

Liverpool Community Health NHS Trust

RY1

# Community health inpatient services

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RY1X7	Alexandra Wing Broadgreen Hospital	Community Inpatients	L14 3LD
RY1E1	Ward 35 Intermediate Care Unit	Community Inpatients	L9 7AL

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

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

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

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

At the last inspection in May 2014, we found improvements were required relating to care and welfare, medicines, staffing, supporting staff and quality assurance processes. Staff also raised serious concerns regarding the trust's culture.

At this inspection we rated community inpatient services as 'Good' overall because;

- We found that the culture and procedures relating to patient care, safety, medicines, supporting staff and reporting incidents, had improved.
- Staff said that they now had access to recent incidents and that they now felt supported by the trust.
- The trust had systems and processes in place for governance and risk management.

- We found that patients had been admitted with needs more complex than was set out in the ward admission criteria. However we found that this had no impacted on staffing levels and the ability of staff to do their job.
- We spoke with 11 patients and relatives of six people who are current patients during this inspection. Most of the patients and relatives spoke positively about the care they had received.
- Patients were fully protected against the risks associated with medicines because the provider had made appropriate arrangements to safely manage them.

# Summary of findings

## Background to the service

Community inpatient services within the trust span three wards comprising a total of 77 beds across two sites; South Sefton and Liverpool. There is one community inpatient ward based within University Hospital Aintree (Ward 35) and a further two inpatient wards (9 and 11) based within the Broadgreen site of Royal Liverpool Broadgreen University Hospital Trust.

The portfolio of inpatient services work in collaboration with the wider Liverpool Community Health intermediate care services and acute providers to contribute to managing a whole system approach. Patients were referred from acute trusts to continue their nursing

intervention and rehabilitation (step down) or from primary care (step up) with the ultimate aim of returning to their home, or other appropriate setting, with on-going support from community services if appropriate.

There were approximately 700 admissions each year across all wards within intermediate care supporting the wider agenda of inappropriate admissions or readmissions to acute beds and supporting the care closer to home agenda.

The team was multi-disciplinary, comprising over 130 staff including advanced nurse practitioners, GPs, nurses, social workers, occupational therapists, physiotherapists, podiatrists, health care assistants, therapy assistants and ward clerks.

## Our inspection team

Our inspection team was led by:

**Team Leader: Simon Regan**, Inspection Manager, Care Quality Commission

The team included four CQC inspectors and a variety of specialists including a nurse and a therapist.

## Why we carried out this inspection

We carried out a comprehensive inspection of this service in May 2014 and rated it as “Requires Improvement” overall. We judged the service to be “Requires Improvement” for effective, responsive, well-led and “Good” for safe and caring.

This was a follow up inspection to the comprehensive inspection of May 2014. We carried out this inspection to identify whether the necessary improvements had been made.

## How we carried out this inspection

To get to the heart of 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?
- Is it responsive to people’s needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service, performance information received from the trust and asked other organisations to share what they knew.

We carried out an announced visit on 2, 3 and 4 February 2016.

# Summary of findings

As part of the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We observed how care and treatment was provided.

We spoke to 11 patients and the relatives of six people who were patients on the intermediate care wards. We also reviewed care and treatment records of 11 patients who were using the intermediate care service. We also

spoke to 28 staff at all levels including managers, senior managers, directorate leads, nurses, care assistants and allied health professionals. Patients also shared information about their experiences of intermediate care services via 43 comment cards.

We also carried out an unannounced inspection visit on 11 February 2016.

## What people who use the provider say

Overall, people were very positive about the inpatient services provided by Liverpool Community Health NHS Trust. People using the service were positive about the care they had received, one person commented: “they are all lovely these girls. ... they always help me and they put up with a lot.” Another person told us; “since I came in they have really been good to me... I can’t fault them at all, especially the physio girls. They are so lovely.”

However, two people we spoke with said that they felt the quality of care was dependant on the staff on duty. One person commented; “some of the staff are lovely. . . but there are one or two who don’t seem to have the same patience.”

## Areas for improvement

**Action the provider MUST or SHOULD take to improve**

**Action the provider SHOULD take to improve**

- The provider should continue to ensure that there is a systematic approach to learning from events which is shared across intermediate care services.
- The provider should continue to engage with all groups of staff.

Liverpool Community Health NHS Trust

# Community health inpatient services

Detailed findings from this inspection

Good 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

We rated community inpatient services as 'Good' for Safe because;

- The level of staffing and mix of skills in the integrated care teams matched patient need. The trust had been monitoring staffing and capacity, using its own tool to determine nursing caseloads; this took into account the acuity (the level of severity of illness or level of need) and complexity of patients.
- There was good use of safety quality dashboards to monitor performance in key areas of patient safety.
- Staff were able to articulate the process for reporting incidents and told us they receive timely feedback and details of lessons to be learned when things went wrong.
- Medicines stock control and the use of patient group directives were in line with the trust's policy.
- Staff followed appropriate infection control practices and care and treatment was provided in visibly clean and well maintained premises.

- All staff knew how to report the signs and symptoms of potential abuse.

However;

- Staff were encouraged to report staffing issues via the management escalation process. This meant that staffing related incidents were not always recorded on the electronic system, potentially giving an inaccurate picture of staffing concerns.

### Safety Performance

- The service had recently started to collect data in line with the NHS Safety Thermometer. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free care'. Monthly data was collected on pressure ulcers, urinary tract infections (for people with catheters), blood clots (venous thromboembolism or VTE) and falls. This provides the trust with a 'temperature check' on harm that can be used to measure local and system progress in providing a care free of harm for patients. This information was reported

## Are services safe?

through the trust integrated performance report. As at the end of December 2015, the trust recorded 97.1% on the harm free care thermometer although this data was trust-wide and not specific to inpatient services.

- Trust data showed that 99% of patients had been risk assessed for venous thromboembolism (VTE) and that there had been no identified cases of VTE in 2015/16 financial year up to the date of the inspection.
- Data received from the trust confirmed that increase in incidence of pressure ulcers had been identified and recorded appropriately. For example the trust had reviewed all incidences of identified low and high level pressure ulcers, to establish if the patient had developed the ulcer on the wards or prior to admission. Once this had been clarified, records received from the trust confirmed what actions had been taken to address the patient issue. Data we received also confirmed that in the care of patients who were admitted with a pressure ulcer, staff had liaised with community services /places of care to ensure that information regarding the patient's state of health on admission was shared.
- Data received from the trust showed that falls per number per 1,000 Occupied Bed Days had risen slightly from 6.03% in the 2014/2015 period to 6.87% in the 2015/2016 period. Records we reviewed confirmed that the trust was taking steps to examine the reasons for the rise in falls. This was confirmed by senior managers we spoke with who told us they were in the process of developing strategies to try and minimise the risk of falls across the service.

### Incident reporting, learning and improvement

- Incidents were reported using the electronic reporting system. Staff could describe the process for reporting accidents, incidents or "near misses" that occurred.
- Data received from the trust confirmed that there were 123 incidents relating to medication errors, pressure ulcers and infection control issues recorded between December 2015 and the end of January 2016. Information received from the trust confirmed that each incident was logged electronically by staff and actions and learning from incidents was reviewed and monitored by managers across intermediate care services. This gave assurance that the trust was actively monitoring its own safety performance over time in order to improve patient experience.
- Senior staff on all wards told us they investigated all incidents and held team meetings to learn from them. Information relating to incidents was also shared with staff via the trust email system.
- Staff across all three wards were encouraged to report incidents and were able to access the trust's electronic incident reporting system.
- Staff said that they got feedback following incidents; they said they routinely had access to an overview of incidents for their services. This was confirmed by records we reviewed.
- Ward managers gave us examples of learning from incidents. For example, discrepancies relating to the disposal of medicines had been identified. Actions were put in place to minimise the risks and these actions were then communicated to staff across intermediate care wards, through team meetings. Staff were able to tell us about the actions that had been taken in relation to the disposal of medicines, across all intermediate care wards. This provided assurance that once an issue was identified, appropriate action was taken by senior staff to address it.
- We talked to senior nurses and saw that serious incidents were managed swiftly. For example on one ward documentation we reviewed confirmed that senior staff had reported a grade three pressure ulcer in summer 2015. Records confirmed that the investigation process was robust and included both a Root Cause Analysis process and a 48 hour initial ward action plan. Staff said they were confident about reporting incidents and were aware they needed to be open and transparent with patients and their relatives if anything went wrong with their care.
- Staff told us if they witnessed poor practice they would have no reservation to whistle blow and escalate their concerns to a senior manager, the safeguarding lead, the social worker or the care quality commission.
- We saw the trust had created a staff flowchart explaining the duty of candour legislation, introduced in November 2014, outlining the responsibility for staff. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The flowchart was available to view in staff offices across all wards.

# Are services safe?

## Safeguarding

- There were trust wide safeguarding policies and procedures in place and there was an internal safeguarding team who could provide guidance and support to staff in all areas. Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- Staff we spoke with across both sites demonstrated a good knowledge of the trust's safeguarding policy and the processes involved for raising an alert.
- Staff demonstrated that they knew and understood how to identify potential abuse and said they would report any concerns to their manager.
- They told us they were well-supported and would seek advice if they had safeguarding concerns
- Data provided by the trust showed good compliance with safeguarding training. All staff in the service had received safeguarding training at Level 1 (for adults and children) and 98.1% at Level 2 (for adults and children). Both were above the trust's target of 95%.
- We saw records which confirmed that safeguarding alerts were completed within the recommended 24 hour timeframe and were relayed verbally during staff handover times to ensure that all staff were aware of any patient safeguarding concerns.

## Medicines

- All three wards had appropriate storage facilities for medicines and systems were in place for the safe handling and disposal of medication.
- We were able to access clear documentation relating to the management of medicines stock. There was a record of medications ordered, receipted and individual patient records demonstrated the medications used.
- There were suitable arrangements in place to store and administer controlled drugs. We noted that stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient and regular checks of controlled drugs balances were recorded.
- We reviewed eight patient medication administration and prescribing records and noted that the appropriate consent for treatment had been obtained and that documentation of the medicines administered was correct and legible.

- We saw records that fridge temperatures were regularly checked, recorded and adjusted as appropriate.
- Appropriate arrangements were in place in relation to the recording of medicines. We looked at the prescription and medication records in detail for eight patients. Prescription charts were complete and indicated that patients received their medicines as prescribed. It was evident from our checks that medicines dose changes and general prescribing were promptly carried out and records we checked were clearly completed.
- We looked at the information provided to patients about their medicines prior to discharge. Take home medicines were efficiently managed and medicines information leaflets were usually supplied with them.
- Patients told us they had all their medicines explained to them by nursing staff and any changes to treatment were clearly explained.

## Environment and equipment

- Records indicated that resuscitation trolleys on each ward had been checked and signed daily.
- Equipment for use by patients and staff was found to be in date, appropriately packaged and ready for use.
- All wards had a good supply of manual handling equipment such as hoists, slings, sliding sheets and condition-specific equipment such as nebulisers, syringe drivers and monitors, which were well maintained, cleaned and had a label saying "I am clean" when stored ready for use.

## Quality of records

- At our last inspection we said that the trust should take steps to improve the quality of assessment and record keeping on inpatient wards.
- As part of this inspection we looked at 20 paper based patient care records across three wards and saw records were well maintained and updated at timely intervals. Each professional had recorded their entries appropriately; documentation was accurate, complete, legible and up to date. There was a plan of care for each patient.
- Nurses maintained a full paper case file and also completed an electronic record using the online system.

## Are services safe?

- Patient records were electronically recorded so that detailed patient information could be shared across intermediate care services for adults. We reviewed six sets of electronic patient records and found these to be up to date.
- All the patient records we reviewed contained necessary information, such as risk assessments, to allow staff to carry out their required clinical activities.
- There were appropriate monitoring documents in place at the end of patient's beds for staff to record the care and treatment people received. These included pressure relief turning charts, food and fluid charts and daily records. We found staff had completed charts and other records as required throughout the day and night.
- Nursing teams on both sites could provide evidence of record audits to provide assurance of how they monitored the quality of their record keeping. This was supported by data received from the trust prior to our inspection, which confirmed quality monitoring was being undertaken via a system of scheduled audits. For example we reviewed a report following a medication audit across intermediate care services, this showed that errors had been identified and actions taken to minimise the risk of a similar incident happening again. Data received from the trust following our inspection confirmed that learning from this incident had been shared among nursing and medical teams in intermediate care services.
- The wards, clinic rooms, hospital corridors and treatment areas we visited were visibly clean and free from clutter and odours.
- We noted cleaning schedules were in place to ensure that individual areas within wards were cleaned regularly and that the quality of this cleaning was checked. All the cleaning records we reviewed were regularly completed and up to date.
- Staff showed us how they accessed trust policies from the trust policy database. We saw the policies for infection control and hand hygiene were in date and had a review date of 31 December 2016.
- Staff had access to the appropriate personal protective equipment, such as gloves and aprons. Staff on all three wards consistently followed hand hygiene practice and 'bare below the elbow' guidance.
- Clinical and non-clinical waste was managed appropriately. Sharps containers and domestic and clinical waste bins were available in relevant areas of the wards and arrangements were in place for the collection and disposal of all waste from the wards. We saw evidence of damp-dusting. Commodes were visibly clean and labelled appropriately.
- All staff had completed infection control training at level 1 at the time of our inspection. However, only 81.3% of staff had completed level 2 against a trust target of 95%.

### Cleanliness, hygiene and infection control

- Information provided by the trust showed that there had been no cases of MRSA in the 12 months preceding the inspection but there had been four cases of clostridium difficile related infections in the same period. However, none of these had occurred across the service in the three months before the inspection.
- This was supported by data received from the trust, which showed monthly infection control audits had taken place over the 12 months prior to our inspection. These audits showed that the intermediate care service had maintained a compliance level of between 95–100% throughout the three months prior to our inspection. Staff were clear on the processes they would follow if an outbreak of infection occurred on the wards. They told us that they had good access to infection control advice both during and outside office hours.
- Mandatory training provided by the trust included fire safety, basic life support, moving and handling, safeguarding adults, health record keeping, infection control, consent, equality and diversity, bullying and harassment awareness, health and safety, infection control, information governance, medicines management.
- The levels of completion of mandatory training varied across the intermediate care units. The trust's target was for 95% overall, of staff to have completed their mandatory training and the majority of subjects showed good compliance. However, there were some concerns with the low levels of completion of Immediate Life Support (ILS) (74.5%), Resuscitation (85%), Venous Thromboembolism (62.5%), Blood transfusion (52.1%), Investigation of incidents using root cause analysis (RCA) (71.4%) and 'Prevent training' for clinicians (14.2%).

## Are services safe?

Records received prior to inspection confirmed that the trust kept detailed records of mandatory training. Data received from the trust confirmed that as of December 2015, the Trust reported a mandatory training compliance rate of 87.1%. Whilst this remains below the 95% target, it is now marginally above the community service provider benchmark of 87%.

- Staff told us that they were encouraged complete their mandatory training, which they were able to complete in work time.

### Assessing and responding to patient risk

- Risk assessments were completed weekly for: manual handling, falls and pressure ulcers. All of the risk assessments we reviewed were clear, legible and up to date.
- Each patients' individual risk assessments were completed weekly or sooner if their condition deteriorated.
- In the patient records we reviewed, there was evidence of risk assessments being completed, and updated, relating to the patients general living environment, venous thromboembolism and specific nutritional needs.
- Staff used ViEWS (vital early warning score) a standardised warning system tool to alert if a patient's health deteriorated; this was monitored at regular intervals throughout the day.
- We asked staff about their actions in the event of any adverse incident such as choking and neurological deterioration and it was clearly evident that they had the necessary knowledge to manage these events.
- The wards were all on acute hospital sites. There was a process in place to call for assistance from the acute hospital should a patient's condition deteriorate and require acute medical intervention.
- Patients were usually seen by their consultant within the first 24 hours of their admission and had access to a doctor daily if required.

### Staffing levels and caseload

- The service used its own tool to determine nursing caseloads taking into account the acuity (the level of severity of illness or level of need) and complexity of patients.
- We reviewed information regarding the patient acuity and nursing caseload tool. We found that there were

criteria for prioritising patients but it was not clear how staff put these into action. However, during our inspection we observed the lead nurse reviewing patient need and requesting extra staff to support one patient who needed one to one care. This provided assurance that staffing was adapted to the needs of patients.

- The matron told us the trust had an ongoing recruitment drive but vacancies across the trust were difficult to fill. However, intermediate care services had managed to recruit two new nurses, which meant once the new staff came in the service was fully staffed. We were informed that in the meantime existing staff were covering most of the shortfall, with any remaining unfilled shifts being supported by bank staff of health care assistance as appropriate.
- We reviewed medical staffing rotas, for the six weeks prior to our inspection, which confirmed that there were adequate staffing levels of doctors and consultants across all three wards. This provided assurance that patient medical assessment, care and treatment were conducted in a timely manner.
- Therapy staffing levels across all three wards were well organised. Rotas were planned in advance and the staffing and skill mix were appropriate at the time of the inspection. We reviewed rotas for the six weeks prior to our inspection and found staffing levels had been consistent.
- We reviewed nursing rotas which confirmed that any unfilled nursing shifts were always filled by an existing member of the nursing staff [as overtime], agency nurses or a health care assistant. We reviewed nursing and medical staffing rotas for the six weeks prior to our inspection and found staffing levels had been consistent.
- We noted that nursing handovers occurred every morning, afternoon and evening. Each ward manager was supernumerary (not counted in the staffing establishment who were there to deliver patient care, so as to give oversight and support as required). However, if there was a need due to vacancies or unplanned leave on the wards, ward managers stepped in to backfill shifts. As part of our inspection we attended one nursing handover during the evening, we noted that staff took the time to share information and update staff coming on shift regarding individual patients.

## Are services safe?

- Staff were encouraged to report staffing issues via the management escalation process. This meant that staffing related incidents were not always recorded on the electronic system, potentially giving an inaccurate picture of staffing concerns.

### Managing anticipated risks

- The trust's risk register identified nurse staffing vacancies as a risk and this was being mitigated by an ongoing recruitment programme and the use of bank or agency staff to cover shifts.
- Risk assessments in relation to patients, such as pressure care, falls and nutrition were complete and updated as patient's needs changed.

### Major incident awareness and training

- At our last inspection we told the trust it should develop major incident plans for all services. During this inspection we found that local plans were in place and staff were aware of the emergency arrangements in place within their teams.
- The trust provided health and safety training, and fire safety training as part of its' mandatory training programme. Data supplied by the trust showed that 97.3% of staff in the community inpatients service had completed health and safety training against a trust target of 95% and all staff had completed the 3-yearly fire safety training. However, only 51.4% had completed the yearly fire safety training.

## 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 community inpatient services as 'Good' for Effective. This is because;

- Care and treatment was evidence-based and was provided in line with best practice guidance.
- Nursing staff had recently reviewed care bundles to ensure that best practice was being followed for pressure ulcer care and catheter care.
- The trust was operating systems to monitor and improve the quality of treatment and care provided.
- Staff worked together to make multidisciplinary decisions for the next steps in joint care planning, based on discussion, evaluation of outcomes and patients' own goals in relation to their rehabilitation.
- Patients and their relatives told us they were cared for by caring staff who were confident and well trained.
- Patients' pain, nutrition and hydration were well managed.
- Therapy competency frameworks and evidence of specialised training was in place.
- Staff had access to information and we saw staff gaining patients consent with each nursing and therapy intervention.

### Evidence-based care and treatment

- Intermediate care services delivered care and treatment in line with evidence-based practice that followed recognised and approved national guidance such as those from the National Institute for Health and Care Excellence (NICE) and the relevant Royal Colleges.
- We saw relevant NICE guidance was in place across the service. For example, guidance relating to specific physiotherapy treatments (shoulder impingement). A physiotherapist spoke with confidence about the national guidance and how this had helped to support and inform the development of physiotherapists.
- Bi-monthly safety metric audits were completed by the intermediate care staff to assess if set clinical care bundles were being followed. For example, catheter

care and pressure area care, we reviewed four of these audits and noted that areas of improvement had been identified and action plans put in place, as a result of the audit process.

- Documentation audits were carried out and in discussion with us, staff said they had identified key issues, taken actions for improvement and were progressing towards review. This was supported by data received from the trust following our inspection, which confirmed that documentation audits had been undertaken monthly and actions taken to address all identified issues. We noted that actions resulting from audits were reviewed for improvement on a monthly basis.
- Staff understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies.

### Pain relief

- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients. We noted that the service used a range of audit tools to assess patient's pain. For example, use of a pain assessment tool and depression score. Patients were supported to manage pain and low mood, following an initial assessment of their clinical condition.
- Patients were given pain relief according to their individual prescriptions. We observed nursing staff actively monitoring patients' pain levels. For example we saw one nurse took time to explain to a patient the importance of taking their pain relief medication even though the patient had stated they were not experiencing pain at the time.

### Nutrition and hydration

- Risk assessments were carried out by nursing staff to identify those at risk of malnutrition or dehydration. The Malnutrition Universal Screening Tool (MUST) was completed on admission and at regular intervals to monitor patients' nutritional status.

## Are services effective?

- Referrals to the dietician were made promptly when required and patients' weight was recorded weekly on each of the three wards.
- Patients who were at risk of developing pressure ulcers utilised the tissue viability service and were assessed by the specialist nurse. Their nutrition and hydration status were incorporated into their risk assessment and included in their care plan.
- We observed patients eating without interruption and that staff were available to support them when required in a relaxed and dignified manner.
- Patients who had difficulty eating/swallowing were clearly identified during staff handover; this was further supported by information held in patient files kept at the end of the individual patient's bed.
- There were notices displayed which gave clear details of protected meal times.
- Hot and cold drinks were offered to patients at regular intervals and fluid balance charts were recorded appropriately.

### Patient outcomes

- The trust was operating systems to monitor and improve the quality of treatment and care provided.
- As part of our visit we held discussions with a ward manager and other senior staff within the trust who had responsibilities for ensuring processes were followed to assess and monitor the quality of the service provided across the intermediate care service. They told us that issues affecting the quality of the service were reviewed by senior staff on a monthly basis, to ensure that actions had been taken to address specific issues. This was supported by information received from the trust which confirmed issues relating to medication errors falls and pressure ulcers, was subject to monthly review. These reviews followed on from action plans designed to address the issues and work done with general ward staff through team meetings and one to one supervision sessions.
- Where risks had been identified, action plans had been developed to manage the risk and monitor the actions taken. We were also shown clinical audits for example relating to infection control.
- Individual wards held performance data to measure the quality of care and the documentation for each patient via a dashboard, which was displayed in the ward manager's office.

### Competent staff

- Staff said they received an annual appraisal, clinical supervision and were meeting their mandatory training requirements.
- Data provided by the trust showed that 78% of staff working across both intermediate care sites had received an appraisal in the last twelve months. This was higher than the benchmark (75%) for community trust's but lower than the trust's target of 95%.
- A report produced by the trust showed that at the end of December 2015, 69.8% of staff at Broadgreen had accessed formal supervision. In addition, 90.9% of staff on the Aintree site had accessed supervision, although 36.4% of this was formal and 54.5% informal.
- Therapy staff demonstrated good rehabilitation competencies of the older adult and were especially skilled and knowledgeable with patients that had neurological needs such as stroke.

### Multi-disciplinary working and coordinated care pathways

- Staff demonstrated good internal multidisciplinary working across all three wards and demonstrated a wider team knowledge, which enabled them to refer patients in a timely manner to other specialist areas such as the wheelchair service.
- We noted there was an obvious professional respect between doctors, consultants, nurses and therapists. This was evident during the handovers, ward rounds and multidisciplinary team meetings we observed as part of our inspection. This meant that communication between clinical, therapy and nursing teams was effective and efficient.

### Referral, transfer, discharge and transition

- Referrals into intermediate care wards came from local acute Hospitals and GPs.
- Patients were referred appropriately to community services, for example community nursing teams to ensure their needs continued to be met following discharge.
- Referrals to clinical nurse specialists such as tissue viability nurse, speech and language therapist, falls lead and dietician were available and provided an in-reach service to wards on request. Staff said the referral process was easy to use and effective.

## Are services effective?

- We were told the average length of stay was approximately four to six weeks, however we saw several patients across three wards had stayed more than two months and one patient with complex housing needs had been waiting for more than three months.

### Access to information

- Patients arriving from acute hospitals were accompanied with paper records which detailed their recent care and treatment.
- We saw paper records for patients on the unit. They included medical records, diagnostic results and nursing notes which gave staff access to enough information to determine the correct care and treatment.
- Discharge summaries were produced for patients discharged home, this included rehabilitation goals met and outstanding ones, current condition, list of medication and follow on appointments.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Prior to inspection we were made aware that the trust had failed to notify us regarding patients who were subject to Deprivation of Liberty Safeguards [DoLS]. This was identified by the trust as part of its own pre-inspection preparation. This was confirmed as a system failure during a period of staff absence. We have received assurance that the trust DoLS process was in

fact, being followed in respect of the individuals concerned. Information received from the trust provided assurance that steps have now been taken to address this system issue.

- We saw that staff involved patients in their care and they obtained verbal consent before carrying out any personal care or treatment. Patient records confirmed that where appropriate, patients had signed a consent to treatment form on entering the ward. We noted that in three of the files we reviewed for patients who did not have capacity to consent to treatment, family members has signed to confirm they had been included in treatment planning and agreed with proposed plans of care.
- On all three wards we saw that there were some patients who were either living with dementia or suffering confusion due to infections. Two of the nursing/care staff we spoke with were unsure of when they should assess a patient's mental capacity. They told us that as mental capacity assessments were carried out by social workers they were not sure a detailed knowledge was needed by all staff.
- In discussion with us, senior staff were aware of capacity and consent and confirmed that they had received training in the Mental Capacity Act [MCA] and Deprivation of Liberty Safeguards [DoLS]. This was supported by information received from the trust prior to our inspection.

## Are services caring?

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

### Summary

We rated community inpatient services as 'Good' for Caring because;

- We observed staff treating patients and their relatives with dignity and respect. Patients told us they felt looked after.
- We saw that staff responded quickly and compassionately to patients in pain or discomfort.
- Nursing and therapy staff promoted and supported patients' independence throughout their stay and provided emotional support to patients and relatives alike.
- People were encouraged to self-care and were supported to achieve their full potential.
- Feedback from people who used the service and their families, was continually positive about the way staff treated people.

### Compassionate care

- We observed that all patients looked clean and well cared for. We also observed that interactions between staff and patients were professional and respectful. For example, staff addressed patients by their chosen name when carrying out treatment or personal care.
- Interactions we observed across all three wards between staff and patients were undertaken in a quiet, dignified and compassionate way. For example, on ward one we saw a patient living with dementia calling out and the nurse attended to them quickly. The nurse then held the patient's hand and made them laugh, before leaving the patient calm and comfortable.
- We observed that vulnerable or frail patients who required extra support were appropriately assisted.
- We talked to 11 patients across three wards and generally patients spoke highly of staff, as did relatives. One person commented: "Since [relative] has been in, all the staff have been lovely...we have never had a worry or concern we couldn't talk to them about." However two people we spoke with, told us that they felt the quality of care was dependant on the staff on duty. One person commented; "Some of the staff are lovely... but there are one or two who don't seem to have the same patience."

- We observed a patient receiving treatment from a physiotherapist in the inpatient therapy room. The patient was supported to walk using a walking aid and the physiotherapist was kind and supportive but continued to encourage the person to self-care.

### Patient understanding and involvement

- Patients were involved in their care at each stage of their rehabilitation. We saw records which confirmed that patient involvement took place by joint discussion, and that plans of care were developed in agreement with the therapists at the first assessment.
- Records we reviewed confirmed that a patient receiving specialist tissue viability treatment, had discussed the options for their care with a specialist nurse and the plan of care was agreed and recorded in their care plan. We spoke with the relative of this patient, who confirmed they were also provided with supporting information.
- We saw patients were encouraged to be as independent as possible and we saw staff give patients support and time when mobilising to and from the bathroom, self-dressing and engaging in therapeutic activities. The views of people using the service were regularly sought. Information was prominently displayed throughout the wards seeking and reporting patient's views. Patients we spoke with said they felt their views were valued and respected.
- The NHS Friend and Family Test results for inpatient wards were positive. The cumulative results from April 2015 to the end of December 2015 showed that 98% of patients were positive about the care and treatment received. The results for the month of November 2015 showed that 100% of patients were positive about their care and treatment with a high (52%) response rate. For December 2015, the results dipped slightly but still showed a positive picture because 95% were positive with a 33% response rate.
- We spent time on all three wards and observed interactions between patients and staff. During our inspection we noted that staff engaged with patients and comforted them if they were distressed.

## Are services caring?

### Emotional support

- Relatives were welcomed when they visited the wards and we saw one relative who was obviously concerned being looked after by a member of the nursing team. The staff member offered to go into a room to talk privately with them and was seen to be approachable and supportive. We spoke with the same person later on that day and they stated that the nurse had been very kind and supportive and had sorted out the matters that were causing concern.
- Patients and their relatives told us they were cared for by caring staff who were confident and well trained to undertake their roles. One patient said, “Oh they all know what they are doing. . . . they are lovely these girls [staff]. If I get panicky about anything, one of them will always calm me down.
- We saw examples of ‘thank you’ cards, expressing the gratitude of patients and relatives for the care and support they had received whilst an in-patient or visiting the intermediate care wards.
- One patient told us the rehabilitation team and the therapy service were enabling them to live an active life within the constraints of their clinical condition. A chaplain was available for patients or their relatives and staff could also access leaders of other faiths if required.

# 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 community inpatient services as 'Good' for Responsive because;

- Patients and relatives concerns were listened to and acted upon swiftly by staff.
- Vulnerable patients were identified on admission and staff provided individualised care to meet their needs.
- Staff communicated well with patients and relatives and involved them in their nursing and therapy care plans, referrals and discharge plans. Both patients and relatives said they felt well informed.
- We observed a multidisciplinary integrated approach to the delivery of care involving nursing staff, health care assistants, therapists, medical staff and pharmacists.
- Staff were aware of the referral criteria for each ward to ensure the patient received the right care to promote the right level of care to meet patient's needs.

However;

- We found that external pressures did often lead to unsuitable patients being placed on the wards.

## Planning and delivering services which meet people's needs

- Following our last inspection we said that the trust should take steps to ensure appropriate patients that fulfil the admission criteria and therefore benefit from rehabilitation are admitted to the intermediate care and rehabilitation wards. During this inspection we found that although improvements had been made, in some instances patients who were unsuitable for rehabilitation were admitted to the service.
- We noted that the majority of patients were referred from local acute hospitals. Records confirmed that these patients were assessed prior to admission to ascertain which ward would suit the patient's needs best. However, we noted that there were external pressures such as waiting times for social care packages' and pressure from acute trusts to take patients, whose condition meant they were not suitable for rehabilitation. This meant that patients on the intermediate care wards across both sites, we not suitable for rehabilitation, due to their current long term

condition or illness. For example we reviewed one patient's records where the therapist had said there were no more therapeutic options available for the patient. The notes had been written by the therapist three weeks before our inspection and yet the patient still remained on the ward. This meant that we were not assured that the services offered by the intermediate care teams on all three wards was meeting patient need in a consistent way.

- Staff understood the different needs of the people they cared for and acted on these to plan and deliver care and treatment.

## Equality and diversity

- The trust provided services to people whose first language was not English. The trust had an external contract with a company that provided face to face interpreter services along with access to a telephone interpreting service, 365 days a year in over 120 languages.
- We spoke with two staff who described their experiences in accessing an interpreter to help them to communicate with patients.
- We found that any identified cultural needs were recorded as part of the care and treatment plan.
- Staff received training for equality and diversity on induction and every three years as part of corporate mandatory training. Data provided by the trust showed that 97% of staff in inpatient services had completed this training up to the end of December 2015.

## Meeting the needs of people in vulnerable circumstances

- The intermediate care wards accommodated people with a learning disability on occasion and received support from community teams to be able to meet patient needs. Staff could articulate examples of how they supported people living with a learning disability. For example, we were documentation in easy read format, for patients living with specific learning disabilities.
- Care pathways were designed to be flexible to make sure that different services worked together to meet the patient's changing needs.

## Are services responsive to people's needs?

- We found that care plans for people living with dementia were person centred and gave staff appropriate guidance to meet the patient's needs.
- Intermediate care services provided a multi-disciplinary response to meeting the individual care and support needs of patients and their families. This provided assurance that the needs and wishes of people living with a learning disability or of people who lacked capacity were understood and taken into account, although some staff said they needed more training in this area, particularly relating to documentation.

### Access to the right care at the right time

- People were able to access the right care at the right time. The referral systems to the intermediate care unit, generally supported choice and enabled people to access the right care at the right time, dependent on bed capacity of individual wards.
- There was a consistent approach to managing referrals, assessments, bed allocation and use of inpatient provision; plans were in place to tackle any problems identified. For example, we met with senior managers from the trust who were able to identify any issues regarding referral and discharge of patients from the intermediate care wards. During our discussion, service managers were able to articulate issues relating to the access and flow through the service. Managers we spoke with were able to give us detailed clear action plans to address issues as they arose. For example we were shown records which confirmed that once patients were identified as having completed their period of rehabilitation, intermediate care services then had to wait until appropriate follow on care was in place before the patient could be discharged. Records we reviewed

showed that senior staff on the intermediate care ward has liaised closely with care providers and the local authority to try to ensure a speedy resolution, which met the needs of the patient.

- However staff we spoke with on the wards confirmed that, they sometimes had to admit patients who may not be suitable for rehabilitation, in order to support local acute trusts.
- Data received from the trust prior to our inspection showed that delayed discharges had increased across both sites. However this was a more defined issue on ward 11, where delayed discharges had increased from 12.6% to 32.6% between December 2014 and November 2015. Ward 35 had also showed an increase of delayed discharges from 5.1% to 11.9% during the same time period.
- Data received from the trust following our inspection confirmed that this was an issue, which was being addressed by the trusts executive team.
- Multi-disciplinary team working was co-ordinated so that the needs of the patients' could be recognised and met, in a timely manner. The intermediate care service had GP cover arrangements for when a patient may require review.

### Complaints handling and learning from feedback

- Staff told us about the trust complaints policy and procedures and how they would advise people using the service to make a complaint.
- We noted that information on how to make a complaint was visible in the corridors leading to all three wards across the service.
- Across intermediate care services we saw many examples of compliment letters and thank you cards displayed in ward areas.

## 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 community inpatient services as 'Good' for Well-led because;

- Since our last inspection, we found that there had been major improvements in the culture within the service.
- All of the staff we spoke with told us that the both the Director of Nursing and the Chief Operating Officer had made a positive difference to the culture of intermediate care services.
- Staff were aware of the current vision of the trust and could clearly articulate the six Cs (a framework for care and support for patients and staff).
- Across all of inpatient services staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Staff felt listened to and involved in changes within the trust; staff told us of their involvement in staff meetings.
- Staff were committed to delivering good, safe and compassionate care.
- The trust had acted in response concerns about the quality of care within the intermediate care service. Managers had made effective changes to the structure and staffing to ensure patient safety.
- Most staff felt valued and listened to and felt able to raise concerns.

However;

- Some staff felt they weren't involved in improvements to the service.

### Service vision and strategy

- Adult Intermediate care services had been through a major period of change as part of the wider trust's transformational changes since our last inspection, relating mainly to the redevelopment of management systems within the service.
- Staff were aware of the trust vision and underpinning values and objectives "to provide high quality services that deliver care for people and communities we serve as close to their home as possible".

- A strategic plan was in place and was being monitored and reviewed regularly including the action plan from the previous CQC inspection.

### Governance, risk management and quality measurement

- We had previously told the trust they should continue to evolve and embed the improvement to the trusts clinical and corporate governance structures, improving governance, quality measurement, risk registers and risk management. During this inspection we found that improvements had been made although senior ward staff were still developing their understanding of risk management and quality measurement.
- Records we received from the trust prior to our inspection confirmed that risks identified as specific to intermediate care, were identified at trust level and actions had been put in place to improve areas of potential risk. There were actions planned to address issues placed on the service risk register and they were routinely monitored and updated to ensure the quality of the service.
- Risk management and quality assurance processes were in place at a local level linking each of the intermediate care wards through to the senior management team.
- We found evidence that incidents and concerns relating to patient safety were being reported and fed through to the trust's quality committee.
- There was a willingness to look at and examine risk in the service and since the last inspection, the trust had sought to address a number of the risks that we identified.
- Senior managers worked to support staff to learn from incidents and act to prevent recurrence. We were shown records which confirmed that Root Cause Analysis (RCA) investigations had been undertaken for serious incidents or where trends were identified, such as an increase in patient falls. Staff we spoke with confirmed that ward teams received feedback from lead meetings where information was shared across locations.

## Are services well-led?

- We saw clear evidence of a systematic sharing of feedback from incidents across all intermediate care wards on both sites. This meant that there was a shared approach to learning for intermediate care services.

### Leadership of this service

- At our last inspection we told the trust it should ensure there was clear, effective leadership so that teams don't work in isolation of each other. All of the staff we spoke with said they now received positive leadership and felt supported by their immediate line manager.
- All of the staff we spoke with told us how proud they were of the care that they provided to people. Staff were eager to tell us how changes to management style and culture have had a positive impact on the service as a whole. Staff said they now felt supported by senior trust management to provide high quality care to patients.
- We were told that the final structures for professional leadership were in place but staff we spoke with said they had not been actively engaged in developing the leadership roles.

### Culture within this service

- Across all three wards we saw improvements in the culture and atmosphere of the wards. There was a culture of openness, team working and support across all of the wards we visited.
- All staff were clear that huge efforts had been made to change and support the delivery of intermediate care services. All of the staff we spoke with told us that support from both the Director of Nursing and the Chief Operating Officer had made a positive difference to the culture of intermediate care services.
- Staff were aware of the trust's whistleblowing procedures and the action to take. However, staff said they would now have no concerns speaking to their line manager if they had an issue.

### Public engagement

- We noted that NHS Friends and Family Test (FFT) feedback was reported as part of the trust's performance reports. The cumulative results from April 2015 to the end of December 2015 showed that 98% of patients were positive about the care and treatment received. The results for the month of November 2015 showed that 100% of patients were positive about their

care and treatment with a high (52%) response rate. For December 2015, the results dipped slightly but still showed a positive picture because 95% were positive with a 33% response rate.

- We found that all three wards across intermediate care services were proactively seeking feedback from patients about their experience as a patient and the overall quality of the service.
- We spoke with the trust senior management team about what consultation had taken place with the public in respect of the reshaping of services taking place within the organisation. We were told no public consultation had yet taken place and was not compulsory at part of the process.

### Staff engagement

- At our last inspection we told the trust they should ensure that communication and staff engagement was on-going and robust. At this inspection all of the staff we spoke with said that everything had improved and the managers were "working with us".
- The most recent staff survey in 2015 showed a 42% response rate which was worse than national average but 4% more than 2014. The results showed 72% of staff would recommend the trust as a place of care and 48% would recommend the trust as a place of work. This was a marked improvement on previous staff surveys. However, the data could not be disaggregated to just inpatient specific data.
- The trust monitored staff satisfaction as part of their integrated performance. NHS Friends and Family Test results for December 2015 showed that 64% of staff would recommend the trust as a place to work and 84% would recommend it as a place to receive treatment. These results were based on a 12% completion rate across the trust and could not be disaggregated just for inpatient services.
- Senior managers said that staff engagement events and had taken place, led by the executive team. Staff confirmed that engagement with senior managers had been helpful. However, some staff felt they weren't involved in improvements to the service. All of the staff we spoke with said they felt that there was still a need to maintain good communication and engagement.
- Staff said they were well supported with mandatory training, clinical supervision and staff appraisals.

# Are services well-led?

## **Innovation, improvement and sustainability**

- The future reshaping of Liverpool Community Health NHS Trust and its services needs to ensure that service delivery is maintained and able to meet the needs of the community the trust serves.