Dorset Healthcare University NHS Foundation Trust

RDY

Community health inpatient services

Quality Report

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Date of inspection visit: 23-26 June and unannounced 9 July 2015
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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)
RDYY2	WESTHAVEN HOSPITAL		
RDYY6	PORTLAND HOSPITAL		
RDYX9	WESTMINSTER MEMORIAL HOSPITAL		
RDYY4	YEATMAN HOSPITAL		
RDYEJ	BRIDPORT COMMUNITY HOSPITAL		
RDYFF	SWANAGE COMMUNITY HOSPITAL		
RDYX4	BLANDFORD COMMUNITY HOSPITAL		
RDYFE	VICTORIA HOSPITAL, WIMBORNE		
RDY22	ALDERNEY HOSPITAL		
RDYFG	ST LEONARD'S COMMUNITY HOSPITAL		
RDYFD	WAREHAM HOSPITAL		

This report describes our judgement of the quality of care provided within this core service by Dorset Healthcare University 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 Dorset Healthcare University NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset Healthcare University NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated this service as requires improvement. Improvements were required to ensure safe, responsive, effective and well-led inpatient services for patients. We found staff were caring and compassionate and treated patients with respect. We rated caring as good.

We found that there were variations in the quality of services across the 11 locations we visited. The services at Swanage, Blandford, Wimborne and Alderney were a better standard but we had concerns about inpatient services at other locations, particularly at St Leonard's and Bridport hospitals. Surgical services were good across all locations, where provided, including Bridport hospital.

- There were processes and procedures which were followed to report incidents and monitor risks. All locations had quality dashboards which recorded healthcare associated infections, avoidable pressure ulcers acquired in care, and safety information related to staffing numbers.
- Essential and emergency equipment such as resuscitation trolleys and suction facilities were available and overall managed safely. However at Bridport and Westminster hospitals, improvement was needed to ensure these were fit for purpose.
- The overall standards of cleanliness and infection control were good in eight of the 11 hospitals where infection control procedures were followed. There were significant shortfalls in these locations where staff did not follow infection control procedures and the management of infected materials.
- There were clear procedures for the management of medicines. Medicines were managed safely most of the time. Although we found issues with safe storage of some medicines including those on the resuscitation trolleys.
- The process for assessing risks such as pressure ulcers, falls and malnutrition were completed and care plans developed to manage them effectively.
- All hospitals used a recognised tool to determine if patients were at risk of deterioration of their health. This system had been used appropriately such as advice from doctors was sought appropriately.
- The trust had effective systems in place to gather information from patients, and used these to improve patients' care. We found staff were caring and willing to go the 'extra mile' in supporting patients with their emotional needs.
- Patients' feedback was consistently positive about their care, treatment and the community was keen to retain this local service.
- There were not always adequate staff to meet the needs of patients in a safe and consistent way and this could impact on patients' care.
- The quality of patient records was variable. Records were securely stored on an electronic patients' record system, but not all agency staff had access and trust staff had limited access to records as patients moved across services.
- Staff followed guidance from the National Institute for Health and Care Excellence (NICE). This included the five steps to safer surgery to ensure surgical procedures were undertaken safely and effectively.
- Staff recognised the equality and diversity of patients when providing care, although written information was only available in English.
- Therapists carried out thorough assessments of patients, however due to shortage of therapists; patients did not always receive therapy in a timely way such as out of hours and weekends.
- We found there was strong ethos of multi-disciplinary working. Multi- disciplinary team meetings were held and led by a consultant, where patients and their relatives were involved in decision about their care and discharge planning.
- Although there were some internal audits, these were not always linked to improvement in quality and safety or patient outcomes.
- Governance across the service was not robust, not all risks were identified or managed appropriately.
- There was a process which staff followed in dealing with concerns and complaints and responses were sent to patients.

Summary of findings

Background to the service

Dorset Healthcare University NHS Foundation Trust provides a range of acute and community services across Dorset, Poole and Bournemouth. Community inpatient services are provided at 11 hospitals. The services provided are based on historical commissioning with more 'step down' acute trust referrals for sub-acute care and rehabilitation, in East Dorset. In rural areas of Dorset the service take more GP referrals and provide end of life care services as well as acute hospital 'step down' services. The trust was developing more integrated locality models in West Dorset.

Alderney hospital has two wards with 25 and 23 beds.

Blandford hospital has one ward with up to 24 patients and an operating theatre; this does not provide surgery under general anaesthetic.

Bridport hospital has 2 wards, Langdon ward has 22 beds all year round, Ryeberry ward has 22 beds in winter and 16 beds in the summer. The hospital has an operating theatre for surgery.

Westhaven has one ward with capacity for up to 34 patients.

Swanage hospital has one ward with 15 patients and an operating theatre for surgery.

St Leonard's hospital has two wards, with 22 and 16 beds.

Wareham hospital has 16 beds.

Westminster has two wards with eight and six beds.

Victoria hospital, Wimborne has one ward with 22 beds (plus three overnight surgical beds)

Portland hospital has one ward with16 beds.

We visited all 11 community hospitals during our inspection.

Our inspection team

The inspection team was led by:

Chair: Neil Carr OBE, Chief Executive of South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Team Leader: Karen Wilson-Bennett Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

The inspection team for inpatient services comprised CQC inspectors, a pharmacy inspector and specialist advisors including: GP, senior nurses, community hospital matron, and physiotherapist. The team included experts by experience; these are people who have personal experience of using or caring for someone who uses this type of care service.

Why we carried out this inspection

We inspected the inpatient community hospitals as part of our ongoing comprehensive inspection programme

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Summary of findings

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

Before the inspection 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 on 23-26 June 2015. We also carried out an unannounced inspection on the 9 July 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists.

During the inspection visit, the inspection team:

- Visited 11 community inpatient hospitals.
- Spoke with about 42 patients and their family.
- Spoke with 49 staff members; including doctors, nurses and social workers, occupational therapists and support workers
- Interviewed senior managers with responsibility for these services
- Attended and observed 4 multi-disciplinary team meetings
- Looked at 56 care and associated records of patients.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider say

- Patients and their relatives were complimentary about the care and treatment they were receiving. There were examples of staff going the 'extra mile' in supporting patients with their emotional needs.
- They were particularly positive about the community hospital providing care and meeting the needs of the local community as this meant they were close to their friends and family
- Patients also praised the voluntary services such as the league of friends which they said made a positive impact for their wellbeing.
- Patients told us the staff were kind and courteous and treated them with respect when providing care and treatment. However they felt staffing could be improved to ensure care is provided in a timely way.
- They told us they received pain control and information about their care and treatment was shared with them.
- Although therapists were available during the week, the lack of therapists did impact on them when they were transferred late on Friday and at the weekend.

Good practice

- In Bridport inpatient beds were part of a locality wide team providing multi agency services to meet the needs of individual patients. The Bridport inpatient team was part of a weekly multi-disciplinary virtual ward meeting to discuss vulnerable patients and the most appropriate services and care pathway to meet their needs. This model was being rolled out to Weymouth in September with co-location of primary medical care and social services with community services and community inpatient beds.
- There was a nurse practitioner who was trained in an extended role and undertook certain surgical procedures at the day surgery unit at Bridport hospital .

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure that-

- Medicines are stored in accordance with their policies and standard operating procedures.
- Appropriate dates are placed on medicines once opened and stored at the correct temperature

Summary of findings

- Infection prevention and control policies and procedures are implemented by staff, and thorough environmental infection control audits are undertaken on all inpatient wards.
- There are, at all times, sufficient numbers of adequately experienced and trained staff to meet the assessed needs of patients.
- Equipment servicing and checks are carried out regularly and a record kept that they are safe for use.
- Emergency equipment is fit for purpose and available in all areas at all times .
- All staff are trained in basic life support to deal with emergency situations
- The environment of all inpatients sites does not compromise patient privacy and dignity.
- There is robust monitoring of safety and quality of the service, risks are identified and timely actions taken to manage risks.

Action the provider SHOULD take to improve

The trust SHOULD ensure that-

- Discharge planning processes are procactive and well co ordinated with social services to reduce delayed transfers out of hospital.
- Referral and admission processes are reviewed and implemented, to reduce the risk of inappropraite admissions.
- Medicines ordering and supply processes are reviewed to minimise delays in treatment initiation and patients have access to their medicines as prescribed in a timely way.
- Staff have access to appraisal, clinical supervision and training to meet the needs of patients in sub-acute inpateint setting
- Service strategies are clear and communicated effectively.
- Staff at all levels are encouraged and supported to raise concerns, promote improvement and contribute to innovation.

Dorset Healthcare University NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- We found variation in the implementation of systems to support safe care and treatments. We had particular concerns about Bridport and St Leonard's hospitals where the monitoring of implementation of safety systems was not robust. Safety processes were followed in the delivery of surgical services at all locations where provided.
- Staff knew how to report incidents, and most reported incidents were investigated and lessons learnt were shared, although processes for this were not always formal. However reporting and learning from incidents was not consistent and not all staff had access to the electronic system for incident reporting.
- Infection control procedures were followed and eight of the locations we inspected were clean, including the theatres. However this was not consistent at the other hospitals infection control process and practices was not robust and put patients and others at risk.
- Equipment was available and maintained to a satisfactory standard and these were tested at regular intervals at all the hospitals. However at Bridport and Westminster Memorial hospitals emergency equipment was not available and maintained appropriately.
- Medicines were available to patients and were managed effectively and according to medicines guidance. The storage facilities and medicines management at some hospitals did not always meet with current guidelines.
- The service used an acuity tool to assess staffing levels. Appropriate staffing levels were maintained at most hospitals and agency and bank staff covered shortages. At some hospitals wards there experienced difficulty in finding staff to cover shifts. There were shortages in therapy staffing. Medical and therapy staff were available for emergencies outside normal working hours.
- Although some staff knew about the duty of candour, some senior staff across the hospitals were not aware of this and of their responsibilities when things went wrong.

Requires improvement

Are services safe?

- There was a training programme including mandatory training for staff. There was low compliance with mandatory training in topics such as basic life support, adult safeguarding.
- Records were securely stored on an electronic patients' record system, but not all agency staff had access and this created a risk as these may not be available and completed in a timely way.

Detailed findings

Safety performance

- There had been no incidents of "Never Events" which are incidents determined by the Department of Health (DH) as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Inpatient community hospitals within the trust reported a total of 51 serious incidents between April 2014 and 2015. The majority (98%) of incidents reported were categorised as grade three and four pressure ulcers.
- The trust collected safety thermometer data in relation to care provided to patients. The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections and falls. Safety thermometer information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- There had been no cases of venous thromboembolism (VTE) recorded. New pressure ulcers fluctuated over the 12 month period in the community hospital wards, reaching a high of six in July and October 2014 and three in March 2015.
- The number of recorded falls with harm also fluctuated over the year, with a peak of three falls in March 2015.
- The incidence of catheter related urine infections and new urinary tract infections (UTIs) was recorded. The incidence of UTIs was low with four reports in May and October 2014. There were three in January and February and two in March 2015.
- Safety thermometer information was displayed at the entrance to the wards so that all staff and visitors were aware of the performance on the ward or department.
- A monthly chart was displayed which showed how many days had elapsed since a patient had experienced any of the above. In Alderney this showed there had been two falls and no pressure ulcer incidents in June 2015.

Incident reporting, learning and improvement

- Incidents were recorded and reported using the trust electronic recording system. Staff at all locations were confident to report incidents. However we found incidents reporting and lesson learnt was not always shared across teams.
- Staff gave examples of incidents they had reported and the outcomes of investigations. At Blandford hospital following a recent incident of clostridium difficile on the ward. A senior staff carried out a root cause analysis, which looked at the cause of the infection and information was shared with the staff. Lessons learnt from incidents were discussed at staff meetings at local level.
- Root cause analysis was undertaken for incidents for hospital acquired pressure ulcers at some of the hospitals, this was not consistent in all the hospitals in order to affect learning.
- Staff at all the hospitals told us they understood the importance in reporting of incidents. All permanent staff told us they had access to the system and were able to use it. The process for reporting incidents was not always robust across the hospitals as agency staff did not always have access to the system even when they were in charge of the wards.
- At all hospitals, the five steps to safer surgery were completed prior to operations. However they were not audited to monitor compliance.
- At Westminster Memorial hospital senior staff could not find details of a recent reportable incident which occurred a couple of days prior to our inspection. Failure to accurately record and report incidents could have a negative impact on the care of patients.
- Other incidents not recorded or monitored included inappropriate admissions, such as patients being transferred outside normal working hours, lack of staff with the appropriate skills. Senior staff told us of incidents where patients had been transferred back to the acute hospital as the staff were not able to administer intravenous fluids or antibiotics at certain community hospitals. These incidents were not

recorded or reported and were not reflected in the trust risk register. Therefore opportunities to enable appropriate action to be taken and lessons learnt were lost and did not improve outcomes for patients.

Safeguarding

- Staff on the wards, including non-clinical staff, were aware of what constituted abuse and the actions they would take to protect the safety of patients from abuse.
- Staff would report to the senior sister or matron. However none of the staff said they would follow this up to see what action if any had been taken.
- Staff were aware of the trust whistle-blowing policy and we were told they could find information on the trust's website. We were not confident nursing staff felt empowered to use it. Staff said they had to follow the procedure and report to their immediate managers first which they did not feel was effective.
- Staff including medical, nursing and ancillary were required to attend safeguarding training. Data showed that between 77% and 100% of staff in community hospital inpatient services had completed their required safeguarding training. The trust data showed compliance levels varied widely at ward level. On Canford ward at St Leonard's hospital, none of the staff had completed level 1 or 2 safeguarding training and update according to the trust's data.

Medicines

- We found medicines were managed appropriately at most of the locations. Staff followed their procedures and medicines were kept securely. Staff liaised with GPs or out of hour's service for prescribing of medicines, they told us this worked well. We found some concerns at Bridport, Portland and Alderney.
- Medicines were stored securely at all the hospital except at Bridport where we found during our unannounced inspection, the treatment room on Langdon ward was not locked leaving a number of medicines unsecured. There was a risk these could be accessed by patients and the public. We raised this with the senior nurse as immediate action was required. The trust was taking action to address this.
- There were a number of instances where liquid medicines such as Paracetamol, Lactulose and Simple linctus did not show the date of opening. Liquid medicines once opened have a limited shelf life and staff could not be assured these medicines were used within the recommended times.
- Drugs such as those used for resuscitation were left on top of the resuscitation trolleys without tamper proof seals. We raised this with the senior nurses during the inspection for action to be taken.
- At Bridport community hospital, the medicines administration record (MAR) charts contained a number of 'missed doses' with gaps on the MAR charts indicating patients may not have received their medicines as prescribed. There was no audit undertaken in order for action plan to be developed to mitigate the risk of patients not receiving their medicines as prescribed.
- Staff followed procedures and ensured medicines were labelled appropriately with the date of opening. However at Portland and Westhaven hospitals insulin pens were stored in the medicine trolleys without date opened recorded.
- The system for ordering and storing medicines was well managed except at Bridport. The named patients' cupboard was overstocked with medicines that were not on the stock list. They were being ordered as temporary stock. These cupboards also contained medicines which were no longer needed by patients. Although the nursing staff had raised these issues with the medicines management team, action had not been taken.
- Staff on several wards also raised concerns about delays to medicines supplies when not stocked by the supplying pharmacy which caused delays to patient's receiving their medicines.
- The controlled drug cupboards were appropriate and met with controlled drug guidance at most locations. However at Alderney hospital these were not compliant with current policies and procedures. This was brought to their attention at the time of the inspection.
- The trust has a policy for all controlled medicines to be checked by registered nurses and this was followed across all the locations except at Bridport hospital.
- There are strict guidelines for the storage of intravenous fluids following recent cases of misappropriation. These were mainly adhered to except at Bridport where storage was not secure, as the treatment room was not locked and they were stored on the floor.

Requires improvement

Are services safe?

- Storage of medical gas at Portland hospital did not follow trust policy; empty cylinders were in a cage open to weather, and the full cylinder store lacked ventilation. At Bridport hospital, oxygen cylinders were stored loose on the floor and were not secure.
- The temperature at which medicines were stored were monitored and records were available to ensure they were maintained according to manufacturer's guidelines.
- At Alderney hospital, we found two packs of antibiotics had expired in May 2015.
- Staff dispensed creams and ointments to patients however these were not labelled appropriately with the patient's name. There was a risk of these being used as communal or for the wrong patient as staff said these were often given to patients when they transferred in between services.
- On one ward we found eye drops labelled for one patient being used for another patient.
- Staff were not aware of the critical medicines list which may impact on care and treatment as these emergency drugs may not be available to patients.
- At Portland hospital, staff advised us that they occasionally administered injectable medicines, however the injectable medicine poster within the treatment room was dated 2004 and may not reflect current good practice guidance. The trolley for medicines and equipment required in an emergency was lockable with the key kept in the lock, rather than tamper evident, and was not in line with the trust procedures.

Environment and equipment

- In the majority of the hospitals, there was a variety of equipment which were serviced at regular intervals; these were maintained safely and were ready and available for patients.
- Staff followed the procedure for checking the resuscitation trolley and defibrillator to ensure they were fit for purpose. We saw this was carried out at Alderney, Portland, Wimborne, Westhaven, Blandford and Swanage. However at St Leonards, Bridport and Westminster Memorial (Shaftsbury) hospitals the records showed this was not checked daily in line with the trust procedure.
- The day surgery unit was clean and clutter free. We observed all of the equipment was new, or nearly new, and well maintained and the resuscitation trolley checked regularly.
- The theatres in Swanage hospital had dedicated cleaning and storage of equipment for endoscopes. Staff told us they had enough equipment and records in theatres showed equipment had been checked and maintained. However, we found some out of date operating equipment outside the operating theatres which posed risk of these not being available if needed. We highlighted the expired items to the senior staff on duty at the time of our inspection for action to be taken.
- At Westminster Memorial and St Leonard's the equipment stores were not well organised, they were over-stocked and clean and dirty equipment in sluices were not segregated appropriately.
- At Bridport, the portable suction machines attached to the resuscitation trolleys had not been tested since 2013. We raised this with senior staff members during the inspection. On our unannounced inspection, the trust had sent the suction machines for servicing and had not put in any replacement. This meant there was no emergency suction machines on either of the two wards if needed in an emergency. Although there was suction facility in each bay, this was not adequate and posed risk to patients or visitors. The trust wrote to us after the inspection and confirmed that portable equipment had been installed.
- The resuscitation trolleys were not always maintained securely and in line with trust's policy. A number of these trolleys were either open or did not have a tamper proof seal to prevent unauthorised access to equipment and drugs. These trolleys also differed between hospitals. Some of the community hospitals had the recommended red trolley. At Westminster Memorial hospital they were using an open "dressing trolley" which was not secure and the drawers were difficult to open. This meant there was a risk of emergency equipment not being available when required.
- At Bridport the 'shelf life' of a suction catheter in one of the rooms had expired in December 2014. Staff could not tell us about the frequency of equipment checks to ensure they were fit for purpose. The management of

used syringe was not safe. There was a risk that that used syringes could be accessed by patients and visitors and others including patients living with dementia who were accommodated at the time of the inspection.

- At Westminster Memorial hospital, equipment such as suction machines and fire safety equipment had not been all tested in line with trust policy. However the suction machine had been used two weeks prior to the inspection. Oxygen cylinders did not all have expiry dates.
- At St Leonard's hospital the temperature of the food fridges had not been monitored and recorded since December 2014. Other food was not stored safely. The trust confirmed action was taken when this concern was raised and the content of the fridge destroyed and meals replaced. During the unannounced inspection we found these issues had been addressed. However the freezer room was very hot and unsecure.
- The premises at St Leonard's hospital were in a poor state of repair. The carpets were heavily stained and worn. The trust has told us this was being replaced with suitable flooring. Staff also raised concerns about security of the hospital at night.
- At Wareham hospital there were on-going issues with call bells not working. Staff were using numbered call bells from other rooms with high risk of confusion as staff may be directed to the wrong rooms and impact on patients' care. The doors to some bedrooms were narrow which restricted access for wheelchairs and beds and may pose risks to patients' safety.

Quality of records

- Patients' records were held electronically and contained detailed information about their assessments including risk assessments and treatment plans.
- We reviewed 48 medical, nursing notes and other associated records at the 11 hospitals as part of the inspection. We looked at if they were stored securely and the quality, access and legibility of the records. The trust was using a combination of paper and electronic records. Staff were issued with a card for accessing the computerised records. Staff confirmed this was secure as the cards were password protected.
- At Portland hospital patient records were updated in real time with input from all multi-disciplinary team members, which meant information was up to date and facilitated discharge planning.
- Good and clear multidisciplinary team working was evident throughout patient notes. Therapists and nursing staff contributed to and shared information on patients' care. At Blandford, Victoria Hospital Wimborne, Alderney, Victoria and Westminster Memorial hospitals care plans were completed and reviewed regularly to ensure they reflected any change in the patient's condition.
- Agency staff did not have access to the electronic patient record system. The trust used a number of agency registered nurses who were responsible for patients' care on the wards. They were neither able to review patients' care or treatment needs, nor add to records directly which may impact on the accuracy of available information.
- Patients' records were stored securely in all the locations except at Bridport where personal and confidential information about patients' resuscitation status was left on the resuscitation trolley. This had the potential of not being secure and accessed by others.
- The quality of documenting in patients' records was variable. In most locations records of care were detailed and reflected their current needs. However some patients' records lacked details of actions taken and evaluations for the treatment of pressure ulcers.
- There was a process to report all patient falls on the trust's electronic system. This was completed and the level of compliance with record keeping was high. The trust monitored and reported on falls as part of their safety thermometer. At St Leonard's a patient's had suffered numerous falls and their record was not up to date. The lack of accurate recording may impact on staff ability to audit and develop action plans to mitigate risks and learn from them.
- Food and fluids records were not always fully completed and staff could not be assured that patients who required their food intakes monitored due to weight loss were supported to receive adequate amount of food and fluids.
- Care plans were held on the electronic patient record system. Staff told us the system was slow and did not contain all the information they required. As a result of this they often had to adapt the electronic record to record the required information. This meant there was a risk that staff might not find information due to inconsistent approaches to completing records.

Requires improvement

Are services safe?

- At all the hospitals staff maintained a daily record on patients which identified if there were any changes in treatment and shared at handovers. At Portland hospital, staff did not write in a patient's daily report if there was no change. There was a risk to patients if staff had forgotten to record vital information including any deterioration or changes to care and treatment .

Cleanliness, infection control and hygiene

- There was clear process for the management and prevention of infection at the majority of the locations we visited. The standard of cleanliness was good and staff followed their infection control procedures. Hand sanitizing gels were available at the entrance of the hospitals and the wards.
- We observed staff adhered to the 'bare below the elbows' policy, washed their hands between patients and used personal protective equipment (PPE), such as disposable aprons and gloves. This included different coloured aprons for meals and personal care.
- Most wards and all operating theatres were visibly clean. Checklists and cleaning regimes were displayed to ensure staff maintained the cleanliness of the area they worked in.
- The trust took part in Patient-Led Assessments of the Care Environment (PLACE). The results for the hospitals were in line with the national average. The assessments looked at how the environment supported patients' privacy and dignity, food, cleanliness and general building maintenance and décor. Dorset Healthcare scored 96% for cleanliness of wards in line with national average.
- However we found concerns at St Leonard's, Bridport and Westminster Memorial (Shaftsbury) where infection control procedures were not robust. These included inappropriate management of infected laundry and waste materials at St Leonard's. During the unannounced inspection there were yellow and orange bags discarded in an open white container outside the back entrance, which was not safe.
- Providers are required to have regard to the Department of Health's 'Code of Practice on the prevention and control of infections and related guidance'. The Code of Practice sets out the basic steps to ensure compliance with the infection control requirements of the Health and Social Care Act, 2008.
- At Westminster Memorial hospital the resuscitation trolley and emergency equipment was covered with dust which would not be safe to use in an emergency. Other equipment such as oxygen trolleys were also rusty which made them difficult to clean appropriately and control the risk of cross infection.
- At Bridport hospital, food was not stored safely. We alerted senior management who reviewed food storage. During our unannounced inspection, action had been taken to change this practice as a result of our feedback. The failure to manage soiled infected material posed a high infection control risk to patients and others using the service.
- The sluice rooms in St Leonard's and Westminster Memorial hospitals were not designed with a clear flow from dirty to clean areas to minimise the risks of cross infection. This included the management of clean washing in the sluice area which was situated between two other machines used for cleaning soiled/infected bedpans. The cupboard doors in the sluice were also broken and chipped which did not meet with safe infection control procedures.
- The sluice at Westminster Memorial hospital was overcrowded with commodes and staff had to stretch over these to reach the bedpan cleaner/steriliser. This created a risk of spillage over clean equipment.
- Staff did not always adhere to the trust policy of using 'I am clean stickers' on clean equipment. This increased the risk of cross infection as staff could not be assured the equipment was clean and fit for purpose.
- The communal lounge at St Leonard's had a strong pervading odour of urine on the first day of our inspection. This had improved when we carried out our unannounced visit and staff told us they had cleaned the chairs.
- There was no evidence at some of the hospitals that infection control audits had been undertaken or action plans developed to mitigate infection control risks and improve outcomes for patients.
- Cleaning checklists were used at Blandford hospital but there were no records of how the cleaning of hoist slings was monitored. Slings for hoists were re-usable and used to support patients to move. Staff told us they were cleaned between patients and were sent to the laundry on a regular basis; there was no records maintained.

Requires improvement

Are services safe?

Mandatory training

- There was an induction programme for all new staff. This covered all the key statutory and mandatory training. New members of staff said they had been supported on joining the hospital and completed a trust wide induction programme.
- Mandatory training included safeguarding adults and children, basic life support, moving and handling, fire, infection control and information governance. There was a training schedule in place and this was monitored and non-attendance was discussed at team meetings.
- Trust data showed a high proportion of staff had not completed their moving and handling practice training. Completion rates were: Alderney 66%, Portland 76%, Westhaven 84% and Wimborne 53%. Lack of moving and handling training may pose risk of injury to patients and staff.
- The community hospitals do not have 24 hour medical cover and patients suffering a cardiac arrest, for example would be reliant on nursing staff to provide basic life support (BLS) until help arrives. Out of the 11 hospitals only three had achieved 87% for staff training in BLS. At Blandford hospital only 42% of staff were up to date with BLS training. Rates at Westhaven and Swanage were 56%and 50% respectively. The lack of up to date training may impact on care and treatment as staff may not have the skills and confidence to provide this level of emergency care.
- At Victoria, Wimborne hospital, the matron told us that currently 93% were up to date with their mandatory training attendance.

Assessing and responding to patient risk

- We reviewed 42 care plans and associated patient records. An assessment was completed on admission which included risks such as falls, pressure injury and nutritional risks. Patients' weights were monitored and referrals were made as appropriate to the dietitians and speech and language therapy team.
- Staff were using the 'SSKIN bundle' to monitor patients' pressure risks and skin conditions. All hospitals used an early warning score, to determine if patients were at risk of deteriorating. Records showed that the early warning scoring system had been used appropriately and advice from doctors sought if the patient required a medical review.
- At Victoria and Westminster Memorial hospitals staff told us they had received training to enable them to assess patients. Patients with a known risk of falls were accommodated in bays closest to the nurses' station for close observation and to minimise risks of falls.
- The early warning trigger tool and the expanded version called the quality, effectiveness and safety trigger tool were used within inpatient areas. The tools help to identify where there may be a potential for deteriorating standards of care. They were completed by wards on a monthly basis and include a number of questions and a score is derived from the responses given. Each tool has a threshold score at which action should be taken to address the issues identified.
- Therapists were involved in the moving and handling assessments and patients, detailed plans were developed and equipment was available to patients as needed.
- Patients attended a pre-assessment clinic to ensure they were fit for the planned surgery. Staff used the five steps to safer surgery World Health Organisation, surgical checklist including marking of the surgical site and other appropriate checks were completed.
- At Swanage staff had developed a procedure to deal with possible adverse reactions to certain anaesthetic drugs with laminated cards providing at a glance instructions for staff.
- The SSKIN bundle were utilised to assess patients' skin condition. Patients' skin was checked, assessed and documented at every shift. We found this to be variable; knowledge and skills were not fully embedded into practices.
- At St Leonards a patient was transferred late in the evening and required continuous oxygen therapy and information had not been received on transfer. Staff told us this patient was not fit for transfer and had to call 111 to get oxygen prescribed overnight and then was transferred back to an acute hospital the following day
- Staff told us that when patients were transferred via hospital transport from the acute hospital there were often delays and patients often arrived between the hours of five and nine in the evenings. This was potentially unsafe practice as the community hospitals did not have any medical cover outside normal working hours.
- Some patients were prescribed anticipatory medicines. Ward staff told us this was to ensure pain control was

available as the out of hours doctors did not always know the patients receiving care on the ward. However patients were prescribed varying dosages of pain control and there were no clear procedures to guide staff's practices. This is well recognised as a risky practice allowing nurses to increase pain control which may be to the detriment of the patients.

Staffing levels and caseload

- At the last CQC inspection in 2013, staffing was highlighted as an area that needed improvement. Compliance actions were set at St Leonard's and Westhaven community hospitals, requiring the trust to meet safe staffing levels.
- A review of staffing levels was undertaken as part of the trust recovery plan and an escalation tool was introduced to highlight areas where wards were not appropriately staffed. In response, assurance came from the director of nursing and quality and the medical director with additional funding committed. The trust gave an undertaking to review staffing levels on a regular basis and further refine the escalation tool to incorporate professional and clinical judgement alongside staffing levels.
- The service used the national safer nursing tool to assess the nursing numbers in providing safe care and identified minimum staffing levels.
- There are now nationally defined minimum safe staffing levels for community or intermediate care inpatient units. These include Safe Staffing: A Guide to Care Contact Time (NHS England, November 2014). Direct Care Measurements (NHS England, January 2015).
- In all the wards we visited, the required and actual staffing numbers were displayed. Staffing rotas demonstrated that safe staffing levels (registered nurse to patient ratio) of 1:8 during the day were achieved. Safe staffing levels at night however were not being achieved where at times they were 1:22.
- The trust provided sickness rates for 13 months to 31 May 2015. The overall sickness rate reported for this time period was 4.7% for 5,436 substantive members of staff. Alderney and Portland hospitals had the highest sickness rates at 6% and 8% respectively.
- Trust data received showed they had vacancies rates of 26% whole time equivalent (WTE) for qualified nurses and 17%WTE for nursing assistants.
- The staff vacancies as at 31 May 2015 varied between 10% at Wareham hospital, 18% at Blandford, 19% at Portland and 20% at Wimborne.
- Trust data as of 31 May 2015 showed the inpatient hospitals had high staff turnover which can impact on continuity of care. Portland had the lowest at 21% and Alderney at 30%.
- Patients and their relatives at some hospitals told us about long delays in responding to call bells. Comments included 'a lot of waiting when you need help.'
- Staff of all grades told us they were experiencing difficulty in recruiting staff and this impacted on care and staff's morale. Senior staff told us they "coped the best way they could" as often the requests for shifts could not be filled. Some staff said they did not put out requests as they knew they would not be filled.
- The trust was aware of the high staff vacancy levels at Swanage, Westminster Memorial and Westhaven hospitals and said they used a high number of regular bank staff and there was a trust wide central bank.
- At Wareham hospital, we observed patients were left unsupervised for some time in the dining room, which was on another floor when staff were on the first floor.
- Staff continued to raise concerns about staffing levels. The trust was using their bank and agency staff to cover sickness, absence and vacancies. At Wareham hospital patients told us they were going to bed too early or too late due to staffing problems. This was raised with the trust at the time of the inspection. They have responded by introducing a twilight shift and looking at more effective ways of working.
- During the unannounced inspection at Bridport, senior staff told us they did not have adequate staff to meet the needs of patients accommodated. This included some patients who were distressed and one person calling out all the time who staff said would have benefited from 1:1 support. The lack of staffing had a negative impact on the care and support patients were receiving.
- Data received from the trust showed there were 26% of shifts were not staffed to the planned level between March and May 2015. The trust filled 2975 shifts and 1045 were not filled. The highest levels of unfilled shifts during that period were at Alderney 151 out of 382 shifts

unfilled, or 40%. St Leonards had 118 shifts which were not filled, Westhaven 112 and Wimborne had 123. In comparison, Yeatman hospital used agency and bank staff to fill 197 shifts and had no shifts uncovered.

- The total number of shifts between 1 January and 31 March 2015 filled by bank and agency staff were 3369 filled and 752 not filled.
- Staff raised concerns regarding the competencies and skills of junior nurses making decisions about admissions from the acute hospitals. These were particularly during out of hours and at the weekends.
- The trust had a process for a senior clinical lead to review patients at the acute hospitals prior to transfer. However information about patient needs was not always recorded correctly. For example, a patient requiring specific support with their breathing was inappropriately transferred to a community hospital. Staff had not received training in the management of this type of patients and may have put the patient at risk.
- At Wimborne, Bridport, Westminster Memorial and St Leonard's hospitals, therapists, nursing and medical staff raised concerns about staffing levels. These impacted on the care of patients as assessments and support for inpatients was not provided in a timely way.
- Information about patients was shared at handover meetings which occurred at each shift change at most of the hospitals. At Alderney the night staff recorded the handover on a dictaphone and this was accessed by all staff which they said worked well. Any additional information was put on their handover sheets and diaries.
- At Bridport not all the staff who came on the afternoon shifts received a handover. This could impact on care as they may not have up to date information about patients' needs following any changes in the patients' care and treatment.
- There was no on-site medical cover out of normal working hours and at weekends. Nursing staff used the 111 or 999 facilities dependant on the needs of patients. At some hospitals staff said the response was variable.
- Staff raised concerns about the lack of therapists as they had to prioritise and concentrated their efforts on supporting patients in the community. This had an adverse effect on inpatients such as delayed assessments and extending the patients length of stay in hospitals.
- At Yeatman medical cover was provided by one consultant geriatrician who each worked one session per week and resident medical officer who provided cover 5 days per week. Both wards had two trained nurses and three healthcare assistants on the morning shift and two trained and two healthcare assistants on late shift with two trained nurses and one healthcare assistant on night shift and was meeting the safe staffing.

Managing anticipated risks

- The trust had developed a major incident contingency plan and senior management had responsibility for this.
- Staff were aware of the safety procedures they would follow in case of emergencies such as fire or flood.
- The trust had a rota system for staff support and getting help in emergencies. Staff were unsure and we received conflicting information about how or who they would contact in an emergency. This was raised with senior staff as valuable time may be lost in securing help. The trust has since reviewed this and taken action.
- There was a joint escalation process, and senior managers were part of the systems resilience group with the acute trusts to manage periods of high demand on acute beds and pressure on community inpatient services to take more complex patients.

Requires improvement

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 rated effective as requires improvement because:

- We had few concerns about the effectiveness of care at Blandford, Alderney, Victoria, Portland, Westminster Memorial, Yeatman and Swanage hospitals. However there were some concerns at Bridport and St Leonard's hospitals.
- Staff had completed appraisal and had access to appropriate training and clinical supervision at several hospitals. But this was not provided consistently to all staff across all sites.
- The referral process to inpatient services was not always effective and there were incidents of inappropriate referrals of patients to some wards.
- Access to information on electronic record system was variable across services. Care plans were not always up to date and the timeliness of discharge information was inconsistent.
- There was a strong ethos of multi disciplinary working and regular multidisciplinary team meetings. However the discharge pathway was not always coordinated effectively and staff raised concerns about the lack of joint up working between the hospitals and social services. In some hospitals there was little evidence of pro-active discharge planning.
- There was awareness of the Mental Capacity Act (2005) but the procedures for renewing the Deprivation of Liberty Safeguards (DoLS) approvals were not always clearly understood and applied, particularly in terms of renewal of expired DoLS.
- Staff provided care based on national guidelines and care plans were developed for management of pressure risks, nutrition and falls. Therapy goals were clearly identified and monitored. Patients received appropriate pain control when required.

Detailed findings

Evidence-based care and treatment

- We found evidence that staff took account of national guidance such as the National Institute for Health and Care Excellence (NICE).
- Staff followed guidelines for the prevention and management of pressure injury in line with national guidelines. All patients had a Braden score, which is a standardised assessment for risk of pressure injury completed on admission. However there were gaps in reviewing these in some records.
- NICE guidelines were used as part of assessments tools to assess patients' needs. These included the malnutrition universal screening tool to assess patients' risk of malnutrition. This was used at a patient's initial assessment was and was in line with the NICE clinical guideline 32 'Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition'.
- The World Health Organization has produced guidance to increase safety for patients undergoing surgical procedures. The guidance sets out five steps to safer surgery that should be undertaken during every procedure to help prevent errors. The guidance forms a basis from which organisations are able to adopt and adapt practice to reflect the needs of their service.
- The Joint Advisory Group on Gastrointestinal Endoscopy had found the services at Swanage and Wimborne hospitals met the accreditation standards framework.
- Dementia care guidance and information was available to patients and relatives.
- The falls programme for exercise was an evidence-based programme which was well organised, implemented and compliant with NICE guidance.

Pain relief

- Staff discussed the need for pain control with patients and assessing their pain. There was a process for pain assessment and the pain tool was completed and included in patient records. Patients told us their pain was well managed and they received pain control when they needed it.
- A patient satisfaction survey was undertaken between May and August 2014 for patients undergoing surgical procedures. Patients were positive about the care and treatment they received in the day surgery unit. This showed 33 of the 35 patients surveyed were satisfied with their pain control.

Requires improvement

Are services effective?

Nutrition and hydration

- The malnutrition universal screening tool was used to assess and record patient's nutrition and hydration on admission. Food and fluid charts were used to monitor patients' hydration status and food intakes.
- Patients who were at risk of malnutrition were referred to dietitians and prescribed supplements as required. These were not always recorded on the fluid balance records and staff could not be assured they had received these as prescribed.
- Patients had access to fluids including beverages. They said they were given choices for food and snacks. However, they provided mixed views regarding the quality of the food available. Some patients said the food was good and cooked breakfasts were available.
- The Patient-Led Assessments of the Care Environment (PLACE) survey showed 86% of patients were satisfied with food and hydration, including choice, taste, temperature and availability over 24 hours. This result was lower than the national average of 89%.
- At Victoria and St Leonard's hospitals, information was displayed to inform staff and patients about the nutritional content of food and to promote healthy eating.
- At Bridport hospital, staff used a system of coloured triangles on headboards to alert staff of patients who were diabetic or required assistance to eat and drink.
- People received were supported with their meals in a respectful way. Meals were not rushed. Staff were aware patients dietary needs such as pureed, soft and diabetic diets were provided as required.

Patient outcomes.

- Swanage hospital participated in the trust wide intermediate care audit. This audit aimed to measure the outcomes of care delivered to patients.
- At all the hospitals therapists used the goal attainment scale with the aim of increasing patients' mobility safely.
- Care plans and risk assessments were completed on admission; these were not consistently updated to reflect changes in patients' care.

Competent staff

- The trust had set a target for 85% of staff to have had regular recorded clinical supervision, in line with trust policy, by 31 March 2015. Data showed they had achieved 79%.
- Senior staff told us they conducted one to one personal development supervision meetings with staff at regular intervals. Registered nurses, healthcare assistants and therapists told us the level and consistency of clinical supervision was variable across the hospitals due to staff's shortage and workloads. There was no process in place for supervision of agency staff.
- At a number of the hospitals, records showed there was a high uptake of appraisal and supervisions. Alderney, Portland and Blandford had achieved 100% compliance. At Swanage 76% of staff had received regular supervision.
- The trust had delivered a training programme on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards between October and December 2014 for registered staff. There had been good uptake of this training and most wards were compliant except for Canford, Fayrewood and Shaston wards.
- At Alderney there was a drive to re-instate falls champions in clinical areas and a forum for developing good practice. The falls champions met regularly for updates and learning and this was shared with their teams to improve practice and outcomes for patients.
- At Bridport hospital an advanced nurse practitioner was trained and performed a certain surgical procedure which benefitted patients.
- The lack of skilled and experienced nurses at some hospitals meant patients were not able to receive therapy intravenously (IV), for example antibiotic therapy or IV fluids for dehydration.

Multi-disciplinary working and coordinated care pathways

- There was evidence of multi-disciplinary working across all the hospitals we inspected. This included the involvement of physiotherapists, social workers, occupational therapists and ward staff.
- Multi-disciplinary team (MDT) meetings took place on a weekly basis to discuss current and new patients. We observed a MDT meeting at Swanage hospital and saw this was well attended and patients were discussed and plans devised to ensure they received effective care.
- At Westminster hospital, the MDT team met on a weekly basis and was consultant led. We observed this was well run with appropriate decision making and involvement of patients and their family. However the community team did not attend and staff told us this would be beneficial for discharge planning.

Requires improvement

Are services effective?

- Across the hospitals the district nursing team worked well together as part of the multi-disciplinary team. However at Westminster the team were not based at the hospital and did not attend the MDT and was not part of the decision making process.

Referral, transfer, discharge and transition

- Patients were admitted from acute trusts, other community hospitals or home. Referrals could be made by GPs, practice nurses, adult community healthcare teams including district nurses and advanced case managers, community matrons, specialist nurses based in acute and primary care, acute trust discharge teams, assessment unit, and the accident and emergency department.
- The hospitals used a single point of access (SPOA) system that enabled them to see which patients required a bed. Staff consistently told us the information contained in the SPOA was not always fully completed. This meant that staff had to contact the acute trust to discuss the patients' medical requirements to ensure they were able to meet the patient's needs.
- At Victoria hospital, the matron told us joint meetings had been held with the SPOA team, physiotherapists and the acute trusts to try to improve the referral process and the outcome for patients.
- Patients were not discharged in a consistently timely way. The trust had 251 delayed discharges from community inpatient wards over a six month period to 28 February 2015.
- The discharge pathway was not coordinated effectively as staff raised concerns about the lack of joined up working between the hospitals and social services.
- Trust data showed the highest numbers of delayed discharges were from Westhaven (44) and Wimborne (42) during the six months to 28 February 2015. Swanage and St Leonard's hospitals had the lowest delayed discharges at 2 and 4 respectively. It was recognised that delayed discharges can have a negative impact on patients' well- being.
- Senior staff told us some of this was out of their control, the length of patients' stay was further confounded by the lack of available beds in the community. At the time of the inspection there were 31 delayed discharges in community beds, 21 were waiting social services support.
- At Alderney a patient told us they had surgery at Poole; had then been transferred to Swanage and then to Alderney. When they arrived at Alderney they were not expected. However staff made a bed available for them.
- Staff raised concerns about inappropriate transfers of some patients from the acute hospitals and being 'under pressure' to accept patients who did not meet the trust criteria.
- At Westminster Memorial hospital, there was a dedicated discharge coordinator who was responsible for discharge planning and this was effective as they also attended the multi- disciplinary team meetings and worked with the wards staff.
- There was some evidence of active discharge planning in patients' records. However this was not consistent across all the community hospitals and patients were not always aware of the discharge pathway and when they were due to leave the hospital.
- At Blandford, discharge was planned with the patients and their relatives early after their admission to the hospital. This was to ensure any further support the patient required at home could be organised. Multi-disciplinary team (MDT) meetings were held and led by a consultant, where patient and their relatives were involved in the discharge planning.

Access to information

- Discharge information was not sent to the patient surgery within 24 hours as per the trust policy. A discharge audit showed 80% of discharge summaries had been sent to the surgeries. This could have a negative impact on the after-care of discharged patients.
- The trust electronic records system meant that patient information was accessible and shared across services and multi -disciplinary teams. Some GPs had access to the electronic system which was password protected. Staff could not tell us how many of the multi-disciplinary teams who did not have access to the electronic system.
- Therapists were able to access the electronic system and regular updates were recorded in the records seen.
- Patients' transfer documents and other paper records of care were scanned into computerised records. However the quality of these records were poor and not accessible. These included records which were stored upside down and staff were unable to rotate these

records in order to view them. This meant there was a risk that important patient's information may not be accessible when required to deliver effective care and treatment.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust made 99 Deprivation of Liberty Safeguards (DoLS) applications between 1 October 2014 to 31 March 2015 across the inpatient community hospitals. The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
- Senior staff had an awareness of the Mental Capacity Act 2005 (MCA). They were able to describe how they would initially support patients to make decisions for themselves wherever possible and the procedures they should follow requesting DoLS.
- However, senior staff did not have a clear understanding of how to maintain accurate DoLS records and the requirement to review patients once DoLS had been granted. Resource packs for DoLS and MCA, to inform staff practices were available.
- At Bridport hospital, staff had submitted DoLS application for two patients. The DoLS were granted for a set period and in both cases the DoLS had expired. Patients may have been unlawfully deprived of their liberty as the appropriate safeguards were not in place. This was brought to the attention of the senior nurse during the inspection.
- At Victoria hospital, DoLS applications had been completed for two patients. These were in line with national guidance. However, these had not yet been authorised by the local authority. We were told this was due to the backlog of applications being processed by the local authority, although these patients may be deprived of their liberty as the necessary safeguards were not in place.
- Where patients' movements were restricted such as with the use of bedrails and locked doors the principles of MCA were not always followed to safeguard patients. For example a patient was trying to leave. Although there was a DoLS in place, this had expired and a senior staff assured us they would contact social services to rectify this.
- Consent was obtained and documented in patients' records including consent to share information about them with other organisations involved in their care.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff were caring and compassionate and treated patients with respect. Where patients were not fully able to participate in their care, their family were involved as appropriate.
- The multi-disciplinary team shared information with patients and their relatives and involved them in the decision making.
- Patients told us they were treated in a caring way, and staff were available to offer support and care when they needed it.
- Patients 'privacy and dignity were upheld including signs on curtains advising staff and others not to enter.
- We saw positive interactions between the staff, patients and their relatives.
- Patients views were sought and action taken to improve the outcome for patients.

Detailed findings

Compassionate care

- We observed patients received caring and compassionate care which was centred on them. Multi-disciplinary meetings involved family members as appropriate. Patients were positive about the care and treatment they were receiving and for the team who supported them.
- Patients were positive and complimentary about the care and treatment they received on the surgical wards. They told us the care was, "very good and, "can't fault care".
- They commented the staff were, "very kind" and treated them with, "utmost care and respect". Another patient told us, "the care is excellent and close to home".
- Patients and their relatives said the staff were friendly and a patient said staff were" always willing to do what you ask".
- Staff told us of arranging the wedding for a patient who was receiving end of life care as this was an unfulfilled wish.
- We observed at all the locations that signs were attached to the curtains around patients' beds to alert staff and visitors not to enter when they received personal care. This was always respected.
- The trust carried out an endoscopy survey at Swanage hospital in December 2014. Results showed 100% of patients said they were treated with dignity and respect and that their journey through the department was well co-ordinated. This included patients being provided with separate facility for changing to promote and respect their privacy and dignity.
- The friends and family test score for September 2014 for Dorset Healthcare showed 90% patients would be 'extremely likely' to recommend the hospital to their family and friends.
- Staff were passionate and committed about the care and treatment they provided and we saw positive interaction with patients in all the hospitals we visited.

Understanding and involvement of patients and those close to them

- Patients told us they were kept informed and doctors and nurses discussed their care with them and their family as appropriate.
- Patients and relatives said they were fully involved in the decision making about their care. At a multi-disciplinary team meeting; a family member was involved in the discharge planning and information shared appropriately.
- The endoscopy survey carried out by the trust at Swanage hospital in December 2014 indicated that 45% of patients felt they were not given information about alternative tests compared with England average of 33%.
- Patients were provided with booklets / leaflets about the procedures and 98% of patients felt they were involved in their care, nursing and medical staff provided them with information about what the tests involved.
- The trust had set a target for 95% of patients' involvement in their care and had achieved 88% and they continued to work with staff to improve this.

Good

Are services caring?

- According to data from the trust, 20% of patients had been given their hospital care and plan of care upon discharge.
- Care plans and risk assessments were stored on the computer and staff told us although some wards had the mobile computers, this was not available in all the hospitals. They said it was a challenge to effectively involve patients to access their care records.
- Patients told us they were encouraged to maintain their independence. Care plans detailed support that patients needed to promote their independence.
- Patients were assessed for equipment to maintain and promote independence. Therapists issued patients with exercise sheets which patients said they found useful.
- We observed doctors, nurses and therapists sharing information with patients and taking time to ensure it was understood. Therapists for example explained the process for carrying out a home environment assessment prior to discharge in order for any equipment to be in place.
- There was a variety of information available to patients including an information pack. The information booklet at Alderney contained information such as contact details, visiting advice, the rehabilitation process and arrangements for home assessments.

Emotional support

- Positive interactions were seen between staff and patients at all the hospitals. Staff took time when supporting the patients to listen to what and how they communicated.
- At Alderney hospital, staff supported patients to a 'memory area', which was a dedicated space with memorabilia and period items for people living with dementia.
- Patients were positive about the care, treatment and emotional support they received. Feedback from inpatients included; "The staff were so knowledgeable, caring, and courteous; made going to hospital a comfortable and helpful experience". This comment came from the trust's friend and family test carried out at Swanage hospital in February 2015.
- Other comments from patients included' 'the staff always go the extra mile'. Another patient said staff 'always make time for you especially when you are feeling down.'
- At Blandford hospital the League of Friends had recently funded the purchase of an interactive television screen for patients living with dementia. Messages from family members could be recorded and played to patients along with other activities to aid communication and reassure patients.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as requires improvement because:

- There were some shortfalls in the planning of services across the trust geography. Nursing staff were not trained to deliver the same level of treatment in all hospitals which impacted on patients receiving care in a hospital of their choice and nearer to their family.
- Bed occupancy levels and delayed discharges were high and the lack of available beds impacted on access to treatment and care for patients.
- Patients' dignity and privacy risked being compromised in some hospitals, due to a lack of facilities and environment issues.
- Surgical services were responsive and were meeting referral to treatment times. The trust had responded to increasing needs of patients by creating additional intermediate care beds to meet the needs of patients and the local community.
- Staff recognised the equality and diversity of patients when providing care and had completed training. However written information was only available in English and needed development to meet the diverse needs of patients.
- There was a process which staff followed in dealing with the effective management of concerns and complaints, and there was evidence of learning and changes in response.

Detailed findings

Planning and delivering services which meet people's needs

- Inpatient services were largely based on historical commissioning for example there were a lot more 'step down' beds in the East part of an intermediate care pathway. There was more 'step up' provision from GPs in the community in North and West Dorset.
- Since the August 2014 CQC inspection report, two community hospital inpatient wards had increased the nurse/patient ratio in order to meet patients' specific needs in a more timely way. An additional 16 intermediate/rehabilitation care beds were commissioned at St Leonard's Hospital (Canford Ward) to support the winter pressures on the acute hospital trusts. This has been extended until September 2015 when it will be reviewed.
- Willows Ward, at Yeatman Hospital, reduced their number of beds from 34 to 30. Shaston and Ashmore wards at Westminster Memorial Hospital had reduced beds from 20 to 16 due to staffing.
- The trust was developing more integrated locality models in West Dorset. In Bridport, inpatient beds were part of a locality wide team providing multi-agency services to meet the needs of individual patients.
- Bridport inpatient team was part of a weekly multi-disciplinary virtual ward meeting where they discussed vulnerable patients and the most appropriate services and care pathway to meet their needs.
- This model was planned for Weymouth in September with co-location of primary medical care and social services with community services and community inpatient beds to make it a more integrated service and meet the demands of the community, and improve care to meet the needs of individual patients.
- At Westminster Memorial hospital a communal toilet was fitted with a sliding door that did not have a lock to maintain the privacy and dignity of patients. We brought this to the attention of a senior nurse during the inspection in order for remedial action to be taken and safeguard the dignity of patients.
- At Westminster Memorial, we also found one of the communal toilets had a window which was open and compromised patients' privacy and dignity as passers-by could see inside. We raised this with the matron and senior nurse who were not aware of this. The trust later confirmed a blind had been fitted following our inspection to safeguard people's privacy.

Equality and diversity

- There were appropriate facilities including safe and level access for patients and visitors with limited mobility. These included designated parking and toilet facilities to accommodate patients and visitors in wheelchairs.

Requires improvement

Are services responsive to people's needs?

- Staff told us they had access to a chaplain and priest but they were not sure how they would support patients of other faiths or beliefs. Some staff told us they would look on the trust website for information.
- Training in equality and diversity was provided and between 93-100% of staff had completed this training at all the hospitals.
- Care practices observed showed staff were aware of people's diverse needs and supported them with respect.
- At Blandford staff told us they did not have many people of different religions living in the community. Staff had acquired a compass and prayer mat for example for use by a certain religion.
- Staff were aware of different dietary needs of patients and said the chef would access different type of food.
- Information leaflets in languages other than English were not available in any of the hospitals we visited. Senior staff at various hospitals said information could be made available in large prints. There was no information in different languages however and staff were not clear how this could be provided.
- The trust was taking part in a pilot for the new NHS accessible information standard, designed to ensure that patients understand the information they are given about their health and care.

Meeting the needs of people in vulnerable circumstances

- The trust has set a target of over 95% for staff to ask all patients over 75 years of age about dementia. This would be part of the assessment of patients' mental and physical needs being considered and care plans initiated. They had achieved 79%.
- At Blandford, patients and relatives had completed 'this is me' documentation. This contained information about the patients' likes and dislikes; previous life history and hobbies. This enabled staff to care for people who may not be able to communicate their specific needs and preferences. Staff said they found this useful and used these in their practice.
- The third edition of 'living well with dementia and memory loss in Dorset had been published. This is a directory of services and support for people with dementia and memory loss, offering information and support for carers and families of patients in the inpatients wards.
- An information booklet for people with dementia had been compiled by the NHS Dorset clinical commissioning group and Dorset HealthCare, in partnership with other local groups. This provided information about dementia through all its stages, including where to find support and how to apply for any relevant benefits. This was available to patients and their family in the hospitals we visited.

Access to the right care at the right time

- The bed occupancy within the community hospitals had been significantly higher than the national average of 88% over the past year. The highest was seen at St Leonard' at 98%. The lowest was at Bridport at 80%. It is generally accepted that bed occupancy above 85% level can start to affect the quality of care provided to patients, and the overall management of the hospital.
- There were instances of inappropriate admission where patients have needed to return to the acute hospital following inappropriate transfer or deteriorating condition. The service leads reported this increased when the acute hospitals had high bed occupancy, particularly in the winter months. They told us that they had more control over the appropriateness of 'step up' provision from the locality in North and West Dorset.
- Patients who required intravenous medication were unable to be admitted to Westminster Memorial, Swanage and Victoria hospitals. We were told this was because of a combination of staff training and access to intravenous medication. This meant that when patients were discharged from an acute hospital their choice of community inpatient care wards could be limited.
- Service leads reported early evidence of 20% reductions in referrals to acute hospitals in Bridport
- The Department of Health guidelines state that if patients require surgery and their operation is cancelled for non-clinical reasons, their operation should be re-arranged within 28 days. A number of the hospitals provided minor surgery; however there was no data collected on cancelled operations.
- Eighty eight per cent of trauma and orthopaedic surgery patients were treated within 18 weeks of referral in February 2015. This was against a national target of 90%.
- Therapists received referrals from the intermediate care teams in Bournemouth and Poole and the long term therapy team responded to ensure that patients' needs were met in hospital wards.

Requires improvement

Are services responsive to people's needs?

- Therapists were also not available at weekends, but staff could access the community team in an emergency. Patients admitted out of hours on Friday had to wait until Monday before they were assessed. Staff told us that this increased risks for patients who were unable to mobilise and in some cases resulted in longer stays in hospital.
- At Blandford patients were able to receive antibiotics and blood transfusions as day-patients on the ward. This prevented an unnecessary hospital admission.

Learning from complaints and concerns

- Patients said they had no complaints and were "very satisfied" with the care they received.
- "Have your say" leaflets were available in all hospitals which explained how to raise concerns or complaints and how to give compliments. We saw friends and family cards being used across the trust. These asked patients and their family if they would recommend the service to others.
- Staff followed the trust's complaint policy and reported any complaints from patients to the senior nurse or matron.
- Data from the trust indicated they had an average of 47 complaints which were investigated and most of these were not upheld.
- Complaints were recorded on the trust reporting system. Following investigations the outcomes were discussed at staff meetings and action plans developed to learn from these and shared with staff.
- At Blandford, there were comments about learning more about dementia care. Staff had responded by offering dementia awareness training sessions on the ward for patients and visitors.

Requires improvement

Are services well-led?

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

Summary

We rated well-led as requires improvement because:

- There were variations in the leadership across the inpatient services. We found proactive clinical leadership at Swanage, Blandford, Wimborne and Alderney were and all services demonstrated a commitment to working together. However the visions and values were not understood by all.
- Governance processes across inpatient services were not sufficiently robust, as risks were not always managed effectively and there were ad hoc arrangements for improving quality. Staff had reported the continued practice of inappropriate transfers at some locations but there was no evidence that actions had been taken to minimise the risks. Other risks such as environmental and infection control risks were not managed safely and effectively and audits were not fully developed.
- Most managers were approachable and knowledgeable and were respected by their staff. They understood their staff and supported them in their roles. Staff felt a disconnect between their work at a particular hospital and the wider inpatients service and the trust. Although committed to their work there was not a strong culture of staff raising concerns or making improvements across the service.
- There was evidence of the service engaging with local communities and using feedback from patients.

Detailed findings

Service vision and strategy

- Service leads had a vision to redevelop services in localities within a model of integrated working, with community hospitals at the hub and inpatient beds as a part of the resource for the local community.
- The trust was developing a plan for community inpatient beds, including long term provision of care for the local community. To support the overall plan, the trust was contributing to an extensive review of local services and consulting with doctors, nurses, other clinicians and health leaders to determine the strengths and weaknesses of the current service models.
- The trust had agreed with the Dorset clinical commissioning group to use its revenue surpluses to modernise the hospitals.
- Staff were not able to able to tell us about the strategic visions and values and felt disconnected from the wider trust. However they were passionate about providing care and serving the local community.
- We received mixed responses about collaborative integrated working. Most of the staff across the hospitals told us they worked well together with other teams although the integrated teams were not fully embedded in practice.

Governance, risk management and quality measurement

- There was a governance structure which fed into the trust quality governance committee. A monthly directorate governance group was attended by locality managers. Locality governance meetings, held a week after directorate meetings, were attended by ward sister and matrons. Quality issues such as complaints, incidents and audits were discussed. Managers shared this information with staff at team meetings.
- A trust risk register was maintained and staff were aware of the high risks included on it, such as staffing issues. Although staff continued to raise issues regarding inadequate staffing and inappropriate transfers, there was little evidence that actions were taken to minimise risks to patients.
- Staff told us that although the sluice rooms at St Leonard's had been on the risk register for a number of months, actions had not been taken to remedy the infection control risks.
- The process for checking of equipment was not robust and could impact on the safety of patients. This had not been recognised as a risk and so action had not been taken to address it.
- There was not a sufficiently robust audit programme, resulting in the identification and management of risks,

Requires improvement

Are services well-led?

across the hospitals. particularly in relation to health and safety and infection control. Audits were undertaken but did not always identify areas of risk and instigate action to improve the quality and safety of services, particularly in relation to health and safety and infection control.

- The trust had developed a clinical dashboard with RAG ratings against quality and performance information. This could be interrogated to ward level but the information and data on quality metrics was still in development. The dashboard was reviewed at board level with attempts to triangulate at high level whether red RAGs, such as vacancies at locations, had impacted on quality performance and if there were themes. This was not yet fully effective at identifying risks in community inpatient services.

Leadership of this service

- Staff across the community inpatient services told us that they felt disconnected from senior managers at the trust. Most staff did not know who the senior managers were and there was an overall feeling that staff worked for their particular hospitals not the wider trust.
- Following the staff survey results which identified improvement was needed regarding communication between senior management and staff, the trust has started a staff engagement process, led by the chief executive, from which detailed action plans will be developed.
- Staff at most hospitals described their line managers as being approachable and having 'an open door policy'. Senior sisters said the matrons had 'made a big difference' in trying to link them with the wider trust.
- Staff across locations reported variable visibility and communication from matrons, however the senior nurses on the ward were supportive and good role models.
- We found proactive clinical leadership at Swanage, Blandford, Wimborne and Alderney hospitals.
- All of the staff at Swanage told us the matron and senior staff were supportive and 'led by example'.

Culture within this service

- Staff felt valued by their immediate managers and peers and told us they really enjoyed working at the hospitals and had strong focus on providing compassionate care.
- Staff were aware of the whistle –blowing procedure but were not confident in using it. Concerns about the work pressure and staffing shortage were not escalated as staff's attitude was "you just get on with it".
- Therapy staff at one hospital told us they felt unsupported and "nowhere to go" due to workloads on their therapy managers, however the team worked hard to provide the best service and worked well together.

Public engagement

- The league of friends had developed good links with the community hospitals and staff told us their support made 'big difference' to patients' wellbeing.
- The trust had effective systems in place to gather information from patients, and had records about people's experience from patient surveys. These were displayed on the wards as "what you said" and "what we did, showing how staff had made changes in response to feedback.
- Data from the staff survey showed fifty per cent of staff said feedback from patients was used to improve patients' care.
- The staff at Swanage hospital had written and performed a pantomime, towards the end of last year to thank the local community for their support. Calendars had been produced depicting members of staff in their areas of work to inform the community about the staff and services at the hospital.
- At Blandford they had developed a partnership with a voluntary organisation to offer a wellbeing centre at the hospital. Positive comments from the voluntary organisation were received and included "a wonderful example of partnership working between the public and voluntary sector".

Staff engagement

- Trustlink, the trust's monthly newsletter, was informative and provided information for staff and celebrated staff achievements.
- The results of the 2014 NHS staff survey were published on 25 February 2015. More staff contributed to the staff survey compared with the NHS average, with a 46% response rate compared with 42%.
- There were some positive outcomes such as 92% of staff believed the trust provided equal opportunities for career progression or promotion. Staff reporting work related stress had also reduced from 42% to 37%.

Requires improvement

Are services well-led?

- Staff were aware of their whistle- blowing policy; however they said they did not feel able to use it as they had to report directly to their immediate managers before raising their concerns higher up.
- Areas which had been highlighted for improvement from the staff survey included communication between senior management and staff. Another area of concern was a small increase in bullying and harassment from colleagues which the trust was investigating.

Innovation, improvement and sustainability

- In Bridport, inpatient beds were part of a locality wide team providing multi agency services to meet the needs of individual patients. The Bridport inpatient team was part of a weekly multi-disciplinary virtual ward meeting to discuss vulnerable patients and the most appropriate services and care pathway to meet their needs. This model was being rolled out to Weymouth in September with co-location of primary medical care and social services with community services and community inpatient beds.
- At Westminster Memorial hospital the development of a co- location area was nearly completed to support the integrated team. This will consist of the elderly mental health team, social services and therapists. However the district nursing teams will remain in local practices. The matron said this will provide better access and continuity of care from the in reach rehabilitation team.
- As recruitment of experienced, senior nurses was difficult, the service was considering offering junior nurses development opportunities.
- The service recognised the challenges in providing medical cover. It had been difficult to recruit to the model of community geriatrician working across community and inpatient beds. There were plans to develop GP extended roles or joint appointments with the acute trust, to improve patient care and pathways, and avoid inappropriate acute hospital admissions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care or treatment because** • Persons providing care or treatment did not always have the competence and skills and experience to do so safely. Regulation 12 (2)(c) • Equipment used for care or treatment was not always checked to ensure it is safe for use. Regulation 12 (e) • Medicines were not always kept safe in inpatient services. Regulation 12 (2) (g) • Procedures to assess, prevent, and control the spread of infections were not followed consistently. Regulation 12 (2)(h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** • All premises and equipment was not always clean, clinical waste was not managed securely, Regulation 15 1(a) • The provider had not ensured suction machines, were available in all clinical areas at all times Regulation 15 1(f) • Processes were not followed to maintain standards of hygiene and ensure multi use equipment and devices were cleaned between patients and ready for use. Regulation 15(2)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met: Systems were not in place to** • Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a) • Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b) • Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • There were not always sufficient numbers of adequately experienced and skilled staff to meet the requirements set out in the fundamental standards. Regulation 18 (1) • Not all staff received the appropriate training, support and clinical supervision to enable them to carry out the duties they are employed to perform. Regulation 18 (2)