff demonstrated how they could access trust policies and guidelines through the intranet.
- We saw from records that staff assessed patients based on national guidelines including falls assessments following NICE guidelines, and the Folstein mini-mental state screening test. Therapists used the Barthel scale to measure performance in activities of daily living. The inpatient unit also used the Malnutrition Universal Screening tool, venous thromboembolism assessments (for risk of blood clots) and the SSKIN care bundle to prevent pressure ulcers. We reviewed records of six patients and these had been completed and reviewed weekly.
- We noted that the record of a diabetic patient contained an individualised assessment of methods to manage the patient's diabetes and the bedside record contained evidence of regular blood sugar checks. There were no extremes of blood sugar.
- Staff understood their roles and responsibilities in delivering evidence based care
- A manager told us about the plan to offer more intensive therapy to suitable patients who would respond well to 14 days or less of intensive rehabilitation.
- The inpatient unit was taking part in the national intermediate care services audit this year, but had not done so previously.

Pain relief

- Patients received pain relief on a regular and as prescribed basis. Staff routinely asked patients if they were comfortable and had any pain and patients confirmed this. Staff undertook intentional rounding every two hours.
- Staff discussed pain management in handover in relation to patient's wellbeing.

Good

Are services effective?

Nutrition and hydration

- Staff understood the importance of nutrition and hydration. All patients had access to water. Aids for drinking and eating were available to patients (modified cutlery, tipping mugs) and we observed patients using these.
- We observed the mid-day meal time. The food looked varied, balanced and portion sizes were good. We spoke to four patients about the food and all commented favourably. In the afternoon patients received tea using aids to drinking as needed. Meal times were protected times in which no non-urgent clinical activity took place so staff were free to help any patients that needed help with meals.
- Where patients had fluid charts, these had been completed accurately.
- The 2016 scores for PLACE assessments of food were 98% compared with a national average of 90%.
- The inpatient unit used the red tray system whereby staff served patients at risk of under nutrition on a red tray, and charted what they ate on the food intake chart so they could monitor their nutrition. We crossed checked four patients who had a red tray at lunch time and saw their food charts had been completed.
- Patients on the inpatient unit had access to dietician.

Technology and telemedicine

- The trust was introducing an electronic rota system at the time of the inspection. They were piloting this on the inpatient unit. The new system had the potential to streamline the roster process and record staff sickness and turnover for HR purposes.
- The electronic record keeping system required manual scanning of a lot of documents.
- Staff told us not all local GPs used the same electronic system which was not ideal for ease of information sharing. Some electronic notes had to be printed off for transmission to other services.

Patient outcomes

- Senior managers used tools based on the Derby Outcome Measure (DOM) of rehabilitation, as well as outcome tools such as the Barthel score and Average length of stay and had set performance indicators for these.
- Patient scores were recorded on admission, including cognition. Data showed that since the tightening of admission criteria, a higher proportion of patients (62%) were alert and oriented but occasionally forgetful. Those scoring less well were those in continuing care beds. 97% of patients had improved functional outcomes on discharge at December 2016. The average admission scores since April 2016 were 25 and the average discharge scores were 13. (The lower the admission/ discharge score, the less dependent the patient, a score of 35 would illustrate a very dependent patient.)
- The average length of stay had dropped significantly following the change in admissions criteria. The number of long stay patients decreased from 20 to 8 in four weeks At November 2016, 19% of rehab patients had stayed over 44 days. The average length of stay of discharged patients had continued to reduce. As a result of time limited interventions, the length of stay at the time of our inspection was generally less than 21 days which is the normal length of time needed for bedded rehabilitation.

Competent staff

- There were appropriate arrangements for supervision and appraisal. Staff told us they had supervision every two months. They had appraisals each year. The appraisal rate at January 2017 was 90%.
- We saw evidence of additional training delivered to 30 clinical staff (nurses and healthcare support workers) on diarrhoea and vomiting and norovirus during November 2016. Training on how to support people with dementia was planned for the month following the inspection and we noted a high number of staff had signed up for this. Staff had access to a range of e- learning as well as workshops. Staff told us the quality of training was good. It was publicised on the intranet and on noticeboards and managers encouraged attendance.
- National online food hygiene training was being secured for staff working on the inpatient unit in response to recent identification of a training gap.
- Nurses told us they had been supported with revalidation. (This is the process where nurse renew their registration with the Nursing and Midwifery Council). All nurses who had undergone revalidation met the criteria and were accepted for registration.
- All permanent HCAs had been encouraged to complete the care certificate by end January 2017.
- Therapists told us they were able to access appropriate training.

Good

Are services effective?

Multi-disciplinary working and coordinated care pathways

- The rehabilitation service had a multidisciplinary approach to assessing, planning and delivering care and treatment. This involved nursing, medical and therapy staff as well as GPs. There were weekly multidisciplinary meetings which involved the social worker in the rapid response and rehabilitation team (RRRT). We saw evidence that the dietitian and tissue viability nurse were involved as needed. A consultant geriatrician attended these meetings.
- There was a robust goal planning system in place involving the MDT and communicated to the patient and family. An occupational therapist (OT) told us they met the patient with a physiotherapist (PT) to set functional goals. The therapists used the Derby Outcomes Measure toolto assess goals in areas such as transfers and mobility, personal care, nutrition to enable people to return to independent living if possible. A therapy assistant was planning some group activities such as a breakfast club involving kitchen and cooking assessments.
- Staff told us the physiotherapists and OTs attended morning handover daily to discuss patient goals. The handover sheet evidenced input from the OT and PT.
- Although the MDT were working together in planning, we observed that the different professionals worked sequentially with patients rather than meeting patient goals through an inter-professional approach. However, in discussion with staff we learned that the service was moving to a new model of care where nurses and therapists would work in integrated teams sharing skills.

Referral, transfer, discharge and transition

- The rapid response and rehabilitation team acted as a single point of access for admissions. Only patients who had a Richmond GP were eligible for admission. A member of the team visited the acute hospital to screen patients due for discharge for suitability for admission to the inpatient unit. Most referrals were from the acute hospital, although some were from the community to avoid acute hospital admissions. The balance was expected to shift over time so the inpatient unit took most admissions from the community.
- Admissions took place during the day to ensure initial assessments were completed.
- We saw evidence of reduction in the length of stay since the introduction of revised and tighter restrictions on patients assessed as suitable for admission. All new patients, whether with long term conditions or post-operative patients were required to be able to engage adequately in core elements of a plan with agreed rehabilitation goals with a discharge plan in place and agreed by the patient. The service manager was gatekeeper on adherence to the admissions policy.
- Therapy services were provided five days a week.
- There remained a small number of continuing care patients on the inpatient unit for whom the CCG had commissioned beds.
- Patients were never discharged at night.
- The OT service did home visits with patients prior to discharge to assess the need for aids and adaptations as well as assessing the patients' ability to cope in the home environment. After patients were discharged, the trust's community health and re-ablement service followed up patients to ensure they had continued access to care.
- A senior nurse was currently undertaking the discharge coordinator role on the inpatient unit until a permanent appointment was made. A social worker from Richmond Rapid Response team was also supporting improved discharge. The local mental health team was also involved as needed for dementia assessments.
- Patient discharge was appropriately planned and managed and most people had care packages promptly organised to enable them to return home. Patients confirmed that they knew when they were due to be discharged and had had discussions with staff about the areas of care and support they required. Electronic discharge summaries were sent internally to community services and to the patients' GPs.
- Delayed transfers of care had been reduced to 1.3% by December 2016 which was a significant improvement from earlier in 2016. The target was no more than two delayed discharges in a month and this had been met in December 2016 and January 2017.

Access to information

- Staff on the inpatient unit demonstrated how they could access the information they needed to deliver effective care and treatment, such as test results. Daily shift handovers enabled transfer of information to in-coming staff.

Good

Are services effective?

- The system for recording and responding to blood results had some potential for error because the online reporting system used by the acute hospital carrying out testing did not feed into the inpatient unit system. The inpatient unit clerk had to print results and scan them onto the inpatient unit's IT system. Sometimes blood results were only reported by phone. However, nurses had access to the system if the inpatient unit clerk was absent.
- Not all the acute hospitals used the same forms for patients transferring to TMH.
- The inpatient unit had a very clear information board at the entrance which gave staff, patients and visitors information about the planned and actual staffing each day, information on the number of harm free days and results from the Friends and Family Test.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The service used the Mental Capacity Act 2005 and the code of practice appropriately. Staff told us there had been training in consent and in the Mental Capacity Act 2005. Those we spoke with understood the requirements of the act where people did not have the capacity to consent.
- We saw staff seeking consent before they started care activities with them. There was evidence in records of written consent from patients for certain treatments or activities.
- One patient had a Deprivation of Liberty Safeguards (DoLS) authorisation in place and this was in date.

Good

Are services caring?

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

Summary

In March 2016 we had rated caring as inadequate because we observed staff ignoring patients in distress, walking past confused patients who were exposing themselves and ignoring call bells. The challenging case mix of patients had it difficult for staff to support patients emotionally.

On this inspection we rated caring as good because:

- Patients' dignity was observed in all the interactions between staff and patients that we witnessed.
- All patients we spoke with said staff were kind, helpful and treated them with respect
- Most patients and relatives felt involved as partners in their care and treatment and understood the reasons.
- The patients we spoke with all spoke positively of their care and treatment and of the kindness of staff.

Compassionate care

- We observed staff consistently responding to patients with care and consideration and taking account of individual needs. Curtains were drawn when staff were attending to patients in the bays and we saw staff knock on doors before entering rooms.
- Staff took time to chat with patients and their friends and families.
- Patients looked well cared for and were wearing their own clothes and footwear.
- We spoke to 12 patients about their experience of the inpatient unit. All patients were positive. Patients told us 'staff are wonderfully kind' , "I have been given marvellous care". Several patients mentioned that the environment and the care was better than they had experienced in other hospitals.
- Patients told us "staff come quickly at night" and other patients said they rarely had to wait long for call bells to be answered. Our observation confirmed this.
- We observed a staff member comforting a patient behind the curtains, reassuring them they would feel better in time after their major surgery and they needed to have periods of rest.
- All patients had a named nurse each day, and the name of the nurse was above their beds although some patients said they did not remember the names of the nurses.
- In January 2017, 97% would recommend the inpatient unit (Friends and Family Test). In December 2016, the response rate was 44%. 99% of respondents said staff respected their privacy and dignity.

Understanding and involvement of patients and those close to them

- We observed staff explaining procedures and spending time with patients encouraging them to participate in their own care. Patients we spoke with knew what their therapy goals were. One patient described how the staff had encouraged them not to use a wheelchair but a frame and they could now walk more easily. Managers were actively monitoring records to ensure people were involved in making decisions about their care and treatment.
- Patients and relatives felt involved and included in care and treatment and reported having explanations of treatment from nurses and therapists.
- Noise at night had been a concern noted in the previous inspection. The results of feedback from patients through the friends and family tests suggested an improvement on night time experiences. Notices were on the inpatient unit so patients and visitors were clear about the designated lights out time with options to continue to watch television in the day room. Only one patient of eleven patients we asked about the inpatient unit at night said they 'sometimes heard staff and other patients at night, but not often'.
- We saw that patients were actively encouraged to dress each morning and this was being monitored. Patients were also encouraged to go to the day room to socialise with others at lunch time.

Emotional support

- All patients and relatives we spoke with were positive about the emotional support staff provided.
- Staff we spoke with were aware of the emotional aspects of being in hospital, away from home.
- A relative said they considered staff took really good care to give their family member support and encouragement.
- A chaplaincy service was available and there was a multi-faith room in the hospital.

Good

Are services responsive to people's needs?

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

Summary

In the March 2016 inspection we rated responsive as requires improvement because hospital routines were arranged to suit staff rather than patients, although intended to be a rehabilitation ward there were a number of challenging patients living with dementia sharing the ward space and taking staff time so rehabilitation patients were not always washed and dressed early in the day. The ward was noisy at night, and there had been limited printed information available to support patients in understanding their condition and their care and treatment options, or even the menu. Patient discharges had been very slow.

In this inspection we rated responsive as good because:

- The service had clear admission and discharge arrangements and was integrated with the community rehabilitation service.
- The inpatient unit provided activities to meet people's rehabilitation needs.
- Specialist equipment was available to meet specific needs such as those of bariatric patients.
- There was information available on the inpatient unit about the complaints and compliments procedure including how to access the patient advice and liaison service Information was provided in accessible formats, large print or pictorial as required.
- There had been no formal complaints and 33 compliments had been received in the nine months preceding the inspection.

Our findings

Planning and delivering services which meet people's needs

- Staff on the inpatient unit understood the main purpose of the inpatient unit was for rehabilitation. Senior staff had worked with GPs and the acute hospital to improve understanding of the purpose of the inpatient unit.
- Managers undertook weekly quality rounds to check that improvements introduced were being maintained on the inpatient unit and that they were effectively meeting patients' needs.
- The facilities on the inpatient unit met people's rehabilitation needs as there was adequate space for patients to mobilise and exercise equipment.
- Patients had appropriate information about their care or treatment, about other local health and support services.
- There was a laminated menu used to assist patients with meal choices. This was available in large print, and we saw that staff could provide cultural menus on request from patients or their family. No one was having such a meal during our visit. There was a variety of snack choices and all menus were coded in terms of low sugar, vegetarian or healthy options. For patients with sensory problems, a pictorial menu was available.
- Tea and cake was provided in the afternoon which patients told us they appreciated.
- The inpatient service was an integral part of the community rapid response and rehabilitation service.
- There unit had strong working links with other services and agencies such as social services, intermediate care service, district nursing service, Princess Alice Hospice and the voluntary sector.
- A range of information for patients, friends and relatives was on display in the day room covering topics such as dementia and advocacy.

Equality and diversity

- Staff we spoke with said they had received equality and diversity training.
- Staff told us that interpreters were available through a telephone interpreting service but this was not often needed.
- We saw patients had access to large print documents.
- There was specialist equipment available for patients with specialist needs such as bariatric commodes and chairs, and aids for people with disabilities such as tipping mugs.

Meeting the needs of people in vulnerable circumstances

- We saw the patient information leaflet given to patients containing the names of their OT and PT and their functional goals. The leaflet was available in a variety of fonts and there was a picture version. This enabled

patients and families to read the goals set. We were told the communication team and lead nurses had reviewed the format of the document to ensure it was at an appropriate language level.
- Walking frames and commodes were placed close to the beds so they were easily accessible if patients required them during the night.

Access to the right care at the right time

- The average referral to admission time was 1.8 days, less than the NHS average of 2.6 days. Reasons for slightly longer waits were if there were delays in acute hospital discharges or a lack of immediate availability of specific beds, male or female, or infection control issues requiring a private room.
- The inpatient unit was almost always full. Bed occupancy information was shared with the rapid response and rehabilitation team. The average bed occupancy on the inpatient unit (including continuing care beds) since September 2016 was 92%. Occupancy of rehabilitation beds was 99%.
- Discharges were timely.
- A patient information board enabled staff to check easily on patient activities, including estimated date of discharge. Length of stay was around 16 days, timed against expected rehabilitation achievements, compared to 44 days the previous year when a number of discharges were delayed because of the need to find suitable accommodation. More patients now returned to their own homes. There was scope to flex length of stay if a patient needed to stay longer.

Learning from complaints and concerns

- There was information available on the inpatient unit about the complaints and compliments procedure including how to access the patient advice and liaison service. A number of thank you cards giving positive feedback were on display.
- There had been no formal complaints in nine months to February 2017 and 33 compliments.
- Staff tried to resolve any patient or relatives' concerns on the spot and patients reported this was helpful.

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

In the March 2016 inspection we had rated well led as requires improvement because there was no cohesive strategy for the inpatient unit which was attempting to meet the needs of very different types of patient in a small unit. There was poor teamwork on wards and insufficient ward management support. Ward staff said the executive team were not visible.

On this inspection we rated well led as good because;

- The vision for the inpatient unit to provide a unified rehabilitation service working closely with community care had been developed with staff and external agencies such as Age UK.
- Managers had responded promptly to concerns arising from the previous inspection and put in place a range of actions to transform the service from a general elderly inpatient unit to a facility primarily for rehabilitation.
- Trust directors and senior managers were visible and visited the inpatient unit regularly and showed interest in and support for the improvements being made.
- Staff found the transformation team established to support the inpatient unit in improving services was considered supportive by inpatient unit staff.
- We saw evidence of a variety of ways of monitoring the service including unannounced visits from members of the executive team and reports to the board.
- Risks were identified and managed effectively.

Our findings

Service vision and strategy

- The trust vision was to enable people to live healthier and more independent lives through high quality seamless care. The service vision within this, for the inpatient unit, was to deliver a unified rehabilitation service coordinated by a named clinician through the entire patient pathway.
- The mission for the inpatient unit was to provide professional, caring and safe in patient care underpinned by the four core values: responsive, care, respect and communication.
- The model of care was focused on avoidance of both A&E attendance and acute admission using the TMH bedded unit as part of continuum of community based care. Managers told us they were resisting pressure from acute trusts to admit inappropriate patients outside the admissions criteria.
- The main focus of staff was on high quality, person-centred care.
- The trust had appointed a transformation leadership team in September 2016 to support staff in changing the way the inpatient unit worked. The team had held an engagement event to help staff contribute to and take ownership of the changes taking place. Work was still in progress but staff understood focused purpose of the service

Governance, risk management and quality measurement

- The CCG's Quality, Patient Safety and Equalities Committee met monthly to consider clinical quality and performance issues, patient experience, serious incident reporting and safeguarding across the trust. Developments in the inpatient unit were discussed with commissioners including through the Richmond Outcome Based Commissioning Programme.
- The trust's integrated governance and risk management committee (IGC) monitored trust activity including the inpatient unit. This was chaired by a non-executive director and membership included the chair of the trust board and representation from Healthwatch.
- Since the previous inspection in March 2016 the trust had set up specific monitoring of the improvement plans for the inpatient unit. There were informal weekly updates with key staff particularly the Director of Quality and Clinical Excellence, and more formal update reports against the improvement plan every two weeks. Performance indicators, audit and internal and external review of services were part of the assurance mechanisms. These were monitored by the trust's Journey to Outstanding Delivery Board and the Quality

Good

Are services well-led?

Governance Committee (a committee of the Board). Unannounced visits by senior staff at different times of day or night had taken place as part of the monitoring process to provide internal quality assurance.

- Inpatient unit staff had regular team meetings and weekly 'Flash' meetings which discussed incidents, complaints and other patient feedback which might identify areas for audit. Notes from these meetings were on the noticeboard in the nursing office so staff could catch up if they had missed the meeting.
- Staff mentioned that senior staff had visited the services unannounced to talk to staff and patients. The manager undertook weekly quality rounds and the Director of Quality and Clinical Excellence had undertaken a number of unannounced visits to the inpatient unit.
- Staff told us local team leadership was effective and managers were supportive. We observed good team working.
- Staff told us they found the leadership of the transformation team responsive and that members of the executive team visited the inpatient unit to monitor and review the service.
- We reviewed the trust risk register for the inpatient unit. There were four items, inconsistencies in nursing care, the need for all staff to have food hygiene training, infection control and one on the need to identify a suitable e-prescribing system for use in the inpatient unit following the loss of the inpatient pharmacy. There was a temporary solution using a Pharmacy Transcription Sheet until training had been completed on the electronic system. We did not identify any additional risks.
- Audit and observation had revealed some inconsistent practice in the application of infection control procedures, (specifically hand hygiene and bare below the elbows compliance from external staff visiting the unit), and isolation and consistent use of PPE. New senior clinical infection control link staff were in place from inpatient unit staff. Infection control audits and incidents were discussed at unit meetings, senior clinical staff meetings and monthly governance meetings. This was on the risk register. The risk was rated as minor.

Leadership of this service

- A new team had assumed management of the inpatient unit since the previous inspection. There was a service manager and a matron with senior clinical support.
- In response to the previous inspection a small transformation team had been set up to work with staff on improvements until March 2017. Staff told us they found the transformation team supportive. Staff also told us members of the executive team visited the inpatient unit to monitor and review the service. We reviewed the reports of two senior 'walk abouts' which confirmed the internal assessments of improvement.
- The Assistant Director for Quality and Clinical Excellence attended monthly unit meetings to discuss patient safety incidents, serious incidents and complaints, and provide senior support.
- Senior nurses were encouraged to take responsibility for the inpatient unit improvements. A leadership development programme was supporting them.
- Both the service lead and clinical lead were visible on the inpatient unit during the inspection.
- Patients and relatives we spoke with told us they were clear who was in charge of the inpatient unit if they had any concerns.

Culture within this service

- Staff spoke positively about working on the inpatient unit. Nurses reported 'been a massive improvement with staffing, documentation and storage. The team work has improved as we communicate better now'. We spoke to a staff member who travelled some distance to work on the inpatient unit. They said 'because I love it'; and some former agency staff who had accepted permanent posts stated 'the team work is good'. We felt morale was good, despite some nurses concerns about the closure of one of the two inpatient units.
- Staff said it had become easier to deliver good quality person- centred now that there was a more coherent patient group on the inpatient unit.
- Staff told us the trust managers had consulted them the previous year about how they felt about the closure of beds and about the development of the rehabilitation service.
- There were mechanisms in place for staff to voice complaints through a Freedom to speak up Guardian. Staff were aware of this, though several staff mentioned it was easy to speak to managers about ideas for change.

Good

Are services well-led?

- Managers were planning a staff survey to test engagement since the changes to the unit in September 2016. This would help identify areas where engagement needed to be strengthened.
- Staff told us they received regular information about the wider work of the trust through email and intranet.

Public engagement

- The transformation team had been set up to work with clinical staff to review and re-design inpatient unit routines in partnership with patients and their families.
- We were told that wider public engagement plans were being developed.
- The inpatient unit was continuing to receive positive feedback through the Friends and Family Test and informal patient feedback including letters of thanks; some of which we saw.
- The strategy for the inpatient unit was discussed with Age UK and Healthwatch as part of its development.
- Staff had undertaken a re-audit of patients' views, following from the patient experience survey in January 2016. All patients surveyed would recommend the inpatient unit, 87% saying they were extremely likely to recommend it. Overall the comments were more positive than the previous survey.

Staff engagement

- The trust scored the highest of all community trusts nationally in the following areas: staff satisfaction with the quality of work and care they are able to deliver, staff agreeing their role makes a difference to patients, staff motivation at work and staff feeling unwell due to work related stress in the last 12 months which was 5% below the national community trust average..
- Staff engagement plans were in place to develop the inpatient strategy.
- Nursing staff and healthcare assistants were positive about working on the inpatient unit and said their colleagues supported them and they felt able to discuss issues with senior staff when required.
- Therapists said their managers were supportive of their work and training needs.

Innovation, improvement and sustainability

- The rapid response and rehabilitation team acted as a single point of access for admissions and was also involved in discharge ensuring that patients were supported to continue their rehabilitation after discharge home.