Berkshire Healthcare NHS Foundation Trust

RWX

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)
RWX86	West Berkshire Community Hospital	West Berkshire Community Hospital	RG18 3AS
RWX85	Upton Hospital	Upton Hospital	SL1 2BJ
RWXX3	St Mark's Hospital	St Mark's Hospital	SL6 6DU
RWXX1	Wokingham Community Hospital	Wokingham Community Hospital	RG41 2RE
RWXW2	Oakwood Unit	<Placeholder text>	SL1 2BJ

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall rating for this core service Good |

We rated the inpatient service in community hospitals as good for safe, effective, caring, responsive and well-led.

- The inpatient wards in community hospitals had safe systems in place to prevent abuse or avoidable harm to patients. There was a system to allow staff to report patient incidents and safety concerns. Patient safety information was displayed for staff and visitors. There was a good track record on the prevention of pressure ulcers. Staff knew how to raise incidents. Incidents were investigated and the learning was shared widely. Staff were aware of their obligations under the duty of candour.
- Medicines were managed appropriately across inpatient wards and in the minor injuries unit. A high percentage of staff participated in mandatory and other training. Inpatient wards were clean and well maintained. There was sufficient equipment to meet the needs of patients, and the requirements of staff to reduce the risk of avoidable harm. There were appropriate systems in place to monitor patients for sign of deterioration. There were sufficient numbers of suitably trained and qualified staff to keep patients safe.
- Care was planned and delivered in line with national and best practice guidance. There were suitable evidence based policies and procedures in place for staff to follow. Patients received pain relief when they needed it. Patients were offered food and drinks. This was available over 24 hours. Patients that needed it were given assistance to eat and drink. There were systems in place to collect patient outcome data in order to monitor quality.
- The trust participated in a programme of audit and also contributed data to national audit programmes. Staff received appropriate appraisals and supervision. There was excellent multidisciplinary (MDT) involvement in patients care and treatment. Regular meetings occurred to review patient progress and plan for discharge. All appropriate MDT staff were involved in these meetings. Patient records were securely but accessibly stored in all wards. Staff were aware of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards, and had received training.
- We observed patients being treated with care and compassion by ward staff. The privacy and dignity of patients was maintained at all times. Patients and those close to them were involved in decisions about all aspects of their care. Patients told us that they were treated with kindness and respect. Staff took time to assess and treat patients appropriately and also to discuss their fears and anxieties. There was support available for patients that required emotional support. There was a chaplaincy service to support patients' religious needs. This service was able to support patients of all faiths through a network of volunteers.
- The trust had open relationships and good communication with commissioners. The trust worked with patients and GPs to organise and develop services. Patients were provided with activities in addition to rehabilitation. Patients' religious and cultural needs were supported. Translation and interpreter services were provided for patients that needed them. Staff participated in safeguarding adults training.
- Staff were aware of the particular needs of patients that were living with dementia or a learning disability. Patients with dementia or a learning disability were given a priority in the minor injuries unit (MIU). Patients admitted to the community hospitals were seen by nursing and medical staff promptly. Ambulance patients had an initial assessment within fifteen minutes in the MIU. Walk in patients were assessed within one hour. Bed occupancy was high in most inpatient wards. There was a waiting list of patients in acute hospitals that needed to access the service. Patients and relatives were given the information they needed to raise a complaint if they needed to. Changes were made in response to complaints and patient feedback.
- Staff were aware of the trust's values, as well as the vision and strategy for the individual wards. Effective governance processes were in place to monitor quality, performance and risk. Patient safety incidents were investigated and the learning shared with staff. Risks to patient safety were identified and recorded on a risk register, along with planned interventions to mitigate the risk.

Summary of findings

- There was an open culture and staff felt confident to raise concerns over patient safety. The trust had effective systems in place to capture patient feedback. This information was used to improve patient care. Staff were engaged and valued the opportunity to be involved in quality improvement projects.
- In the inspection of the inpatient wards at community hospitals we spoke with 64 members of staff, 27 patients and six relatives. We also reviewed 24 sets of patient records.

Summary of findings

Background to the service

Information about the service

- Berkshire Healthcare NHS foundation trust provided care to patients requiring inpatient treatment and rehabilitation. There were 186 inpatient beds spread across five hospital sites. Inpatient services were provided at West Berkshire Community Hospital, Upton Hospital, St Mark's Hospital, Wokingham Community Hospital and The Oakwood Rehabilitation Unit at Prospect Park Hospital. Services provided to patients were rehabilitation, intermediate care, nursing and medical care for people with long term, progressive or life-limiting conditions and care of the elderly and frail.
- The inpatient service could be accessed by GPs, community matrons and through referrals from acute hospitals such as Wexham Park Hospital and The Royal Berkshire Hospital. There was a waiting list for admissions into the community hospitals from these acute hospitals.
- The inpatient services were primarily designed around the needs of elderly patients that required rehabilitation. There were two beds specifically for patients that required end of life care at the West Berkshire community hospital.
- There was a nurse led minor injury unit (MIU) based in West Berkshire Community Hospital in Newbury. This was open from 8.00am to 10pm, seven days a week. Patients are booked in up to 10pm. The clinic has three rooms. The number of patient attendances to MIU in 2015 was 20,200.

Our inspection team

Chair: Dr Ify Okocha, Medical Director and Responsible Officer, Oxleas NHS Foundation Trust

Head of Inspection: Natasha Sloman, Head of Inspection for Mental Health, Learning Disabilities and Substance Misuse, Care Quality Commission

Team Leader: Lisa Cook, Inspection Manager, Care Quality Commission

The team that inspected community in patient services for adults included CQC inspectors, medicines inspector (pharmacist specialist), a senior nurse, therapist and two experts by experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of NHS trusts.

How we carried out this inspection

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

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

Before visiting Berkshire Healthcare NHS Foundation Trust, we reviewed a range of information we held about the trust and asked other organisations to share what they knew. We carried out an announced visit over three days between 8 December 2015 and 10 December 2015.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses and

Summary of findings

therapists. We talked with people who use services. We observed how people were being cared for, talked with carers and/or family members and reviewed care or treatment records of people who use services.

We carried out visits to Highclere ward, Donnington ward and the minor injuries unit at West Berkshire community hospital, Oakwood ward at Prospect Park hospital, Windsor / Ascot wards at Wokingham community hospital, Henry Tudor ward at St Marks hospital and Jubilee ward at Upton hospital. We interviewed 64 staff and managers and checked equipment, facilities and medicines. We also reviewed 24 patient care records as well as policy documents. We spoke to 27 patients and six relatives.

What people who use the provider say

We asked patients and relatives to tell us their experiences of using the inpatient wards in community hospitals. There were many positive comments about the compassionate caring attitude of staff. People commented that they felt safe and at ease with staff. We heard consistently from previous patients that considered the staff to be particularly caring. People also told us that they felt treated as individuals by staff in the services they used, and this made a powerful impression. One person commented "it's excellent, even the receptionist makes me feel welcome". Previous patients told us that the service was first class, due to "their [staff] attitude, professionalism and reliability".

Good practice

- There was excellent multi-disciplinary working and cooperation within the community hospitals that worked for the benefit of patients.
- There were also rotational therapy assistant roles that were being developed to work across the occupational therapy and physiotherapy disciplines.
- There were was a vision to more closely integrate nursing and therapy into an overarching rehabilitation model that included all staff. One of the newly appointed ward leaders was a therapist by background and was part of this vision.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that there is safe storage for spare oxygen cylinders on community hospital wards to reduce the risk of injury.
- Consider implementation of an early warning system in the minor injuries unit, to help ensure the early detection of a deteriorating patient.

Berkshire Healthcare NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

By safe, we mean people are protected from abuse and avoidable harm

We rated safe for community hospital inpatient wards as good.

- The inpatient wards clearly displayed patient safety and quality information, such as numbers of pressure ulcers, falls and hospital acquired infections. There were low numbers of incidents that led to harm to patients. There had been no acquired category 3 or 4 pressure ulcers reported by any of the inpatient wards during the past year. Henry Tudor Ward at St Marks Hospital had no acquired pressure ulcers reported for the last two years.
- Staff were aware of the method of reporting incidents and the importance of doing so. Incidents were investigated thoroughly and learning from them shared in team and locality meetings. Staff were aware of the requirements of the duty of candour legislation. There were policies in place for dealing with safeguarding concerns, staff understood and adhered them.
- Medicines were stored and managed appropriately in all inpatient wards. There was regular oversight of medicines supply and prescription by a pharmacist. Systems were in place to ensure the correct storage and checking of controlled medicines and those that required refrigeration. There was regular audits of medicine administration carried out which had been effective at reducing omitted doses.
- There was poor storage of spare oxygen cylinders observed on Highclere Ward.
- There was a variety of patient accommodation provided across the community hospitals, from 'Nightingale' wards at Upton Hospital to single rooms at the Oakwood unit. All wards were well laid out, clean and designed to maintain patient safety, privacy and dignity. There were two rooms provided specifically for the care of patients at the end of life, located at West Berkshire community hospital. All community hospitals had well equipped and spacious therapy rooms. There was sufficient well maintained equipment for the prevention of pressure ulcers and the moving and handling of patients. Facilities were designed and suitable for use by elderly frail patients or those living with dementia.

Good

Are services safe?

- Patient documentation we reviewed reflected the patients' care requirements, rehabilitation goals and individual preferences. Care records recorded progress and were mostly up to date. Patient care plans were reviewed regularly and completed to a high standard.
- Community inpatient wards we visited were clean and well maintained. Staff had access to personal protective equipment such as gloves and aprons; we observed these being used appropriately. Medical equipment was maintained regularly and stored clean and ready for use.
- There was an early warning system in use on the inpatient wards to assist staff in the assessment of patients. This system also helped in the communication or escalation of concerns about a deteriorating patient. The minor injuries unit (MIU) did not use such a system; this concern was escalated during the inspection. The MIU had appropriate systems for ensuring that sick patients were seen quickly by a clinician. The clinician then decided on the level of urgency.
- There was a gap identified in availability of medical cover between 5pm and 6.30pm, except for West Berkshire Community Hospital where a GP on call covered this period. Although there had been no incidents reported as a consequence of this gap in medical cover.
- Staff carried out patient risk assessments for pressure ulcer risk, falls, infection control and malnutrition. These risks were communicated effectively by patient information boards and staff handovers. Measures were put in place to reduce the risk of falls for patients assessed as at high risk. Effective visual alert strategies were used to inform staff of a patients high falls risk. Risk assessments were carried out for patients that required the use of bedrails.
- There was an appropriate number of suitably trained staff to ensure patients were safe. Gaps in the rota were filled with the wards own staff, or agency staff that were block booked or that were familiar with the ward.

Detailed findings

Safety performance

- The trust monitored safety thermometer data in relation to care provided to patients at community hospitals. The NHS safety thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls.
- There was patient safety information displayed on all of the wards. This included performance information about pressure ulcers, hydration and falls and displayed ward targets for the reduction of avoidable harm. Safety thermometer results showed no inpatients had developed a pressure ulcer for a year.
- Staff used a 'safety cross' system to record each day if there had been a pressure ulcer incident. There had been no acquired pressure ulcers notified by any of the inpatient wards during the past year. There had been no acquired category 3 or 4 pressure ulcers reported by any of the inpatient wards during the past year. Henry Tudor Ward at St Marks Hospital had no acquired pressure ulcers reported for the last two years.

Incident reporting, learning and improvement

- Trust data showed inpatient wards for community health services reported 14 serious incidents requiring investigation between August 2014 and July 2015. The majority of these incidents were patient falls with harm.
- We reviewed a root cause analysis of an incident. Thorough and robust reviews or investigations had been carried out with all relevant staff and people involved in the investigation. The majority of the incidents reported by the inpatient units were low or no harm to patients.
- Staff from inpatient wards at all the locations reported incidents using the trust wide electronic reporting system. As part of their induction, staff in the minor injuries unit at West Berkshire Community Hospital said they had received training on the incident reporting system. Staff could explain what incidents they would report, such as pressure ulcers, slips, trip and falls.
- Staff shared learning from incident investigations at monthly locality or unit meetings. There were also monthly clinical forums held within each locality which included discussion and learning from incidents. Larger meetings to discuss learning and best practice, that brought representation from the whole trust, took place quarterly. Themes from incidents were also shared more widely in the staff bulletin.
- Staff were aware of their responsibilities to be open and honest with patients about incidents and how to apply

the duty of candour legislation. 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.

- There had been an incident where a patient had a cardiac arrest in the physiotherapy gym at Upton Hospital. As a result of this patients attended the gym with their records in case of an emergency (including a 'do not attempt cardio-pulmonary resuscitation' form if the patient had one). Panic buttons had been installed to summon help, and staff did not use the gym alone with a patient. There was also a 'grab bag' that contained resuscitation equipment provided.
- MIU staff told us they had access to the NHS national safety alerts and resources on the intranet. This enabled staff to respond to safety alerts

Safeguarding

- Ninety-five per cent of staff had participated in mandatory training on safeguarding adults at risk to level 1. Level 2 training was available in the portfolio of essential staff training. Eighty nine per cent of staff had completed safeguarding children training at level two. The clinical lead and the manager of the MIU told us that all staff had completed level three, safeguarding training, appropriate for their roles.
- Staff were aware of their responsibilities in protecting patients from abuse. Staff had received mandatory training in safeguarding, and were aware of how to escalate a concern.
- All staff could tell us what they would do if they witnessed an incident indicative of safeguarding concern and how they would escalate this to the local authority.
- Inpatient wards had local safeguarding leads to offer advice and escalation of concerns.
- The trust told us there had been 14 safeguarding alerts or concerns raised for the inpatient wards, since September 2014 and all but one had been closed. Safeguarding concerns were mainly around staff not responding to patient call bells.
- There were clear policies for dealing with any suspected abuse of adults or children at risk including domestic violence and female genital mutilation.

Medicines

- We observed that spare oxygen cylinders on Highclere Ward were not stored correctly; these were not secured and could fall over.
- Medicines were stored and managed appropriately on the wards we visited.
- There was evidence stock rotation took place to ensure the oldest was used first and that staff were aware of when medicines were coming close to their expiry date. We found all medicines were in date.
- Staff operated safe systems for reconciling a patient's medicines against hospital and GP records.
- A pharmacist attended the wards three days a week, supported by a medicines technician. At the Oakwood unit a pharmacist visited the ward every day. We saw evidence of pharmacists reviewing patient medicine charts regularly. The pharmacist also attended ward rounds and multi-disciplinary team meetings. There had been an improvement in the numbers of missed medicine doses over the previous twelve months. This was demonstrated by an audit of medicine charts. There had been changes in practice as a result of completed audit cycles.
- The trust pharmacy was located at the Prospect Park hospital. Staff on inpatient wards told us they were able to access medicines when required urgently from pharmacy. Normal procedure was that medicines for patients to take home would be dispensed in good time for the discharge. However, staff told us they had difficulty obtaining medicines not held in stocked quickly and this could cause delays to patient discharge. There was no evidence that discharges had been delayed waiting for medicines to be made available.
- In the MIU items supplied for individuals to take home were labelled safely, including instruction on how they should be used.
- We observed medicines being given in a safe way. Staff that were undertaking medicine rounds wore a red tabard. This was designed to inform patients and visitors that the nurse was not to be disturbed and to reduce

the risk of errors. Medicines were checked against the patient's prescription chart, dispensed to patients in clean paper pots and the identity of the patient was checked. The patient was told what the medicine was being taken for, and the staff observed the patient taking the medicine. The prescription chart was signed after the patient had taken the medicine. The medicines management team counselled patients on their medicines throughout the inpatient stay.

- In all areas, the refrigerators used for storing medicines were secure, tidy and not overstocked. The temperatures were checked daily and recorded to ensure medicines were kept the correct temperature.
- The wards also had appropriate storage and processes for managing controlled drugs (CDs), such as strong painkillers. Controlled medicines were checked and reconciled every week. We found that some staff did not know the procedure to dispose of CDs, incorrectly dispensed and wasted.
- Assessing patients for self-administration of medicines was not embedded in to the rehabilitation process. The Trust had started training staff to assess patients for self-administration. There was a policy in place and patient's own medicines lockers on some inpatient wards.
- In the MIU medicines were stored safely including flammables and those requiring extra controls such as controlled drugs. The keys to access the controlled drugs storage were kept within the secure treatment room and within a safe. There was signature system in place to indicate that an independent check of the controlled drugs by a pharmacist had taken place.
- There were good processes in place to obtain medicines in MIU and monthly checks by an appropriate member of staff (pharmacy assistant) to ensure medicines remained safe to use. This member of staff communicated any supply issues to the rest of the team in order to put any necessary contingency plans in place. There was a regular review of stock holdings to make sure appropriate medicines and stock levels were maintained. The medicines management committee approved any new medicine for use.
- On the MIU there were regular audits to ensure medicines were prescribed according to the protocols set by the unit. Staff discussed the results of these audits at staff meetings and followed up as part of clinical supervision.
- Patient Group Directions were in place to allow some registered health professionals to administer or supply medicines in specific circumstances without them having to see a prescriber. Staff confirmed there was a record of staff who were non-medical prescribers.
- FP10 prescriptions were stored and managed safely and a log of serial numbers was kept to ensure appropriate use. This was necessary to ensure prescriptions were only issued to patients who required the medicines.

Environment and equipment

- The ward environments varied between community hospitals. At Upton hospital the inpatient ward was of the 'nightingale' ward style, with the ward divided into male and female ends. This ward also had two side wards. The offices and servery were located in the middle of the ward, this effectively divided the ward. Male and female patients were segregated in all the community hospital units, with separate toilet and washing facilities provided.
- The Oakwood unit at Prospect hospital had 35 single rooms, arranged around a suite of rehabilitation rooms. The layout of accommodation and shared facilities supported privacy and dignity for patients.
- At the West Berkshire Hospital there were larger 'rainbow' rooms that were intended for use by patients at the end life. These rooms had en suite facilities.
- Each hospital location had a well-equipped and spacious therapy room, designed for one to one therapy or exercise and balance classes.
- Emergency medicines were available on the resuscitation trolley. The resuscitation trolleys were checked daily to make sure the trolley seal was intact and thoroughly checked once a month for the contents.
- There was an appropriate supply of equipment for the moving and handling of patients. Eight patient hoists out of 11 that we checked displayed labels to demonstrate they had been inspected within the last six months. Equipment we checked was cleaned and ready for use. Staff on the wards also had access to standing aids and standing hoists if required by patients.

Good

Are services safe?

- There were bathrooms with level-access showers and toilets. Areas that had been refurbished had 'dementia friendly', high contrast fittings and paintwork. There was also suitable signage for patients to be able to find their way around the facilities.
- Fire doors were alarmed, and these alarms were tested frequently across all the community hospitals.
- If staff assessed that patients required pressure relief mattresses, they could obtain this equipment from trust stores or by hiring them from an external provider.
- There was a large and well equipped room for patient activities at the Oakwood unit at Prospect Park Hospital. This included suitable patient seating and a display cabinet of items that would be familiar to older patients, for reminiscence therapy. There were also resources to allow the room to be used for worship.
- The facilities were designed for use by elderly frail patients. They were easily accessible facilities. Decoration and the design of the wards and signage was helpful to patients living with dementia.
- In the MIU staff told us they had sufficient supplies and appropriate equipment they required to treat patients. Maintenance staff checked equipment in the MIU regularly.

Quality of records

- Patient records were completed to a high standard, and contained risk assessments for pressure ulcers, nutrition, falls risk and risk of venous thrombo-embolism.
- We checked 24 patient records. These were detailed and laid out consistently. Patient documentation we reviewed reflected the patients' care requirements, rehabilitation goals and individual preferences. Care records recorded progress and were mostly up to date. Staff reviewed patient care plans regularly and completed them to a high standard.
- Each patient had a discharge booklet which was started on admission and documented progress and goals for patients. All staff worked to ensure that this document was up-to-date and that the patient was informed of changes to their expected discharge date.
- There was good record keeping at the MIU. We saw evidence of matron undertaking monthly audits of random samples of patient records. Areas of concerns were identified and the findings were shared with staff to support improvement.
- We reviewed 10 patient treatment records in MIU and found all to be fully completed. All tests results including electro cardiograms taken in the MIU were scanned and attached electronically to the patient record.
- Some units had lockable notes trollies that were stored in the patient bays.
- Patient records were accessible, yet stored securely in all locations. This meant that records were stored close to patients if required, but access to them was controlled. Other areas used lockable trollies stored by the nurse's station. At Wokingham community hospital, notes trollies had just been delivered at the time of inspection to be used in each ward bay. As this was a new development, staff were not able to tell us if this was an improvement on having records stored at a central point.

Cleanliness, infection control and hygiene

- The wards at all locations were visibly clean. Cleaning services at the Oakwood unit, Prospect Park Hospital and West Berkshire Community Hospital were provided by a contractor. Cleaning services for the other sites, Upton Hospital, St Marks Hospital and Wokingham Community Hospital were provided by trust staff. The cleaning staff worked on regularly on the same wards and felt that they were included in the team. There were cleaning rotas against which quality control inspections were carried out.
- Staff could access aprons and gloves easily, to protect themselves and patients. Staff adhered to the trust 'bare below the elbows' policy to help reduce the risk of infection.
- The trust infection prevention and control (IPC) team undertook infection control audits every month and sent compliance reports to each community hospital. The IPC team ensured that any concerns about compliance on a ward, was fed back to encourage improvement. This team also provided guidance and education for all wards, as required and when support was requested.

Good

Are services safe?

- Staff assessed each patient for their risk of infection on admission. All patients were screened for MRSA unless the patient was known to be MRSA positive. Patients were screened for clostridium difficile if admitted with diarrhoea. Isolation facilities were available if necessary to minimise the spread of infection. Staff could access advice from the infection prevention and control team.
- The results of the latest hand washing audit showed more than 98% compliance to the standard.
- Trust data showed that 93% of staff had participated in training on infection control and prevention.
- Data from the patient-led assessments of the care environment (PLACE) survey told us that all hospitals, with the exception of West Berkshire community hospital, scored above the England average for cleanliness.
- There was sanitising hand gel available for staff and visitors to use. This was in addition to hand washing facilities. There were sufficient hand washing stations for staff and for patients and visitors to the unit.
- The MIU had been purpose built. It was visibly clean and well maintained. All the areas we visited had a cleaning schedule. These schedules were completed and checked daily by the nursing staff. The cleaning staff told us they had access to equipment and training necessary for undertaking cleaning. Cleaning staff that carried cleaning duties received training and supervision.

Mandatory training

- The trust provided staff with mandatory training. This included conflict resolution, the Mental Capacity Act (this included consent) and the associated Deprivation of Liberty Safeguards (DoLS), information governance and safeguarding level 1 (adults and children). Staff were also required to have training and annual refresher updates on basic and immediate life support. This course was specifically for staff working in hospital inpatient units. Staff were given the time and support to participate in mandatory training.
- The trust collected data on staff participation in mandatory training; this showed that they were above their own target of 90%. Line managers identified when staff were due their training and staff were given protected time to complete the training.
- Mandatory training was mostly provided on-line. Staff on some wards were able to access an education room that had two desktop computers and a docking station to allow staff to complete training during their work hours. The education room also provided a venue for face to face training, such as basic resuscitation training.

Assessing and responding to patient risk

- There was no early warning system in use in the MIU. At the inspection, we raised concerns that staff in the MIU did not use an early warning score system. Such a system can help assess a patient's severity of illness and thus enable a timely intervention.
- On the inpatient wards, staff recorded patient observations, using the national early warning system (NEWS) which highlighted when patients' health deteriorated. Staff called for medical assistance when patients' health deteriorated. There had been an audit carried out on the recording of NEWS for rehabilitation patients.
- Staff assessed patients for key risks to their health and wellbeing. This included carrying out risk assessments of falling, developing pressure ulcers, malnutrition and VTE. This information was recorded in the patient record and shared through handover. If these risks were assessed as high, a care plan was completed. Identified risk of developing a pressure ulcer and falling were also recorded on the patient information board.
- These boards displayed risks that had been assessed for each individual. To ensure good communication of risk, symbols were used. For example, a red dot indicated that a patient was at high risk of falls. Other information was also displayed in an accessible but discreet way, such as dietary requirements or risk of pressure ulcers. These boards were legible and contained up-to-date information relating to important risks for patients.
- Handovers for staff were well organised. A printed sheet was produced by the night staff with basic patient details, this was updated and notes made on it by the staff taking handover.
- The trust had a high level target to reduce the number of unwitnessed falls on the in-patient wards.
- Whenever possible, staff arranged for patients at high risk of falls to be in a bed near the nurse's station for easy observation. When appropriate, they also referred

these patients to the therapy team to help them with strategies against falling. Staff also used pressure mat alarms for patients with impaired mobility, so if the patients got up from chairs the alarms would alert staff to provide assistance. Staff also asked patients to wear a distinctive red identification band if they were at a high risk of falls to prompt all staff to provide suitable support.

- Patients that required the use of bedrails to stop them falling from beds had a risk assessment completed for this before they were used. Staff provided a low level bed for those patients where bed rails presented a hazard.
- Staff volunteered for ward 'champion' roles to improve staff skills in assessing patients for pain management, falls and tissue viability. Each ward had champion boards displayed with key resources and a photograph of the responsible staff member.
- If a patient deteriorated in the MIU, staff could provide basic life support in a room with resuscitation equipment until an ambulance arrived.
- A receptionist saw all patients on arrival at the MIU and, if they were obviously in need of urgent care or treatment, alerted nursing staff immediately. Receptionists had received training on the conditions that needed to be seen by the emergency nurse practitioner as a priority. Receptionists reported urgent conditions such as chest pain, back pain, shortness of breath, excessive bleeding and head injury with loss of consciousness and vomiting to the emergency nurse.
- Staff told us that any patient who had severe illness would be rapidly transferred to a local emergency department by ambulance. Observations and necessary resuscitation would be commenced while waiting for emergency services.

Staffing levels and caseload

- The staffing levels were defined based on a safer staffing model. Each ward displayed the template level of staffing required for each shift. The actual staff numbers was displayed against this so that patients and relatives could see the levels of staff on any shift.
- Managers or the nurse in charge reviewed the levels of nursing staff every day. If there was a staffing deficit, the nurse in charge would order agency nurses to cover the shortfall.
- Staff vacancy levels were low in the inpatient units. Where there was sickness absence, ward managers told us that they were often able to fill shift with their own staff working extra shifts. Staff that agreed to work extra shifts were paid or offered time in lieu. When staff shortages could not be filled with trust staff, managers could authorise the use of agency nurses. Agency nurses that we spoke with had completed a ward induction and had worked on the ward before and were familiar with the unit. When necessary, agency nurses were block- booked to provide a continuity of care.
- Patients told us that the nursing staff were very busy but that they received the help they needed. Some patients commented that when they used the call bell it could take a while for staff to respond.
- There were doctors available to review patients on community hospital wards during 9am-5pm working hours. Outside of these normal working hours staff called the trust's out of hours' service. However, there was a gap in medical cover for inpatient wards, except for West Berkshire Community Hospital, as the out of hours service did not start until 6.30pm. This presented a potential risk to patient safety. This gap in continuity of medical cover had not been highlighted in any incidents.
- Managers told us that recruitment and retention of staff was an on-going issue for the trust, as the county of Berkshire has a high cost of living. Other trusts nearby are able to offer staff extra London weighting payments. Staff whose work base was in Wokingham, Bracknell, Windsor, Ascot and Maidenhead or Slough were paid an additional high cost of living allowance.
- In the nurse led MIU, the nursing establishment was based on a trust staffing model and was sufficient for the current number of patients. The model took account of the requirement of the service and patient safety. Staff told us they were consulted on the agreed staffing levels.
- There were two longstanding vacancies on the MIU, which the unit had not been able to recruit to despite

various initiatives. Staff shortages were filled by the use of agency staff or through flexible working or bank staff. Staff told us that there was on going recruitment for nursing staff through open days.

- The MIU had appointed a part-time accident and emergency consultant who provided medical leadership to the unit. A part time A&E consultant was employed to support the MIU for half day per week for clinical consultations and supervision. The consultant was also available to give advice via email outside of these hours. The administrative and clinical lead of the service welcomed this medical input as it ensured the service was safe.

Managing anticipated risks

- Pressure relief mattresses were provided for patients that were assessed as being at high risk of developing a pressure ulcer.
- There were contingency plans in place for staff availability in adverse weather conditions. Staff that access to a four wheel drive vehicle were on a register held by unit managers.

Major incident awareness and training

- In the MIU there were clear protocols to support major incidents or events and staff were aware of their role. There were flow charts in place and staff were aware of what actions were required.

Good

Are services effective?

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

Summary

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.

We rated effective as good across the community hospital inpatient units.

- Care was planned and delivered to meet patients' needs and was based on clinical evidence and national guidelines.
- Assessment tools and resources developed by the trust were also based on national guidance.
- Policies and guidance had been produced for staff on the prevention of pressure ulcers, the management of falls and nutrition for adults.
- In the minor injuries unit (MIU) staff used on-line guidance to ensure that care and treatment was delivered in line with best practice.
- Pain relief medicines were given to patients that required them. The effectiveness of pain relief was checked. In the MIU pain was assessed as part of the triage process. Patients with pain were immediately referred to a nurse by reception staff.
- Foods of different textures or for special diets were available quickly. Patients' dietary requirements were identified and communicated by staff. Patients were able to sit together to eat in designated dining areas. Patients that required assistance with eating were given appropriate help.
- There were systems in place to collect patient outcome information and rehabilitation outcomes. The trust participated in national audits.
- Ninety six per cent of staff had received an appraisal in the previous year. Staff were positively encouraged to participate in training and development activities. There were appropriately qualified staff in MIU that could prescribe medicines.
- Multidisciplinary team meetings occurred weekly in all community hospitals. These meetings included doctors, nurses, therapists, pharmacists and discharge coordinators. Therapy teams worked in conjunction with nursing staff to provide active rehabilitation for patients. Occupational therapists and physiotherapists jointly assessed patients where possible to improve communication and goal setting for patients. The MIU communicated effectively with other services such as the out of hour's service and other local hospitals.
- Each ward discussed complex patient discharges at MDT meetings. For Wokingham, Oakwood and West Berkshire Hospitals there was a discharge coordinator that supported these and led planning for complex discharges. An Integrated Discharge Team based at the Royal Berkshire Hospital worked with the wards to facilitate admissions.
- Patients were admitted to community hospitals by their GP, community matron or from acute hospitals. There was good communication between the ward staff and the community nursing teams.
- Patient records were stored securely but were accessible to staff in all locations. Information about patients' risks such as falls or pressure ulcers were displayed prominently for staff, identities were protected. Relevant patient records were stored electronically on the discharge of a patient; this ensured that community staff had access to the full care record.
- Staff had participated in training and understood the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. Staff requested consent from patients before carrying out examinations, observations or care. Staff were aware of the process for documenting decisions made in a patient's best interest where they were assessed as lacking capacity.

Detailed findings

Evidence based care and treatment

- Staff were aware of National Institute for Health and Care Excellence (NICE) guidelines for the assessment and treatment of pressure ulcers. The tools devised by the tissue viability team in use across the trust were based on this national guidance. All patients had a pressure ulcer risk assessment score on admission with a review at least weekly.

Good

Are services effective?

- We found evidence that staff took account of evidence based NICE national guidance. For example, 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 and was in line with the NICE clinical guideline 32 'nutrition support in adults, oral nutrition support, enteral tube feeding and parenteral nutrition'.
- The falls programme for exercise was an evidence-based programme which was well organised, implemented and compliant with NICE guidance.
- In the minor injuries unit (MIU) staff routinely used up to date online guidance to ensure the care and treatment provided was according to best practice.
- All policies and procedures seen made reference to the NICE guidelines and staff had access to these policies. For example, the nutrition policy made reference to NICE guideline CG32, nutritional support for adults.

Pain relief

- Staff discussed the need for pain control with patients and assessed their level of pain. There was a pain assessment tool completed and included in patient records. Patients told us their pain was well managed and they received pain relief medicines when required.
- Patients were monitored for signs of pain after pain relief was given. All patients spoken with said they were getting their pain relief as and when needed. For example, we observed a nurse asking a patient if they needed pain relief. The patient said yes. The nurse gave the prescribed medicine then asked the patient about their pain and if they required anything stronger (as this was also prescribed).
- The pain score was recorded on the early warning (NEWS) chart, to monitor whether it was an on-going problem or an unmet need. The results were escalated to medical staff if a patient's pain was not managed adequately with prescribed medicines.
- In MIU staff assessed patients for their levels of pain during the triage process. There were no formal pain scoring tools in place. However, we found receptionists did ask patients if they were in pain, if the response was yes, they were immediately referred to a nurse for further treatment. Pain relief medicines was administered, as required, under patient group directions (PGDs).

Nutrition and hydration

- Staff on the wards enabled patients to have sufficient time and provided help with eating, by ensuring 'protected mealtimes'. This meant that other activities and appointments were suspended over mealtimes.
- For patient that required hydration and nutrition monitoring, food and fluid intake were recorded by staff. Patients were also weighed weekly to ensure that weight loss was detected.
- Food and drinks were available for patients over 24 hours. In addition to hot meals there were extra sandwiches and snacks provided for patients if they required these out of hours'. Staff could offer pre-prepared meals that could be heated up for patients outside of patient mealtimes.
- Food was provided by an external contractor and was heated on the premises. There were appropriate safety checks in place to ensure that food was safe, including audits of food temperatures.
- Staff assessed patients for their swallowing and foods of different consistencies were provided to suit patients' specific swallowing needs.
- Meals for patients requiring special diets could also be provided very quickly.
- Patients told us that they liked the food that was offered. They also commented that other food choices were provided if they did not like what was on the daily menu.
- Data provided by the patient feedback 'PLACE' survey of the in-patient wards (2014) showed that the trust had performed better than the 97% England average for food. All areas scored 100% with the exception of Wokingham community hospital (93%). The hospital had improved the presentation and quality of assistive crockery designed to help patients feed themselves.
- On the Oakwood unit each patient's specific dietary requirements were highlighted on their room nutrition board. This helped remind staff of each patient's specific needs.
- At all of the community hospitals there was a space in which patients could sit together to eat. Patients were actively encouraged to take their meals in the communal dining room to promote activity and reduce social isolation. Staff told us that many patients needed encouragement to do this, but once they had been to

the dining room they were happy to continue to go. This was considered particularly important at the Oakwood unit where patients were accommodated in single rooms.

Patient outcomes

- At all the hospitals, therapists used the Derby outcome measures tool to monitor patient progress toward rehabilitation goals. The Derby outcome measures are used to objectively determine the baseline function of a patient at the beginning of treatment. The tool is then used to record progress and the effectiveness of the therapy. The therapy teams had only recently started to collect this data as a key performance indicator and were not aware of any results as yet.
- The trust participated in audits such as the national diabetes audit and intermediate care audit and chronic obstructive pulmonary disease audit and sentinel stroke national audit programme.
- The MIU undertook clinical audit of treatment protocols. For example, clinical audits on radiology reporting were undertaken to ensure the unit followed national guidelines.

Competent staff

- Trust data showed that 96% of staff had received a values based appraisal in the previous year. Staff told us their professional development was supported and encouraged through the appraisal process. Staff told us they were supported to attend courses to support their roles as ward champions, for example with pain management and care of people living with dementia.
- At Prospect Park Hospital, where mental health older people's wards and the Oakwood unit were on the same site, joint training took place with mental health and physical health ward staff. This training was designed to raise awareness and understanding of providing physical and mental health care, for elderly patients. Staff that had experience of caring for people with a learning disability were also encouraged to participate.
- Staff volunteered to become ward champions for many aspects of clinical care such as tissue viability, pain and falls. These staff received additional training and acted as a resource for other ward staff.
- In the MIU staff were experienced and well qualified to be able to work independently in providing diagnoses and treatment for injuries and emergency conditions. Nurses in the MIU had completed a minor injury and minor illness care qualification or an emergency nurse practitioner course.
- Most clinical staff were non-medical prescribers. They were qualified to diagnose and treat the conditions or injuries of patients.

Multi-disciplinary working and coordinated care pathways

- We attended a weekly multidisciplinary team (MDT) meeting at West Berkshire community hospital. This meeting was attended by an occupational therapist, a physiotherapist, and a discharge co-ordinator as well as medical and nursing staff. The multi-disciplinary team discussed all the patients on the ward to review their progress and discharge plans. There was effective communication between staff and actions were allocated to team members. Realistic goals were set in consultation with the patients and often their relatives.
- A pharmacist attended the wards three days a week. They were supported by a medicines technician. The pharmacist attended the ward round when able and advised medical staff of prescription of medicines.
- The occupational therapists and physiotherapists carried out joint assessments of patients to prevent duplication of work. This also enhanced care planning and the setting of goals for patients.
- The trust were piloting a therapy assistant role that combined the occupational therapy and physiotherapy assistant roles. This new role enabled each ward to have additional therapy support that contributed to recovery pathways.
- Some occupational therapists we spoke with, felt that their role in rehabilitation of patients had been reduced. This was because of pressure to arrange equipment assessments to support complex discharges. Managers were aware of this and were looking at new ways of integrating therapy roles.
- The MIU had promoted close links with the out of hours' service to enhance communication and understanding of the service they could offer. Patients were sometimes referred from the out of hours' service.
- MIU staff told us they worked collaboratively with other professionals. For example, they had good relationships with other health professional teams on the wards at a nearby hospital. They told us other health and social services could always be contacted for advice.

Good

Are services effective?

Referral, transfer, discharge and transition

- Each ward discussed complex patient discharges at MDT meetings. For Wokingham, Oakwood and West Berkshire Hospitals there was a discharge coordinator that supported these and led planning for complex discharges. Discharge coordinators worked closely with the MDT to support effective, safe discharge decisions. Patients had an estimated date of discharge displayed above their bed, this was discussed with the patient at the MDT. This date was reviewed after each MDT meeting.
- Patients were admitted to community hospitals by their GP or through a waiting list managed by the trust on behalf of acute hospitals. Patients that were registered with a GP in West Berkshire could be admitted directly and remain under the care of their own GP.
- When patients were discharged back to their own home and there was concern about their ability to manage independently, it was possible for a bed to be held on the ward for 48 hours. This prevented complex readmission procedures.
- There was good communication with community services and patients and their relatives to facilitate discharge from hospital. Discharge planning and information was available to the community nurses and social services.

Access to information

- Key information about each patient was recorded onto prominent white boards. These were used to show the location and key risks of each patient. Patient names were either shortened to initials, or covered with a hinged flap to protect their identities. This system provided 'at a glance' reference information for staff.
- Patient records were completed on paper. On the discharge of a patient, relevant records were stored electronically, this ensured that community staff had access to the full care record. This meant that community nursing and therapy staff were able to access the full hospital record of the patient.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Eighty nine per cent of staff had completed mandatory training on the Mental Capacity Act, this course included consent. There was separate training provided on the Deprivation of Liberty Safeguards (DoLS) 86% of inpatient ward staff had completed this training.
- Staff understood the impact of the Mental Capacity Act on patients and were able to tell us how they would support patients' to make decisions.
- We observed that patients were asked for their consent before observations, examinations or care was carried out.
- Staff understood the legal framework underpinning DoLS and how to seek authorisation. Data on the applications for DoLS provided by the trust showed that of eight applications only one was declined across community health services.
- If patients lacked mental capacity, staff were aware of the processes to record decisions made in the patient's best interest.
- In MIU staff told us they had attended training about their responsibilities relating to the Mental Capacity Act best practice guidelines and Deprivation of Liberty Safeguards. Staff we spoke with were aware of the Deprivation of Liberty Safeguards policies and procedures.
- We spoke with patients after their visit to the unit and they told us that clinical staff had sought their consent prior to examination.

Good

Are services caring?

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

Summary

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

We rated caring as good across the community hospital inpatient units.

- We observed patients being treated with care and compassion by staff. The privacy and dignity of patients was maintained at all times. Patients told us that the staff behaved in a caring and respectful way towards them. They told us that the standard of care provided in community hospitals was high.
- On the minor injuries unit patients told us that they were treated with kindness and received a high standard of care from staff. They told us that staff spent time with them assessing their needs and providing care and treatment in an unhurried way.
- Patients told us that they were involved in decision making about their care as much as they wanted to be. Patients and relatives were involved in all decisions, in the setting of goals and planning for their care and discharge. Patients and their relatives were given appropriate emotional support by the staff when needed. Therapists helped patients to regain independence and confidence through active patient centred therapy. There was support available for patients of all faiths accessed through the chaplaincy service and by a network of volunteers.
- In the MIU staff took time to discuss patient's fears and anxieties about their care and treatment.

Detailed findings

Compassionate care

- We observed staff treating patients with compassion and care. Their privacy and dignity were maintained at all times. On the inpatient, wards staff ensured curtains were closed before they provided any personal care and other staff always checked if they could enter. On the MIU staff checked rooms before entering to ensure other staff were not treating patients. Treatment was provided in private rooms to maintain the privacy and dignity of patients.
- The needs of patients were assessed as well as their preferences. For example, at one community hospital, sisters had been admitted and kept together as this was their preference.
- Confidential information about patients was respected and protected by staff.
- We observed that staff spent time with patients, and supported them in an encouraging and respectful way. For example, at meal times we observed staff asking patients if they would like to use a disposable apron to protect their clothes before giving one.
- Patients in the minor injuries unit (MIU) told us that staff were kind and treated them with respect. Patients spoke highly about the care, treatment and support they received.
- The patients attending the MIU told us that staff spent a considerable time in assessing their needs and providing treatment and advice. Patients told us they were given time to explain their injury and background information.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in decisions about their care and treatment as much as they wanted to be. They said their treatment and care was explained to them in a way they could understand.
- Relatives assisted staff to understand patients' preferences by helping the patient to complete a 'this is me' document. This then help inform staff how care should be carried out.
- In the MIU staff spent time asking patients about their pain and other concerns. They made sure patients understood the questions they asked.
- We spoke with five patients who told us they were all given full explanation before their treatment was carried out. Patients also told us they were asked before they left if they had any concerns about their care before they were discharged.

Good

Are services caring?

- We observed a registered nurse instructing other staff in the use of hand massage. The treatment was being promoted to staff so that they could give hand massages to patients, especially those who got few visitors.

Emotional support

- Patient records reviewed showed that patients and relatives were given a range of emotional support by staff. For example, time to discuss with them how they would manage independently or accept care assistance after discharge. Patients and their relatives were also supported during difficult conversations about prognosis or planning a residential placement.
- The therapists helped patients to develop their independence and regain confidence.
- Chaplaincy support was available for patients' this service could be accessed at any time. There were regular visits from trust chaplains and clergy from churches local to the hospital sites. There was support for patients of many faiths through a network of volunteers.
- In the MIU, staff were attentive and empathetic when treating patients. We observed a nurse gave sufficient time to allow a patient to discuss fears and anxieties around their treatment. In this way, the nurse gained the trust of the patient that helped facilitate treatment.

Good

Are services responsive to people's needs?

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

Summary

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

We rated responsive in community hospital inpatient units as good.

- The trust had open and transparent relationships with its commissioners. The service worked with GPs to design services for patients living with long term conditions. Medical staffing on one ward at West Berkshire community hospital was provided by GPs on a rota. GPs had direct access to these beds where the patients were registered in West Berkshire.
- A waiting list system operated for patients that required admission to community hospital wards from acute hospitals.
- All the wards provided activities for patients. The Oakwood unit, West Berkshire Community Hospital and Wokingham Community Hospital had activity coordinators. Dedicated facilities were provided for patients' activities.
- The minor injuries unit (MIU) had a service specification to ensure that appropriate patients were treated in the unit.
- The trust had policies in place to ensure that staff and patients diversity was respected. Chaplaincy support was available for people of different faiths. Wards and facilities were accessible to patients, relatives and staff with physical disabilities. The trust provided access to translators and interpreters for patients whose first language was not English. Patients who communicated with sign language could also be supported.
- Staff were able to recognise patients that were vulnerable and explain their responsibilities for adult safeguarding. There was access to other trust staff for advice or assessment for patients with a mental health problem or learning disability. Ward facilities in community hospitals were suitable and accessible for patients living with dementia. In the MIU patients with a learning disability or dementia would be seen as a priority by an emergency nurse practitioner.
- Patients admitted to community hospital wards were promptly assessed by medical and nursing staff. However, out of hours' medical assessment could sometimes be delayed.
- Therapists at Upton hospital had access to a car, this allowed them to carry equipment and convey patients in order to carry out assessment visits.
- The bed occupancy for all but two community hospitals was above the trusts' target of 85%. There were 388 delayed transfers of care from community hospitals in the past six months. The main reason for this was the availability of nursing home placements for patients that had been assessed as requiring them.
- The MIU assessed all patients in emergency ambulances in 15 minutes which is above the national target of 95%. For routine patients, 88% were assessed within an hour, this exceeded the national target of 50%.
- Patients and relatives had access to information on making a complaint about the inpatient service. The wards made changes in response to patient complaints and feedback. There had been an increase in complaints in 2014/15 on the previous year. However, the number of complaints that were upheld remained the same. There was evidence that learning occurred after the investigation of incidents, this was shared across the trust. There were a low number of complaints about the MIU service at West Berkshire Community Hospital.

Detailed findings

Planning and delivering services which meet people's needs

- The trust had effective relationships with the clinical commission groups (CCGs), with frequent two- way conversations about progress towards quality targets. Trust senior managers invested time in developing these relationships and sharing information about local clinical needs. The CCGs were positive about their relationship with the trust.

Good

Are services responsive to people's needs?

- The trust worked with seven CCGs to plan and deliver services across the population of Berkshire. Senior managers told us that differences in commissioning arrangements were always mitigated so that patients were not aware of any differences.
- The service also worked with GPs to design services for patients with long term conditions. The inpatient beds were accessible to GPs and community matrons. The medical cover for Highclere ward at West Berkshire Community Hospital was provided by local GPs, who worked an on-call rota to clerk admissions to the ward. They had direct access to the beds for patients registered in West Berkshire.
- All wards within community hospitals provided activities for patients. This was seen as part of rehabilitation and was valued by the patients. There were a range of activities available such as arts and crafts, board games and bingo sessions.
- The Oakwood Unit, Wokingham Community Hospital and West Berkshire Community Hospital had activity coordinators to plan and provide activities for patients.
- To prevent the isolation of patients in side rooms, activity coordinators and therapy assistants would ensure that activities were provided to them.
- The MIU was commissioned by the West of Berkshire CCG's. The unit had a service specification that included admission criteria, outlining the types of injuries and circumstances that would lead to the use of the minor injury service.
- The MIU would see and treat patients with a range of minor injuries for example, allergic reactions, dislocation of fingers and toes, small lacerations and foreign bodies in the eye, ear or nose. The unit would also treat uncomplicated fractures (there was access to X-ray facilities), minor injuries after road accidents and sports injuries.

Equality and diversity

- Policies were in place to ensure that the equality and diversity of staff was respected.
- There was a multi-faith room at Prospect Park Hospital known as the sanctuary, and a chapel at West Berkshire Community Hospital. These facilities were open 24 hours a day. It had resources to support worship of different faiths and there was a service held each Sunday that was suitable for all faiths.
- Chaplaincy support promoted cultural awareness and diversity. The chaplaincy service had volunteers to ensure that patients could access support from a range of faiths.
- The wards, therapy and dining rooms were accessible to patients with physical disabilities.
- A translation service was available if required and staff knew how to access it. There were no signs in other languages that would suggest to patients who did not speak English that they could access an interpreter.
- The trust provided sign language interpreters if needed.
- Printed resources were available in different languages when requested.

Meeting the needs of people in vulnerable circumstances

- Since the trust had integrated, medical and nursing staff told us accessing assessments from mental health colleagues had improved significantly. Staff reported they could easily access advice and assessment for patients that had a learning disability or mental health need.
- Ward facilities were designed to be dementia friendly as much as possible. This was difficult due to the age of some of the buildings, but refurbishments had been sensitive to the needs of people living with dementia. Dementia care guidance and information was available to patients and relatives.
- Data from the patient-led assessments of the care environment (PLACE) showed the trust scored 94% for dementia; this was considerably above the England average of 75%.
- Staff were identified on a picture board; this explained their individual job roles to patients and visitors. There was also a board to describe the different uniforms and roles of staff.

Good

Are services responsive to people's needs?

- In the MIU patients living with learning disability and dementia were seen as a priority by the emergency nurse practitioners. Staff in MIU had received training in learning disability and dementia.

Access to the right care at the right time

- Patients admitted to the wards had a prompt assessment by nursing and medical staff. If patients were admitted out of hours' there may be a delay in being seen by a doctor. Most patients were admitted to hospital in working hours and were seen promptly by the ward doctor.
- During normal hours, GPs or speciality doctors admitted and clerked in patients and offered advice in a timely manner. However, out of hours' and at weekends there were some delays in patients being seen by a doctor and having medicines prescribed.
- Admissions to the community hospital wards from the acute hospitals were managed by a waiting list system managed by the trust. There was daily oversight of community hospital bed availability. The criterion for admission to inpatient beds was that patients required a time limited, intensive, clinically-led period of inpatient care. However, this was flexed when the service was required to be responsive to the bed state of the acute hospitals. This sometimes meant that patients with limited rehabilitation potential were admitted to inpatient beds.
- Occupational therapists at Upton hospital used a trust vehicle to take patients home on assessment visits. As this was a trust vehicle, equipment to use in the assessment could be taken with the patient. This reduced the requirement for repeat assessment visits by the therapy teams.
- The bed occupancy within the community hospitals had been significantly higher than the national average of 88% over the past year. The trust target for bed occupancy was 85%. The highest was at Donnington ward, West Berkshire community hospital, at 95%. The lowest was at The Henry Tudor ward at St Mark's hospital 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.
- The trust reported a total of 388 delayed transfers of care over the past six months. Donnington and Highclere wards at West Berkshire community hospital had the highest number of delayed discharges at 148. The Oakwood unit had 130 delayed discharges and 92 at the Windsor and Ascot Wards at Wokingham Hospital. The main reason cited for this was awaiting the availability of a nursing home placement.
- Patients we spoke with during the inspection of the MIU were happy with the waiting time for treatment. We saw audits of waiting times that showed the unit met the local target of the waiting time of all patients to be seen within two hours.
- The MIU had a list of exclusion criteria and if any patients attended with ailments such as severe trauma or stroke, staff would assess them but also call for an ambulance to convey them to a local A&E department for appropriate treatment.
- An advanced nurse practitioner saw patients generally within 10 minutes of presentation and a clinical assessment was undertaken. Through this, patients were seen based on the urgency of their condition.
- All patients were seen by reception staff on arrival and clinical staff alerted to any patients in need of urgent attention. The MIU assessed all emergency ambulance patients within 15 minutes.

Learning from complaints and concerns

- "Learning from experience" 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 that there had been an increase in the number of complaints received in 2014-15, however the percentage that were upheld remained very similar at 45%.

Good

Are services responsive to people's needs?

- Staff logged complaints on the trust's reporting system. Following investigations the outcomes were discussed at staff meetings and action plans developed and shared with staff.
- Patients and relatives were encouraged to speak with senior staff with the aim of resolving concerns locally and quickly.
- Each ward had a 'you said, we did' suggestion board. We were shown examples of where feedback from patients had led to changes. For example, one patient fed back that the custard was unpleasant (cold). As a result, staff introduced insulated jugs to keep the custard hot.
- A patient also fed back that they were bored. This comment was followed up and more activities were arranged to help to combat boredom and isolation.
- Overall, patients told us that they were "very satisfied" with the care they received and had no complaints.
- In the MIU patient information on how to make a complaint were clearly visible throughout the reception and waiting areas. The MIU monitored complaints and there were very few complaints about the MIU service.

Good

Are services well-led?

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

Summary

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

We rated well-led as good across community hospital inpatient units.

- Staff understood the core values of the trust as well as the vision and strategy for inpatient services.
- Each ward produced and shared its improvement plan for the current year.
- Staff on the minor injuries unit (MIU) were clear about the purpose and specification of the unit. This ensured that inappropriate referrals to MIU could be redirected to the correct service.
- There were effective governance arrangements in place to monitor quality, performance and patient safety.
- Staff shared information about incidents, complaints and risk at regular governance meetings. We found that there was good communication of learning from incidents and best practice guidance.
- There was a system of audits in place to measure quality; these were monitored by senior staff.
- Risk registers were used to record identified risks and actions put in place to mitigate them. Staff were aware of the key risks in their areas.
- Local leadership was visible and staff told us that they felt supported. Senior leadership, although less visible were known to staff that spoke highly of them. Senior staff conducted audits of inpatient wards. Managers were given a report with observations and praise for staff.
- There was an open culture across the service with staff confident to raise concerns about patient safety with managers. We found motivated and proactive clinical leadership across most wards we visited. Staff generally told us they felt well supported and in-touch with broader trust strategy and issues. Many staff we spoke to told us they enjoyed working in the community hospitals. Locum medical and nursing staff told us that they would be happy to return in future if required.
- The trust had effective systems and processes to capture feedback from patients. Information from this was used to improve patient care. We found that staff were engaged with the trust and valued the opportunity to be involved in quality improvement projects.
- There was an innovative development in the scope and role of therapy assistants, designed in increase the impact of rehabilitation interventions.

Detailed findings

Service vision and strategy

- Staff were able to tell us the core values of the trust. A values based appraisal system had been implemented that helped ensure staff were familiar with the values. Community hospitals had posters that reflected and explained the trust core values to the staff, patients and visitors.
- Staff we spoke with were confident about both the leadership and the long term strategic direction of the trust. Each community hospital displayed a summary of their service plan for the year. This was presented as a 'plan on a page', progress towards the ward plan was discussed at staff meetings.
- There were was a vision to more closely integrate nursing and therapy into an overarching rehabilitation model that included all staff. One of the newly appointed ward leaders was a therapist by background. This appointment was part of this vision.
- Staff on the MIU were clear that the unit was a minor injuries unit and not a step down emergency department. This clarity was welcomed by staff.
- In the MIU staff were aware of the service that was to be provided as commissioned for the local population. Staff were also aware of the context of the MIU service in relation to GPs, out of hour's services, and local emergency department provision.

Governance, risk management and quality measurement

Good

Are services well-led?

- Governance arrangements to monitor quality, performance and safety were in place.
- Governance meetings were attended in each locality on a monthly basis. In addition to learning from incidents these meetings were used to share information about complaints, best practice guidance, service risks and developments.
- The inpatient services had risk registers that were held at locality level. Staff were aware of the risk register and items that were on it.
- Larger meetings that included representation from East and West Berkshire were scheduled every quarter. These meetings ensured that learning was shared more widely across the geography of the trust.
- There was a system of audits in place to monitor quality. Audits were carried out on medicine administration, medicines management, the use of NEWS scores on rehabilitation patients.
- The director of nursing and governance reviewed a range of quality indicators on a monthly basis. For example, a fall where the patient is found on the floor (an unobserved fall), developed pressure ulcers and medicine related incidents.
- The Trust started an initiative to reduce omitted medicine doses 12 months ago. We saw evidence of audits being conducted on inpatient wards and changes in practice as a result. For example, medicine charts were checked at handover or by a colleague after medicines round. As a result of this we found a low incidence of omitted doses on inpatient prescription charts.
- Matrons attend the Patient Safety and Quality meetings where medicine incidents are sometimes discussed.
- In the MIU there were clear governance arrangements in place. Monthly clinical governance meetings took place and staff were invited to these to share their ideas to improve the service.
- The MIU had a risk register in place. The recruitment of appropriate staff had been identified as a risk and the unit tried to recruit more staff more staff but without any success.

Leadership of this service

- Staff described ward leaders and matrons as approachable and always able to spend time with staff to discuss concerns.
- Ward leaders felt well supported by their locality managers, and were given sufficient autonomy to make beneficial minor changes in response to patient and staff feedback.
- Ward managers and matrons were highly visible to staff. Locality managers were also visible, but less so to the junior staff.
- Many staff had met the chief executive and told us they found him approachable and spoke highly of him.
- Senior managers conducted a 'fifteen steps' audit every other month, during which they visited ward areas to assess the patient experience. Feedback reports were given to all ward managers, praising good practice and making recommendations for continuous improvements.
- The trust was supportive of staff to develop their leadership and management skills. Staff at band 6 level and above were encouraged to enrol on the trust management course.
- Recently (November 2015) the trust reconfigured the nursing leadership of the MIU by appointing a matron to be the overall person in charge of the department. Staff we spoke with welcomed this appointment as it was felt this would give the unit one individual responsible and accountable for safety, quality and finance. The newly appointed matron was responsible for the overall quality of the service.
- Staff told us that although the matron had taken up the role recently, they felt there had been a positive impact on the quality of the service. For example, there was increased input from the A&E consultant in supporting nursing staff with their professional development. There were also new quality audits introduced including the audit of clinical care.

Culture within this service

- Staff told us that they were proud to work for the trust. Staff were aware of the importance of their service to local communities and were proud they provided a service that met local needs. There was a high level of staff engagement with specific areas of patient care, such as the ward champion roles for specific aspects of patient care. Ward champions received extra training and were valued as a resource by their colleagues.
- There was an open culture, with staff telling us that they would feel safe to raise a concern about patient care.

Good

Are services well-led?

- The trust had a quality priority objective to foster an environment where staff are confident to raise concerns about patient safety. In all wards patients, relatives and staff were encouraged to share concerns with ward leaders. Staff told us that ward leaders were supportive of their safety and wellbeing. They said they would be confident to approach them with safety concerns.
- The trust rewarded staff with a cake, presented by the chief executive or director of nursing, on wards where there had been no pressure ulcers for a year.
- We found proactive clinical leadership in all of the community hospital wards. Staff told us that they felt valued by leaders, and they were informed about trust level issues. There was a high level of staff satisfaction and engagement from data provided by the NHS staff survey.
- Support staff also told us they felt the ward leaders would listen to their concerns and made them feel an important part of the team.
- Locum doctors and agency nurses told us that they enjoyed working at the community hospitals due to the good communication and friendly atmosphere.

Public engagement

- 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 "you said / we did", showing how staff had made changes in response to feedback.
- Data from the staff survey confirmed that staff said feedback from patients was used to improve patient care.
- There were on-going campaigns to recruit volunteers to help patients at community hospitals. Staff told us their support made a big difference to patients' wellbeing. The coffee shop at St Mark's hospital was provided by the Royal Volunteer Service that contributed to the provision of hospital facilities.

Staff engagement

- Staff opinion data from the Friends and Family Test told us that 68% of staff recommended the trust as a place to work; this is above the England average of 63%. 81% of staff would recommend the trust as a place to receive care, the England average is 79%.
- Staff were involved in planning and improving services through the 'Listening into action' programme across the trust. For example, the staff on Highclere and Donnington wards rotated through both wards in order to develop similar routines and harmonise the use of patient documentation across both.
- Data from the NHS staff survey showed there was a high level of staff engagement. Staff had a good knowledge of improvement plans in their wards and felt involved in processes.
- Staff were kept updated through the trust intranet 'Team net' where key information was shared.

Innovation, improvement and sustainability

- There was the development of therapy assistant roles that would work across the disciplines of occupational therapy and physiotherapy. These were rotational and intended to increase the levels of skill of the assistants and increase the time patients spent on therapeutic activities.