

Harrogate and District NHS Foundation Trust

RCD

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)
RCD02	Ripon and District Community Hospital	Trinity Ward	HG4 2PR

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated community inpatient services as requires improvement. This is because:

- We saw that community inpatient services were caring and responsive. However we found the service required improvement for safe and effective care and also required improvement for well led. The care provided did not always focus on patient rehabilitation and reablement.
- Feedback from patients and relatives was very positive and we observed staff to be compassionate and caring in their approach. Patients were not empowered to take control of their rehabilitation.
- We saw evidence of good multi-disciplinary working across nursing, therapy and medical teams but there was a lack of leadership within the multi-disciplinary team which meant that plans of care for individual patients were not clear or focussed or holistic.
- The service did not provide an effective rehabilitation service. It was not performance managed or monitored and lacked leadership.
- There was a lack of consistent therapy input as the therapy staff working in a community team that responded to crisis intervention in the community.
- Medicines management was generally good but patients were not offered the chance to manage their own medication as a means to prepare for leaving the hospital environment.
- Patient records were well managed and national guidelines were followed for falls prevention and pressure ulcers. However there were some gaps in the management of patients' nutritional needs and a lack of documentation to support what actions had been taken to meet these needs. Patients' notes and records were not securely stored.
- Staff felt involved in patient care, mandatory training was managed well and some staff had received appraisals.
- Most staff followed infection control procedures and all areas we inspected were clean. There was not a comprehensive or robust system in place for the maintenance, servicing and safety checking of electrical equipment on the ward.
- Food and fluids were within patients' reach and most patients told us they enjoyed the food provided and were supported if necessary. Patients felt safe and cared for during their stay and staff were sensitive, compassionate and maintained dignity and respect for their patients.
- Patients and their relatives were not given adequate information about their environment, the purpose of the ward and what to expect during their admission or on discharge from hospital.
- The ward environment was challenging due to the age of the building and the layout in terms of space and visibility of patients. There had been no reasonable adjustments made to the environment for those patients living with dementia.
- Admissions and discharges were well managed although the ward team sometimes felt under pressure to accept patients who did not meet the full admission criteria, particularly those with dementia or confusion. Delayed discharges were mainly due to family choice, lack of nursing home places and waiting for packages of care to be put in place.
- The service received very few written complaints and was very much appreciated by the local community. The hospital was extremely well supported by the local Friends of Ripon Hospital committee who have raised many thousands of pounds to support the care and comfort of patients using the service.

Summary of findings

Background to the service

Information about the service

Harrogate and District NHS Foundation Trust provide community inpatient services for the populations of their local communities on Trinity ward, which is a nurse and therapy led rehabilitation and re-enablement unit at Ripon and District Community Hospital. The unit has been part of the urgent, community and cancer care directorate since the trust re-configured its management structure in April 2015.

The population profile of the area is that of an ageing one and thought by the commissioners of services in the area to be a decade ahead of the national ageing average curve. There are 1:5 people currently aged over 65 years, this proportion is set to increase to 1:3 over the next twenty years.

As part of the proposed New Care Model, the service is to be involved in and part of the Harrogate and Rural District Clinical Commissioning Group vanguard, which is made up of the following organisations; Harrogate and District NHS Foundation Trust, Harrogate and Rural District CCG, North Yorkshire County Council, Tees, Esk and Wear Valleys NHS Foundation Trust, Harrogate Borough Council and the Yorkshire Health Network.

The purpose of the vanguard is to deliver access to advice and information for individuals in crisis 24/7 without defaulting to hospital accident and emergency departments as the first point of contact. The aim is to provide support to people to remain independent, safe and well at home with care provided by a team that the person knows they can trust and encompassed in a universal care plan. This service will be provided by community hubs and an integrated team which includes

GPs, community nursing, adult social care, occupational therapy, physiotherapy, mental health services and the voluntary sector. It is planned that there will be a community hub in the city of Ripon.

This means that patients, who, for example, have multiple long term conditions and live alone, will have an agreed care plan going forward that people involved in their care share and understand. Patients will be able to access advice and information in times of crisis 24/7 which will be supported to stay in their own home whenever possible.

Patients were admitted to Trinity ward at Ripon and District Community Hospital from the acute hospital wards in Harrogate District General Hospital and occasionally from other hospitals such as York District General Hospital, The James Cook University Hospital in Middlesbrough and the Friarage Hospital at Northallerton. Patients could also be admitted from the community as a step-up facility, avoiding acute hospital admission or for end of life care. The ward is a mixed sex rehabilitation ward with 16 beds with appropriate segregation with the physical capacity to increase to 20 beds. This included two dedicated palliative care beds in a separate part of the ward specifically for end of life care. There was a plan to increase the number of beds used to 20 the week after our inspection pending additional nursing staff being available.

The ward provided rehabilitation for adults over the age of 18, following falls, infection, fractures, amputation or neurological conditions. Most patients were elderly but the ward occasionally cared for younger adult patients. The average length of stay in the service in the seven months prior to our inspection was 27 days. At the time of our inspection there were only 14 beds occupied due to higher patient dependency.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Independent Chair

Head of Inspection: Julie Walton, Care Quality Commission

Team Leader: Karen Knapton, Inspection Manager, Care Quality Commission

Summary of findings

The team included CQC inspectors and a variety of specialists including a senior community inpatients nurse.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by

the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 2 to 4 February 2016, at Ripon and District Community Hospital, Trinity ward.

We spoke with seven patients, two relatives, eleven staff and reviewed 11 patient charts. We also reviewed six sets of medical notes and 11 nursing/therapy records during our inspection. We also observed a nursing handover, a medication round, a meal time and a multidisciplinary team (MDT) meeting.

What people who use the provider say

Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered.

The community of Ripon value this local service highly.

Areas for improvement

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

The trust should:

- Ensure that all patients are assessed for VTE risk on admission.
- Carry out pressure area risk assessments consistently and with regular reviews.
- Improve the focus on rehabilitation on Trinity ward.
- Ensure that patients and those close to them are at the centre of the rehabilitation process and have the information they need to facilitate this.
- Enable patients to self-medicate to facilitate rehabilitation.
- Ensure that good practice, learning and improvements achieved elsewhere in the trust is shared across all units.
- Ensure that staff assess patient's nutritional needs accurately and follow the appropriate plan of care if a risk of malnutrition is identified.

Harrogate and District NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the domain of safe as requires improvement. This was because:

- Patients were not assessed for venous thromboembolism risk on admission to the ward from the acute hospital which was a risk to patient safety.
- There were concerns about the maintenance and servicing of some of the electrical equipment on the ward with a lack of assurance that all the equipment had been appropriately checked and was safe to use.
- Some patient records and risk assessments were not always completed regularly or consistently reviewed and updated. Patients' notes and records were not securely stored.
- Reporting and learning from incidents was not well managed. Staff did not always receive feedback or learning from the outcomes of incident investigations.

- Out of hours medical cover was accessed from the local GP out of hour's service and was sometimes unable to respond to requests for patients to be seen in a timely manner on the ward.
- The ward environment was challenging in order to keep patients who were at a high risk of falls safe. There was no assistive technology available to assist in keeping patients safe.

However:

- Trinity ward was clean, tidy and clutter free in most areas and most staff followed infection control principles. There was sufficient and clean equipment available for staff to use.
- Patient records were mostly well laid out and patient risk assessments were completed appropriately on admission for most patients. Nursing handovers took place at every shift change. Medicines management was generally good with pharmacist support.

Are services safe?

- A relatively new management system had seen a reduction in the number of new pressure ulcers. Staff were aware of safeguarding principles and able to follow the correct procedures and most staff had received the full range of mandatory training.
- Nurse staffing levels met national requirements but there had been staff shortages for nurses and therapists. Recruitment processes were well underway with new staff appointed but some not yet in post.

Detailed findings

Safety performance

- The NHS safety thermometer was completed monthly. This measured the occurrence of new and old pressure ulcers, new and old catheter associated urinary tract infections, patient falls which resulted in harm or no harm and venous thromboembolism (VTE).
- The percentage of harm free care ranged from 87.5% in April and August 2015 to 100% in May, June, September and October 2015.
- A total of three new, hospital acquired pressure ulcers was recorded in the six months prior to our inspection: one grade three pressure ulcer in July and another in October 2015 and a grade two pressure ulcer in December 2015. This information was not on display on the ward and there was limited opportunity to feed this back to staff as there had been no ward meetings for some months. The ward Quality of Care meeting minutes in November 2015 stated that a grade 4 pressure ulcer that had been acquired on the ward was being investigated. This was not recorded as a grade 4 on any other information we were provided with. The Quality of Care meeting held in January 2016 referred to a grade 3 pressure ulcer.
- There were six falls between July 2015 and January 2016 none of these were reported to have caused any harm to patients. These averaged one incident per month with a peak in October 2015 when there were two reported falls.
- There was a large whiteboard on the ward displaying information about falls and pressure ulcers for the current month.
- The service did not undertake VTE risk assessments on patients that transferred from other hospital settings. Staff said this did not happen as this had already been undertaken in the previous clinical area. This is not in line with the National Institute for Health and Care Excellence (NICE) guidance (clinical guideline CG92) and patients could be at risk of developing a venous thromboembolism.
- A doctor would undertake VTE risk assessments on patients who had been admitted as a step-up from their own homes. There were no patients admitted via this source on the ward at the time of our inspection.
- There had been no incidents of Never Events which are incidents determined by the Department of Health as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The ward participated in the trust's monthly saving lives audits. Compliance had been good between April and September 2015 at over 95% compliance although there were some months (May and June 2015) when the data had not been submitted.
- During the Quality Review of Trinity Ward in August/September 2015 it was found that a patient receiving a blood transfusion as a day case on 28 August 2015 did not have the appropriate documentation for the insertion of a cannula. Actions were recommended to resolve this from happening again but this was not recorded in the Quality of Care meetings minutes neither was it reported as an incident.

Incident reporting, learning and improvement

- Incidents were reported using the trust electronic recording system. Staff were trained how to identify an incident or a near miss and how to use the system. We found that staff were confident to report incidents.
- There had been some recent improvements to the governance arrangements and staff told us they were informed of incidents and outcomes by e-mail bulletins. There had been no team meetings held on the ward. Therefore this was not a method used for cascading information to staff about incidents and any action planning required or implementation of new processes.
- There were 142 incidents recorded on the trust's electronic system for this service between September 2014 and October 2015. None of these resulted in severe harm, nine resulted in moderate harm, 26 in low harm and 107 no harm. Most incidents (70) related to patient injuries/incidents and of these 40 were falls and 12 were pressure ulcers.
- The trust completed Root Cause Analysis (RCA) investigations on serious incidents. The locality

Are services safe?

manager undertook the investigations that related to Trinity ward and was required to do these within a set timescale. The matron and the locality manager supported staff in dealing with incidents and provided feedback to all the ward staff via email.

- We did not see any evidence of cross directorate learning as a result of incidents that may have occurred elsewhere in the organisation. Elderly care was in a different directorate (integrated care) to Trinity ward and it is possible that valuable learning from other areas was lost.
- In November 2014, the duty of candour statutory requirement was introduced and applied to all NHS Trusts. The trust had a policy in place relating to the new requirement and provided evidence of communication with staff in the form of a staff bulletin in August 2015. They had also used the intranet screen saver to promote the requirements.
- The trust had also informed staff about the duty of candour via an information leaflet. There was also a trigger on the electronic incident reporting system. The trust told us that this regulation was also now included in the induction programme for staff.
- Most of the staff we met understood the term Duty of Candour and its meaning in practice, particularly the more senior members of staff. All staff were aware they needed to be open, honest and demonstrate transparent behaviour. They knew they must communicate with patients and families when incidents occurred.
- Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services provided to patients. Serious incidents should be reported on the Strategic Executive Information System (STEIS) within two working days and reported to the National Reporting and Learning System (NRLS) or regulator as appropriate.
- Only one serious incident was reported between January and December 2015 from this service to the Strategic Executive Information System (STEIS). This was in relation to a grade three pressure ulcer.
- The ward were trialling a sensor to prevent falls in high risk patients with a view to purchasing a sensor in the future.

Safeguarding

- The trust lead for safeguarding was the chief nurse. There was also a designated safeguarding doctor and nurse.
- Staff told us that they completed safeguarding training as part of statutory mandatory training. Information supplied to us by the trust showed 96% compliance for safeguarding children Level 1 training, 91% compliance for safeguarding children Level 2 training and 91% compliance for safeguarding adults Level 1 training.
- Staff were able to identify the circumstances when an alert to the safeguarding team would be required. All staff we spoke with were aware of the safeguarding process and were able to give examples of this through experiences.

Medicines

- We found that medicines were stored securely and appropriate emergency medicines were available.
- There was no piped oxygen on Trinity ward. There were eight large oxygen cylinders stored in individual wheeled trolleys in a locked cupboard on the ward with the appropriate signage on the door. The hospital porter was responsible for checking the cylinders daily and completed a check list. The nurse in charge of the ward had access to the cupboard at all times. There were no patients using oxygen at the time of our inspection.
- We checked the storage of controlled drugs and looked at the daily recording book and found this to be correct and had been checked on a daily basis.
- Refrigerators used to store medicines were checked daily to ensure that the temperatures were appropriate. We saw records of this and there was only one omission noted in January 2015. Staff could describe the procedure if there was a recording that was out of the safe range.
- There was also a blood fridge in the locked room where medicines were kept. This was checked three times daily. Records showed that this had taken place.
- The service used an electronic prescribing and administration system. This was relatively new on the ward and staff had received training on the use of this system with support from the pharmacy team. Staff reported they were still learning and improving their skills in using the new system.
- We observed a medication round being undertaken and saw that medicines were being administered according to the prescribed instructions and any omissions were recorded with an explanation.

Are services safe?

- Patients were not offered the opportunity to manage their own medicines whilst on the ward. This could be important for people who would be returning to their own homes without support. This should be offered as part of a rehabilitation plan.
- A pharmacist and pharmacy technician visited the ward every week and we saw that they were involved in medicines' optimisation processes including medicines' reconciliation, discharge planning and stock ordering and control.

Environment and equipment

- The layout of the ward was challenging in terms of visibility for nursing staff to observe patients from the nurses' station.
- The Quality Review of Trinity Ward undertaken in August/September 2015 identified issues regarding the security of the building. Staff told us that in the evenings and overnight they sometimes felt vulnerable. There had been an incident where a member of the public had violently gained access to the building late at night. The matron was planning to undertake a security review and we were informed that a digital locking system was to be fixed to the ward door in the near future. This would improve the safety of patients who may attempt to exit the ward and prevent members of the public entering without staff's knowledge.
- The resuscitation trolley and equipment were regularly checked, fully stocked and records were complete and up to date.
- Equipment stores were well organised, well-stocked and clean and dirty equipment was segregated appropriately. No supplies were found to be out of date.
- A wide range of appropriate therapy and mobility equipment was in use and was found to be clean and in good condition.
- We found a number of items of equipment without safety checking labelling or with out of date labelling. For example a portable hairdryer had a sticker indicating the portable appliance test (PAT) check was due in 2012. We also found a six socket extension lead at the nurses' station had not been checked according to the label since 2010. New pieces of equipment such as the portable electronic medication devices had no stickers on. The information that was available to the ward manager regarding electrical checks did not include some of these items. Therefore staff could not be assured that the equipment they were using was safe to use.
- Staff told us that a sink in a patient area which was a handwashing facility for staff was broken and despite being reported some weeks earlier had still not been repaired.
- The building had recently been inspected to ensure safety relating to the presence of asbestos.
- The fire door to the day room was wedged open with a stack of chairs that were for visitors' use. The ward sister informed us that the automatic fire door stopper was not working and a repair had been requested.
- There was a well maintained and accessible outdoor area for patients and relatives to use but we were informed this space was not used very often.
- There was a lack of therapy space for patients to practice independent living skills. Patients attended the adjacent Leon Smallwood Unit to use the occupational therapy kitchen.
- A plug in a bathroom had a large paper clip instead of a chain in situ for pulling from its hole.
- The Patient Led Assessment of the Care Environment (PLACE) in 2015 gave the facilities at Ripon and District Community Hospital a score of 85.8% which was lower than the England average at 90.1%.
- The fabric of the hospital building was a concern to the trust due to its age and condition and was on the risk register. The building was owned by NHS Property Services Ltd.

Quality of records

- Patients' medical records were stored in three notes' trolleys close to the nurses' station. We found these to be unlocked during our inspection but did have the facility to be locked.
- Nursing and therapy notes were kept in an individual folder for each patient on a shelf behind the nurses' station. These were not secure and meant that there was a data protection risk if there were no staff at the nurses' station.
- Individual observation records and charts were kept on clip boards at the patient's bedside.
- Notes for discharged patients were stored at the nurses' station. They were not in locked cupboards or in locked rooms.

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- Good multidisciplinary team working was evident throughout patient notes. Therapists and nursing staff contributed to and shared information on patient care but there was a lack of clarity regarding goal setting and planning for discharge.
- Documentation was not comprehensively reviewed and monitored by senior staff. An audit of documentation in April 2015 identified 100% compliance with legibility, dating and signature, but only 93.7% compliance in recording patient's allergy status. This could mean that patients were at risk. There had been no further audits.
- We reviewed six sets of medical records and 11 sets of nursing/therapy records and found these were not always completed regularly or consistently and regularly reviewed. For example the fundamental nursing care plan was not always updated when a patient's condition or needs changed. We found one care plan had not been updated since 15 January 2016. This meant that staff were not completing patient care records in line with recommendation of their governing body (The Nursing and Midwifery Council, Record keeping: Guidance for nurses and midwives).
- There was a lack of documented actions in the nursing and therapy records, for example there was a nutrition assessment completed but recorded actions were not found.
- We reviewed six medical records and found that patients were clerked by a doctor within 24 hours of arrival on the ward; however the handwriting of one of the doctors was extremely difficult to understand.
- Hand hygiene audits for both staff and patients were completed monthly and results were between 90% and 100% for the period April 2015 to September 2015. This information was on display for patients and visitors to see.
- We observed patients being offered hand wipes prior to lunch being served.
- There was some discrepancy relating to cleanliness of commodes. The saving lives audit was at 100% in September 2015 but the infection prevention and control spot check showed 67% in the same month.
- Monthly audits and spot checks on commode cleanliness had been consistently at 100% until September 2015 when the spot check showed 33% of commodes not to be clean. We observed all commodes to be clean at the time of our inspection.
- The ward environment was visibly clean and tidy but in some areas it was cluttered due to the lack of space and the layout of the ward.
- Some sinks on the ward had been decommissioned and were no longer in use due to a lack of mixer taps and overflow problems. However there was a sink in the main ward without mixer taps still in use.
- The ward kitchen did not look visibly clean in some areas, for example on both days of our inspection there was dried milk in the bottom of the fridge. The ward fridge temperature was checked daily and records showed that the current temperature only was recorded on a very old form.
- Cleanliness and equipment decontamination checklists were completed which included Legionella flushing. We saw that this documentation was kept up to date and was sent to the supervisor for checking and entering onto a database. We did not see any cleaning products being stored inappropriately. The cleaning staff were proud of what they did.
- Curtains around the bed areas were fabric rather than disposable ones. There was a six monthly rotation schedule for these to be changed that the supervisor managed. This was a long time frame. The supervisor told us that this schedule was set by managers.
- Cleaning staff knew that curtains around bed areas had to be changed when soiled and if there had been a patient with an infection.
- Quality of Care meeting minutes from January 2016 indicated that the linen trolley may have been left uncovered and that a new cover was available. We observed this to be in use at the time of our inspection.

Cleanliness, infection control and hygiene

- Staff completed Infection Prevention and Control training as part of their statutory mandatory training.
- There had been no Clostridium Difficile episodes on the ward for 1,150 days at the time of our inspection and no Methicillin-resistant Staphylococcus Aureus (MRSA) infections for over six months.
- Most staff followed infection control principles and were seen to wash their hands and use hand gel appropriately. One member of staff was observed not to wash their hands between patient contacts. Most staff were bare below the elbow; we observed visiting GPs not to be so on occasions and the ward clerk was noted to be wearing a long sleeved cardigan.
- Personal proactive equipment (PPE) was available for staff to use and we observed this being used appropriately during our inspection.

Are services safe?

- Patient led assessment of the care environment (PLACE) carried out in 2015 gave cleanliness the rating of 99.7% which is above the national average of 97.6%. Patients and visitors we spoke to on our inspection were very satisfied with the ward environment and stated that it was very clean.
- On review of a patient's records we found that it was recorded the patient had experienced diarrhoea and vomiting. The patient was not isolated at the time and there was no documentation explaining why this was the case. The incident was not reported to the infection prevention and control team at the time.
- An incident report in November 2015 showed that staff had not followed the correct procedures for returning blood bags to the department at the acute hospital. The outcome from this was for staff to have education sessions in January 2016 but there is no evidence this occurred in the minutes of quality of care meetings sent to us.

Mandatory training

- There was a trust mandatory training policy in place which referenced 30 statutory training requirements and training in essential skills, which included such topic areas as safeguarding for adults and children, infection prevention and control, medicines management, the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and others.
- For each training element staff groups were identified and the frequency of each training element stated. Employees had a "Personal training account" which reflected the mandatory/essential training needs required by them as an individual and reflected if their training was up to date and when it would expire. The employee's manager had access to this account and was responsible for tracking the employee's training compliance. The trust training lead requested weekly updates on the training status of the staff in the service. We saw an example of a person training account.
- Compliance with training was managed through a RAG (red, amber, green) rated system for the individual through to directorate and trust level.
- Staff received all mandatory training as part of their induction and did not start work in the clinical area until they had completed the corporate induction.
- The compliance rates for the directorates/trust were set at 95%. They were rated as green if they were 75% or

above – this was explained as the Trust identifying that they would have been on track to meet trajectory. Figures below 75% were rated as red or amber dependent on the percentage.

- At the end of August 2015 mandatory training compliance for this service was 93% with the trust target being 75%.
- Staff requiring updates were booked to attend training where it was available but in some cases dates of additional training courses were awaited.
- Some staff told us they did not like the amount of e-learning they were required to undertake for mandatory training. They also did not like having to travel to Harrogate District General Hospital for training due to the time it took and the difficulties with car parking.

Assessing and responding to patient risk

- Advice was issued to NHS organisation when issues arise, via the Central Alerting System. National patient safety alerts (NPSA) are crucial alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death. We did not see any evidence of safety alerts being displayed. Staff told us this was communicated via e-mail.
- Nursing staff worked a three shift pattern rota with early and late shifts as well as a night shift. There was a handover of patients at the beginning of each shift. This took place in the clean utility room. A comprehensive nursing handover sheet updated by nursing staff during the previous shift was used by all nursing staff. The handover sheet included patient allergies, resuscitation status, moving and handling requirements, diet and fluids, nursing needs and the multi-disciplinary plan including outstanding actions. This ensured that any changes in the patient's care or condition were relayed to new staff members.
- A wide range of patient risk assessments, screening tools and record charts were used. We saw that patients' skin condition was checked and documented twice daily. The patients' Waterlow score (for pressure ulcer risk) was clearly documented but reviewed on a less regular basis which is not in line with recommendations.
- The Trust had developed new policies and care plans for prevention and early identification of pressure ulcers with the support of the Tissue Viability Service. However

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we found in the patient records that assessments did not link to the actions taken. For example on the patients' observation charts the frequency of skin inspection was not specified on eight out of 11 records.

- One patient told us they were experiencing soreness to their sacral area. The charts and written records did not reflect this.
- The ward also used a national early warning score tool (NEWS) for all patients to enable staff to recognise and respond to a deteriorating patient. These were completed on at least a daily basis. Staff were aware of what to do if a patient's score had increased. On one chart we reviewed a patient who should have had daily observations of vital signs had not had these undertaken for four days.
- Staff were using appropriate tools to assess risk including falls risk assessments, skin risk assessments and nutritional risk assessments. In one set of records we reviewed a patient had not had any risk assessments undertaken since their admission.
- Patient's transfer and mobility status and the level of assistance required for washing and dressing was displayed on the board above their bed.
- There were escalation policies and procedures in place for deteriorating patients and staff knew what these were. Any urgent medical needs were accessed via the 999 service and patient transfers could be made to local acute hospital as necessary.
- Staff carried out care and comfort checks on every patient at least every two hours and recorded this on a chart by the patient's bedside. We looked at 11 patients' charts and found these had been completed. However on some charts it was not possible to ascertain how frequently the checks should take place or who had decided on the frequency of the checks or the rationale for the frequency of the checks.
- At the nursing handover more experienced nursing staff were allocated the more unwell patients.
- An incident report in November 2015 showed that a patient who lacked mental capacity was sent from Trinity Ward to an outpatient appointment at the acute hospital without an escort. This resulted in the patient being sent back to the ward without any meaningful outcome as the patient was unable to give any history about their condition.

Nurse and Therapy Staffing

- Nursing staff levels were good with trust information showing planned versus actual staffing levels near or above planned from June 2015 to December 2015.
- There had been only three reported incidents of staffing problems in the six months prior to our inspection which were related to requiring additional staff for patients who needed one to one support.
- Therapy staff and the multidisciplinary assistants worked between the ward and the community. There is one whole time equivalent (wte) physiotherapist, one half time equivalent occupational therapist and 2.5 wte multidisciplinary assistants. The therapy staff were managed by the community fast response and rehabilitation team which provided a seven day service in the community.
- The multidisciplinary assistants were not included on the ward off duty rota.
- We were told that the fast response team were a priority and when there were less staff on duty or if the team had an increase in referrals it could result in there being little therapy input on the ward. We observed this to be the case during our inspection where there were no therapy staff on the ward for a whole morning.
- More nursing and therapy staff were being recruited as part of the plans for re-modelling the community services as part of the vanguard work.
- A ward clerk was present during office hours and was responsible for administrative and clerical duties on the ward and also helped on the hospital reception if required.
- Staffing was planned based on the number of beds being used. A responsive acuity and dependency score was not used to assess the required number of nursing staff on a daily basis.
- We reviewed the nursing rosters for the six weeks prior to our inspection and saw that planned versus actual levels of staff was consistently achieved on day shifts.
- On day shifts there were two registered nurses on an early shift and two on a late shift as well as the ward manager on duty. On the MDT meeting day an additional registered nurse was on the early shift. There were also two healthcare assistants (HCA) on an early shift and one on a late shift. On a night shift there were two registered nurses and one HCA. These staffing levels offered a safe level for the number of patients on the ward.

Are services safe?

- We were supplied with information from the trust after our inspection that showed there had been an increase in daytime and night time staffing levels that corresponded with the opening of four additional beds on 07 February 2016.
- All nursing staff rotated from day shifts onto night shifts and some staff worked long shifts.
- There were no nurse staffing vacancies in January 2016 as there had been some recent recruitment – there had been registered nursing vacancies from July 2015 to December 2015 with a maximum of 1.5 wte vacancies in September. There had been health care support worker vacancies from October 2015 to December 2015 at less than 0.5 wte vacancy.
- Some prolonged nursing staff absences had impacted on levels in recent weeks. An increase in patient acuity and dependency at the same time had led to a reduction in beds being used.
- Staff sickness rates were high and had consistently been over the Trust target of 4% since April 2015 with the exception of July 2015. Sickness rates peaked in October 2015 at 8.5% and 8.1% in November 2015. The ward manager was aware of the high level of sickness and was working to improve this.
- Bank and agency usage in the service was variable and the information supplied to us from the trust shows that usage increased to meet the demands of the service. For example an increase in agency use when there was a patient with challenging behaviours requiring one to one support from a health care support worker for a period of time. Staff told us that additional staff were not always available when they were requested and this caused some concerns regarding the safety of patients.
- Between September 2015 and January 2016, 11 agency health care support workers were used to cover night duty. During the period August 2015 to January 2016, 188 bank shifts were used to cover gaps as a result of maternity leave, sickness, one to one support and vacancies.
- There was a band 7 locality manager who had responsibility for the management of the ward and other services based at Ripon and District Community Hospital. This senior nurse was not included in the numbers on the nursing rota.
- There were 2.3 wte band 6 nursing sisters who were included in the registered nurse numbers. These senior nurses were given approximately 40% of their time for management duties.

Medical Staffing

- Medical cover was provided by general practitioners (GP) from the three practices in the city. A GP from each of these practices visited the ward daily, usually in the morning from Monday to Friday. Trinity ward was nurse led and medical presence was not provided all day.
- A consultant geriatrician from Harrogate District General Hospital visited the ward once a week on a Wednesday morning and attended the multi-disciplinary team meeting as well as advising on more complex medical issues on an outreach basis.
- Out of hours medical cover was provided by the out of hours GP service for North Yorkshire. Staff told us there could sometimes be delays in a doctor attending the ward out of hours. For example we saw in one set of medical notes that a patient had not been seen for five days after admission to the ward from the acute hospital. This was over the New Year period.
- An incident report in October 2015 showed there were three patients on the ward who had not had regular medical reviews and the visiting consultant was concerned about this. Senior managers were aware of this and said a service level agreement was to be developed and a review of the medical cover on the ward would be part of the vanguard work. The GP we spoke with was not aware of any planned changes to the current arrangements.
- Patients who were admitted to the ward out of hours would be seen by the out of hours GP service if needed. Otherwise they were clerked in by a visiting GP from the surgery during the next day.

Managing anticipated risks

- We saw a copy of the trust's Integrated Care Directorate Business Impact Analysis dated November 2014 which was a comprehensive business continuity plan covering all community services environment.

Major incident awareness and training

- Major incident and fire escalation plans were in place and available on the wards. These were incorporated into local induction and orientation information for all new staff. Staff were aware of their role if a major incident affected the acute hospitals in the area.

Are services safe?

- The trust provided details of three major incident-training events that had been attended by staff from community health services. These included the following:
 - A local Test Scenario on 20 October 2015. This was a table top exercise arranged by Harrogate & Rural District (HaRD) Clinical Commissioning Group focusing on preparations for winter pressures. Six members of Harrogate District NHS Foundation Trust staff including staff from community services attended this.
 - A Community Outbreak & Pandemic Flu (NHS England) event on 19 November 2015. Again, this was a table top exercise arranged by NHS England – North (Yorkshire & Humber) to test both the local responses to a community outbreak incident and separately, the arrangements in place for an influenza pandemic. Eight members of trust staff including colleagues from community services attended this.
 - A Communication & Networking Critical Incident Live Play Incident on 13 January 2016. This incident affected the whole of the trust including Community Services. This was completed in line with the NHS England emergency preparedness, resilience and response (EPRR) framework and following a trust wide debrief session held on the 21 January 2016 an action plan was in developed to respond to lessons learned during the incident.

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

Overall we rated this service as requires improvement for effective. This was because:

- There were limited clinical audits carried out and there was a lack of evidence, actions and outcomes on display for staff, patients and visitors to view.
- Access to therapy was not a priority for in patients receiving rehabilitation.
- Patients were not offered the opportunity to manage their own medications.
- Patients' pain was not adequately recorded or evaluated.
- There was no key worker or named nurse system in operation.
- Patients' nutritional needs were assessed but there were omissions in actions taken to address identified needs.
- There were some inappropriate admissions to the community wards from the acute services and these were reported and investigated by senior managers.
- Discharge planning was not integral to the care of patients and there was a lack of proactive planning from the first day of admission. Delayed discharges were mainly due to family choice, lack of nursing home places and waiting for packages of care to be put in place.
- There was no formal clinical supervision available to the nursing staff.

However:

- A range of assessment and screening tools were used and documented in patient notes and national guidelines were followed for stroke, falls and pressure ulcers.
- Most staff had received an appraisal.

- Food and fluids were within patients' reach and most patients told us they enjoyed the food provided. Patients who required assistance with eating and drinking were well supported.
- Staff involved patients in their care and obtained verbal consent before carrying out any interventions.

Detailed findings

Evidence based care and treatment

- Trust policies and procedures reflected national best practice guidance e.g. The National Institute for Health and Care Excellence (NICE).
- Nursing and therapy staff we spoke with were aware of best practice guidance and they told us that policies were easily accessible via the trust's intranet.
- A documentation audit of nursing records in April 2015 identified 100% compliance in seven out of 12 categories. The least compliant category was 'completing patient consultant' which was 80% meaning that staff had not been recording which consultant was responsible for the patient.
- The service had previously participated in the National Intermediate Care Audit in 2014 but had not done so in 2015. We were told by managers that there was an intention to do so in 2016.
- National guidelines were followed for falls and pressure ulcers with specific efforts being made by staff to reduce the incidence of both.
- There was no named nurse or key worker system in operation so patients and their relatives did not know which nurse or therapist was responsible for their care, treatment and rehabilitation.
- There were no specific care pathways or care plans in use for particular conditions. There was a reliance on the nursing handover sheet for communication and nursing interventions. The trust's fundamental nursing care plan was used for all patients. This was a continuation of what was used in the acute hospital setting.

Pain relief

Are services effective?

- We reviewed 11 patient records and charts which showed that pain assessments were not completed regularly. For example a patient with a fractured pelvic bone did not have their pain assessed more than daily with seven omissions in 14 days.
- The matron had also found that pain scores were missing from patients' charts in January 2016 following a walk round which is recorded in the Quality of Care meeting minutes.
- Patients we spoke to said they had received pain relief when they required it; this usually coincided with the medication round.
- We observed that patients were asked about pain at medication rounds and that analgesia was prescribed and administered appropriately. It was not possible to establish from the written nursing notes if a patient's pain relief was being evaluated.

Nutrition and hydration

- Nursing teams used a nutritional assessment tool to assess if patients were at risk of malnourishment. The scoring system identified patients at risk and listed measures to be implemented if a patient scored 2 or above. We observed that patients who had a score of 2 were not having measures implemented such as the red tray to indicate that a patient required assistance with eating and drinking. No red trays were being used at the time of our inspection. The tool used was not the Malnutrition Universal Scoring Tool (MUST) which was the tool recommended for use in the hospital setting.
- Some patients had a food and fluid intake chart which was kept at the bedside. These were mostly kept up to date however one patient had not had a chart kept for three days despite having the need for a red tray discussed in the MDT meeting.
- Most patients had been weighed on admission and weekly thereafter to ensure nutritional needs were being met. Quality of Care meeting minutes from November 2015 and January 2016 indicated that staff had not been documenting patient weights and making appropriate referrals to dieticians.
- Food and fluids were within patients' reach and most patients told us they enjoyed the food provided.
- Observation of a lunch time showed that all patients received what they had ordered. The food was hot and appetising. Staff were available to give assistance if required. All meals were served at the patient's bedside.
- The PLACE assessment score in 2015 for food was 95.4% which is above the national average of 88.8%.
- Breakfast, evening meals and snacks were prepared in the kitchen on the hospital site, with the main meal at lunch time coming from the acute hospital site and being kept heated in a trolley. The on-site cook made a variety of snacks for patients. There were signs encouraging patients to request snacks.

Patient outcomes

- Patients were not fully involved in their own rehabilitation, goal setting and discharge planning. Arbitrary discharge dates were set by the MDT at their weekly meeting but not effectively communicated to the patients or their families.
- Goal setting and individual needs and rates of recovery were considered at multidisciplinary meetings but were not managed robustly. For example no one took responsibility to chase up results or other services that would have ensured patient progress towards discharge.
- We saw that weekly independence scoring was done for all patients on the ward but this did not link to patient progress monitoring.
- No other tools or scales were used to determine patients' expected length of stay, such as the goal attainment scale (GAS) so there was no clear way to track the patient's journey or progress.
- We saw evidence that the trust had participated in first National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme in 2015. We saw a document designed by the trust to disseminate the results, learning and areas for improvement from the national audit.
- The Therapy Outcome Measure (TOM) allowed professionals from many disciplines working in health, social care and education to describe the relative abilities and difficulties of a patient/client in the four domains of impairment, activity, participation and wellbeing in order to monitor changes over time. TOM had been rigorously tested for reliability and clinical validity. It was quick and simple to use, taking just a few minutes to complete, and is used for treatment planning, clinical management, audit and research. It allows for the aggregation of data so that comparisons can be made for the purposes of internal and external benchmarking.

Are services effective?

- The community rehabilitation team were not collating any patient outcome measures. However, they had set up a focus group to look at implementing TOMS as their pre and post treatment outcome measure, for evidence, audit and further development of their service. We saw evidence of this working group's work.
- The Sentinel Stroke National Audit Programme (SSNAP) was the single source of stroke data in England, Wales and Northern Ireland. SSNAP measured the quality of care that stroke patients receive throughout the whole care pathway up to six months post admission. The trust contributed to this audit with the therapy staff providing data to the programme. The data for the period April 2014 to March 2015 showed that in both team and patient centred key indicators scanning and thrombolysis were rated as worst and occupational therapy was rated as best.
- Trinity ward was listed as an outlier in terms of mortality rates by the Summary Hospital-level Mortality Indicator (SHMI) which was an indicator reporting on mortality at trust level across the NHS. The trust have undertaken an investigation into this and identified clinical coding for palliative care patients who use the dedicated end of life care beds on the ward was incorrect and therefore resulted in the data being skewed.
- We were told that the ward objective was to ensure a holistic package of care is provided to meet individual needs and ensure a return to either a previous level of independence or achievement of the optimum level of independence possible for that individual. However the process of assessment, goal setting and rehabilitation planning did not reflect this objective.
- One patient record we reviewed had no occupational therapy input since late December with no indication as to why or what future plans for input were. However another patient had very clear goals recorded in the therapy goals and treatment plan document.
- In the 11 records we reviewed we found that ten had poor annotation of assessment tools and no clear outcomes in terms of rehabilitation goals and independent living. There were only three records that had a plan documented and in one record it was identified a cognitive assessment was needed but this had not taken place.
- Discharge destinations for the 175 patients discharged from the ward between January 2015 and December 2015 were 112 to their usual place of residence, 20 deceased, and 43 to other care providers.

Competent staff

- Staff appraisals were completed using the trust values. Most of the staff we spoke to had received an appraisal in the past year and staff undertaking appraisals had received the appropriate training. The rate of appraisals completed at the end of January 2016 was 77.3%.
- Staff told us they were given opportunities to develop for example some health care support workers had undertaken a National Vocational Qualification in end of life care.
- All registered nurses on the ward had received blood transfusion training and competency had been signed off by the trust's transfusion nurse specialist.
- Most registered nurses had undertaken syringe driver training.
- The ward manager had recently undertaken a leadership course and had found this to be beneficial.
- There was no formal clinical supervision for nursing staff.
- The plans for Nursing and Midwifery Council revalidation for registered nurses working in the service were not clear and very little was in place to support nurses to ensure they met the requirements of this new process. Dates for training were planned.
- New staff had received full Trust induction and local induction, including mandatory training, trust information and emergency procedures and spent four weeks as a supernumerary member of staff during their induction period.
- Staff told us that the trust was usually supportive releasing staff for training to attend external courses but securing funding could sometimes be a problem.
- There was a competency portfolio for non-registered nursing staff for competency in core skills such as record keeping and infection control as well as tissue viability, catheter management, tests and investigations, bowel care and topical medication administration.

Multi-disciplinary working and coordinated care pathways

- Bed occupancy on Trinity ward since April 2015 had averaged at 97.8%. The optimum bed occupancy rate for hospital beds are context dependent and vary between organisations but the National Audit Office

Are services effective?

suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.

- The ward team included registered nurses and healthcare assistants, physiotherapists, occupational therapists and multi-disciplinary therapy assistants. A pharmacist and pharmacy technician visited the ward weekly. Dieticians and speech and language therapists made visits to the ward when required. The nurses were also able to contact the tissue viability nurses for advice and they would visit the ward if required. The pharmacist attended the weekly MDT meeting.
- Multidisciplinary team meetings took place once a week and involved the visiting consultant geriatrician, the nurse in charge, a pharmacist, a physiotherapist, an occupational therapist and social worker. MDT meetings were used to discuss patient progress, plan discharges and check care packages were in place, however these meetings lacked leadership, co-ordination and direction.
- We observed therapists and nurses working together with patients to support and encourage them to carry out therapy activities with confidence.
- A new traffic light system had been introduced by the occupational therapist to indicate a patient's level of dependency with red being fully dependent and green being independent.
- Most patients were seen on a daily basis by the therapy team, mostly individually as there was a lack of space for group settings. However due to pressure in the community fast response team the amount of therapy input could be variable. Senior managers were aware of this and additional support was planned for the therapy staff.
- The nursing handover that we observed was detailed and informative however the column for discharge date was not completed on most patients. The planned discharge date or expected discharge date was not included on this either. This resulted in a lack of focus in terms of discharge planning.

Referral, transfer, discharge and transition

- There was a clearly written criterion for admission to Trinity Ward. The criteria were for step up from the community and step down for intensive rehabilitation

from the acute hospital. There was also criteria for patients to be admitted as day cases for blood transfusions and for palliative care patients for end of life care.

- Therapy staff in the acute hospital or in the community made a referral and the decision to admit the patient was made by the therapy staff. Patients had to be medically fit, stable and agree to rehabilitation. However, when the ward received inappropriate referrals, where patients were not suitable either for the environment and facilities available or lacked rehabilitation potential, nursing staff told us the medical staff and managers were supportive and on occasions admission was refused.
- Staff were able to refer to other disciplines who were not on site such as dieticians, tissue viability nurses and diabetes nurse specialists who were based at the acute hospital. Referrals were sent via fax. We were told that patients would be seen if necessary and telephone advice would be given. We noted from a review of a patient record that a podiatry referral had been made and the patient was seen within two weeks.
- The referrals from the acute hospital were received by fax and screened by the therapy, medical and nursing staff. This was done on a specific form which included the patient's diagnosis, treatment and other medical conditions. A Next Step to Home Rehabilitation Plan should also have been sent at this time. We found that this was not present on all referrals from the acute hospital that we reviewed.
- Discharge summaries were completed electronically and printed out on the day of discharge, to be delivered with the patient to the receiving community team or GP and copies were filed in patient notes.
- The doctors' surgeries that provided cover to the ward used an IT system that was not the same as the IT systems used elsewhere in the area. Staff had processes in place to ensure that communication between them and the patient's GP was not compromised.
- Staff reported that discharges usually went well. There were sometimes delays in transport arriving to take patients home and this could on occasions cause problems if a package of care had been arranged for the patient. The team worked closely with social workers. However there were delayed discharges for a range of

Are services effective?

reasons including family choice, necessary alterations being made in the home, continuing healthcare needs, waiting for the correct package of care and the availability of nursing home places.

- We spoke to the relatives of a patient who was planning for discharge. They did not know when the patient would be discharged as they were waiting for equipment to be delivered to the home. They were a little disappointed at the lack of communication with health and social care staff.
- Patients would be seen at home post discharge by the fast response team if required which meant they were seen by the multidisciplinary assistants who worked on the ward. This was good for continuity of care.

Access to information

- Staff felt involved and were encouraged to give feedback on patient care both informally and at handovers. Therapy staff were not included in patient handovers at shift changes but did report information back to the rehabilitation team.
- Staff were able to access the trust intranet and were able to access results from the pathology website.
- The main source of information was the nursing handover sheet; there was detailed information on this about the patient's medical conditions, plans, observations and nursing needs. This was updated by the nurse in charge of the ward ready for each handover.
- There were white boards at the entrance of each of the sides of the ward – one for the male side and one for the female side. This had the patient's full name on display along with a colour indicating which GP practice was responsible for the patient's medical cover. For patients living with dementia a butterfly symbol was also placed next to the patient's name.
- We reviewed patient records and found that discussions with family members had not been documented. In the MDT meeting discussions regarding a patient highlighted this which caused a delay in discharge planning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to had a good understanding of the Mental Capacity Act and how this worked in practice to support and protect patients who were unable to make decisions themselves.
- Mental capacity was assessed when appropriate and the capacity to consent was recorded in MDT assessments and patients' notes. Some staff had received training on how to undertake assessments and a link nurse had been identified for the ward.
- Patients' agreement to rehabilitation as part of the admission criteria and their consent was not always recorded in the documentation.
- Written consent from patients was not evident throughout patient records either in care plans or in therapy notes. However we saw that verbal consent was requested by staff before and during personal care and interventions.
- Nursing and medical staff undertook Mental Capacity Act (MCA) training via e-learning as part of the mandatory training schedule. The trust had recently updated the MCA policy and DoLS policy.
- Where bed rail risk assessments and falls risk assessments were in place, there was a lack of clearly signed consent by the patient or a record of discussion with relatives.
- There had not been an audit of the documentation for the process of application of DoLS.
- Plans to introduce a digital locking system to the ward door may have an impact on the patients in depriving them of their liberty. Staff we spoke to were aware of the Deprivation of Liberty Safeguards and the process for applying for this. There were three patients on the ward at the time of our inspection subject to these measures but there was limited understanding demonstrated at the MDT meeting about how or if this impacted on discharge planning.

Are services caring?

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

Summary

We rated caring as good. This was because:

- The patients and relatives we spoke to told us that the care they received from staff was excellent and patients said they felt safe and cared for.
- Patients and visitors told us that all staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered. We observed staff speaking to patients in a sensitive and compassionate manner. Staff knocked on doors before entering private areas and used curtains for privacy.
- The wards issued friends and family test comment cards with a good response rate. Results were displayed on ward noticeboards.

However:

- Patients were not given an information leaflet on admission so they did not know what to expect during their stay or have contact information and visiting times in writing.
- Patients required more opportunities and empowerment to self-care.

Detailed findings

Compassionate care

- We spoke to seven patients and two visitors who all told us that the care they received from all staff was excellent. Patients said they felt safe and cared for during their stay. Staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being administered.
- We observed staff speaking to patients in a sensitive, caring and compassionate manner. Staff knocked on doors before entering private areas and used curtains when required. However the PLACE assessment in 2015 gave the ward a score of 74.7% for privacy, dignity and well-being which was lower than the national average score at 86%.

- There was a lack of engagement between staff and patients in providing clarity in the rehabilitation programmes; however some patients told us that they were encouraged to be as independent as possible but staff provided appropriate assistance in a sensitive way.
- Patients and visitors told us that nursing and therapy staff were extremely caring and they had been treated with dignity. They also reported that call bells were responded to quickly. We observed this to be the case at the time of our inspection with one exception when the call bell took three minutes to be answered by the nurse in charge.
- The matron undertook weekly walk rounds the ward to look at cleanliness, safety and patient comfort as well as answering any questions from patients.
- Ward meeting minutes from January 2016 indicated that staff should be using a peg, known as the peg of dignity, for curtains. We observed on our inspection that space around the bed when curtains were drawn was limited and the use of the peg helped.
- Some staff members and a patient did report a lack of compassion from some of the team. We did not see evidence of this at the time of our inspection. The ward manager assured us there were processes in place to deal with staff behaviours and good support from the human resources department.

Understanding and involvement of patients and those close to them

- Patients were unable to confirm that their care plans had been explained to them and that they understood and agreed with the content.
- The Friends and Family Test was completed and recent results showed the 81% of patients would recommend the ward as a place to receive care and treatment.
- The ward displayed visiting times of 11:00 to 19:00. We were told the times had recently changed to this extended period. However some relatives we spoke to said they had not been informed of this recent change to the visiting times. They also said there had been a lack of flexibility regarding visiting on Christmas Day. They also commented that these visiting times still meant they were not able to easily speak with a doctor about their loved one's care and treatment.

Are services caring?

Emotional support

- Staff provided emotional support when patients displayed anxiety during rehabilitation activities.
- Therapy staff listened to patients' concerns and explained what they were hoping to achieve.
- Additional staff were requested to provide support to keep patients calm and help keep themselves and other patients safe if they were agitated.

Are services responsive to people's needs?

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

Summary

Overall we rated this service as good for responsive. This was because:

- The service was meeting the needs of the local population and was appreciated by the local residents. Plans for the vanguard work reflected this and the local population were to be involved in the development of this
- A 'Pets as Therapy' dog visited the ward on a regular basis and was well received by patients.
- Admission criteria were clear and patients were assessed in the acute settings before transfer to the community wards.
- Bed numbers could be reduced depending on staffing availability and additional staffing could be requested when required. For example patients with complex care needs that were at a high risk of falls could have additional one to one support to maintain safety.
- Some staff had received additional training in the care of people living with dementia.
- The service received very few written complaints. There had been no formal complaints received by the trust about the service in the three months prior to our inspection.
- Visiting times had been changed to be more carer friendly as a result of patient/carers feedback. However this had not been communicated very effectively.

However:

- Patients with a diagnosis of dementia or confusion had been inappropriately referred to the ward and staff had sometimes struggled to manage their needs.
- There were delays in transferring patients with complex needs to a more suitable setting.
- The ward environment was not suitable for the needs of people living with dementia.

Detailed findings

Planning and delivering services which meet people's needs

- Staffing levels could be flexed depending on patient need. For example patients with complex care needs had a nurse allocated to care for them on a full time one to one basis although we were told by staff there were sometimes difficulties in accessing additional staff.
- The criteria for admission to Trinity Ward included transfers from acute hospitals, palliative care (end of life care only) and step – up from community care as well as haematology patients for day case treatment. The exclusions or types of patients deemed unsuitable for admission were also listed. The criteria document did not have a date of publishing or a date for review on it. The criteria were used in conjunction with a flow chart (dated October 2014) that was available to staff across the Trust.
- The trust and its local health and social care commissioners were working together to develop a Ripon Project which is to incorporate a health hub and new care models in the future.

Equality and diversity

- There was no repository for items on the ward which patients may have found helpful in order to exercise their religious beliefs if they wished to do so. A chaplain was available on an on-call basis from the acute hospital site.
- A hospital chaplain visited the ward twice a week and communion was provided on Sundays.
- Staff knew how to access translation services if required.
- Specific religious dietary requirements could be met from the catering department at the acute hospital.
- At a Quality of Care meeting a member of staff fed back and shared information received regarding equality and diversity.

Meeting the needs of people in vulnerable circumstances

- Patients with a diagnosis of dementia or confusion had been inappropriately referred to the ward and staff had struggled to manage their needs and behaviour.

Are services responsive to people's needs?

However, in most cases this was managed well under the circumstances with additional staff being utilised and a reduction in the number of beds occupied to keep staff available to meet the needs of the patients.

- There were sometimes delays in transferring these patients to a more suitable setting due to their complex needs and family wishes.
- The ward environment was not appropriate for people living with dementia. This was reflected in the PLACE assessment for dementia in 2015 which gave a score of only 66.6% which was lower than the national average of 74.5%.
- There were a limited number of clocks on the ward particularly ones with large faces and some patients were unable to a clock from their bed or chair. There was no distinct difference in the colour of door frames and the toilets did not have helpful signage or coloured seating. There were no calendars on the ward to assist patients in orientating themselves.
- The day room was small and lacked stimulation for patients with a limited range of books and puzzles. There was no calendar in the room and the clock was not at the correct time when we inspected.
- There were very few materials available to patients to keep themselves occupied or stimulated. For example there were no large print books available for patients to read and patients were not actively encouraged to use the day room.
- Staff were planning a reminiscence box to help but this was in the early stages of development.
- Some staff had received additional training in dementia care.
- There was a lack of opportunity for patients to watch television. We were informed that televisions had been ordered. There had been a delay in installation due to an assessment of the building being required to ensure the ceilings were safe for attachments and that asbestos was not present.
- There was no information leaflet available to give patients and their families on admission. This would have assisted in patients knowing what to expect during their stay including their intensive rehabilitation plans, discharge processes, things they would require, contact information and visiting times. The ward manager was aware that this was needed but no action plan was in place.
- A 'Pets as Therapy' (PAT) dog visited the ward regularly; we saw this at the time of our inspection. The volunteer

who brought in her pet dog was very friendly and engaged well with the patients on a one to one basis. The patients responded well to the dog being on the ward.

- A nurse had recently been identified to be the ward link nurse for learning disability.
- At the time of our inspection there was a patient on the ward with a learning disability. This patient had been on the ward for five days before a 'Recording of Reasonable Adjustments Made' form had been completed.
- The physiotherapist had made contact with the learning disabilities team to obtain information about the patient with a learning disability the first working day after the patient was transferred from the acute hospital. There were no recordings by any other member of the team with the patient's family or the learning disability team up to 04 February 2016.
- The ward had a method of making tablets easier for visually impaired patients to see.
- The ward was appropriately segregated in order to meet the same sex accommodation requirements with separate toilets and washing facilities for male and female patients.
- Staff told us that on one occasion a female patient had been in a bay on her own on the male side of the ward with male patients further down the ward. This had been done to maintain her safety as this was the nearest bed to the nurses' station. This patient had not used the male washing facilities or the male toilets during this time.

Access to the right care at the right time

- Patients and relatives told us their needs were responded to efficiently and quickly and during our inspection we observed nursing staff responding to call bells in a timely fashion with most patients only waiting a short period (less than a minute) for staff to attend to them.
- Staff told us that sometimes patients were admitted at weekends and acknowledged this was not ideal as only limited medical and therapy staff were available. There were no incident reports indicating this had caused any patient harm.
- The criteria for admission document stated that a therapy transfer form and the next steps to home rehabilitation plan should be completed prior to transfer. On review of patient records we found that this was not always the case.

Are services responsive to people's needs?

- There was no evidence that the process of referral to the rehabilitation beds were audited. A trial of using the Barthel Scoring tool was starting to help staff understand the dependency of patients who were on the waiting list to come from the acute trust. Managers hoped this would assist in ensuring the staffing on the ward matched the acuity and dependency of the patients.
- We were told by the nurse in charge that sometimes there was a waiting list for admissions from the acute hospital in the trust. Liaison with the trust bed management team took place and directly with the ward where patients were waiting to transfer to facilitate timely transfers.
- Therapists in the acute hospital setting initiated a referral for transfer to Trinity ward, the referral was sent via fax for the attention of the therapists on Trinity ward. The therapists would check the details and either accept or decline the patient. The nursing staff were responsible for making the arrangements for transfer taking a nurse to nurse handover from the discharging ward in the acute hospital.
- There had been a patient recently who had been attending the ward for regular blood transfusions for a haematological condition. Staff reported this had worked well for the patient and meant less distance for the patient to travel to receive the treatment.
- The Friends of Ripon Hospital had purchased a blood fridge in order for patients to attend as day cases for blood transfusions.
- Staff told us that transport to take patients home could be late which impacted on care delivery in the home environment. This could be stressful for patients and their families as services in the community could not wait for the patient to arrive at home.
- Staff told us that re-admissions back to the acute trust did not occur often and these would be reported as an incident. The incident report did not show any instances of this happening. Re-admission back to the acute hospital would occur if a patient's condition deteriorated.

Learning from complaints and concerns

- There were leaflets available for patients and visitors about the Patient Experience Service in the trust which explained how to make a complaint, compliment or raise a concern. These leaflets were out of date as the previous chief executive was named in these.
- In March 2015 a complaint was received about poor discharge planning and poor communication. Following investigation of this a number of actions had been recommended including training for staff on chairing best interests meetings and discharge planning meetings. The actions also included cascading this to staff at a staff meeting. We did not see evidence of this occurring in any minutes provided to us.
- There was not a clear or robust process for learning from complaints to be cascaded to all staff.
- We spoke to some relatives who were currently in the process of discharge planning for a patient who lacked capacity to make decisions about discharge destination. They told us the meeting had not been handled very well by the health and social care professionals present.
- Another complaint which we were made aware of at the time of our inspection that involved a number of services in the trust and was still being investigated also highlighted issues with poor communication with relatives.

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

Overall we rated this service as requires improvement for well led. This is because:

- Safety risks were not being managed effectively such as electrical equipment maintenance, servicing and safety checks. Measures such as the use of assistive technology to reduce the incidence of patient falls were not in place.
- There was a lack of consistency in information being cascaded to staff from incidents, lessons learned and actions to be taken.
- There was a lack of innovation on the ward and the staff lacked a sense of purpose and direction. They did not challenge themselves to develop an effective rehabilitation service.
- The ward was not providing an effective rehabilitation service that was performance managed or focussed. The ward lacked a philosophy and motivation to improve the service.
- There was a high risk regarding the lack of an integrated IT infrastructure.

However:

- Immediate managers were well known to the team from face to face visits, emails and regular communication.
- Staff were happy in their work and this reflected in the care delivery. Staff were looking forward to the vanguard model of working starting in their area.
- Staff reported that there had been a recent positive change in the senior leadership which led to a positive, supportive attitude and culture.

Detailed findings

Service vision and strategy

- All staff we spoke with were aware of the trust's vision and values. We saw posters displayed in all areas we visited.

- The trust has a strategy for delivering a new care model in the future which involves the use of the rehabilitation beds on Trinity ward at Ripon and District Community hospital. This is part of the local vanguard and there were ambitious plans to improve the health and social care services in Harrogate, Knaresborough, Ripon, Boroughbridge, Pateley Bridge and the surrounding rural areas. This vision also included improved access, good quality services if and when they are required and that people living in this area play an active role in making decision about their own health care and their lives.
- The new care model intended to increase the bed base in the community but it is not yet clarified where these beds will be located. The bed base at Trinity ward was to be increased from 16 to 20 in the coming weeks. There was also rehabilitation provision in a local authority care home in the area with the trust providing the therapy service to the patients in this setting. The Harrogate Heath Transformation Board which was a collaboration of the agencies involved in the vanguard had not put any timescales on the priorities for working together at the time of the inspection.
- All the staff we spoke to were aware of the vanguard plan but were less clear on how this was going to affect them in reality and had no details about any changes in the ways of working. Senior managers were clear that the rehabilitation unit and the Ripon and District community hospital site were going to be a key part of the project.
- The trust were also developing an elderly care strategy but it was not clear how this linked to the vanguard plans.

Governance, risk management and quality measurement

- Senior managers had undertaken a Quality Review of Trinity ward in August/September 2015. There were a number of actions highlighted as part of this review. These included reducing the number of inappropriate referrals and being able to discharge patients home in a timely manner.

Are services well-led?

- There was a risk register which recorded identified risks appropriately and rated them according to severity and impact. Risks were assessed and updated regularly and actions taken were recorded clearly, monitored and reviewed. At the time of our inspection there were seven risks identified by the service on the risk register. These were rated as moderate risk with a range of 6 – 9. However, it was not clear whether staff at ward level were able to contribute to or influence the risk register directly.
- Managers were aware of the risk to the service in relation to the lack of a locality wide integrated IT system. This was a high risk to the organisation and plans were in place to address this.
- The trust worked to support staff to learn from incidents and act to prevent recurrence. Root cause analysis investigations on serious incidents were undertaken by the locality manager.
- Staff told us how they contributed to incident reviews and root cause analyses with the locality manager but did not always receive information and feedback on themes or actions to be taken.
- Patient falls were a concern due to the number of incidents recorded. Staff were using appropriate tools and reporting patient falls. A sensor that detected patient movements was being trialled at the time of our inspection.
- The Quality of Care meetings had only recently been established and attendance at these meetings was limited. It was not clear if all staff had access to the minutes from these meetings.
- The trust had recently increased the availability of on-call matrons at weekends on the acute hospital site. Staff on the ward knew about this and knew who to contact if there was an emergency or problem out of hours.
- Staff told us that their matron was approachable and listened to them.
- Staff were aware of the chief executive as they had visited the ward and were also aware of their immediate line managers from face to face visits, emails and regular communication.
- Staff reported there had been a positive change introduced with new chief executive and felt there was good senior leadership and robust processes at the trust board level.
- The locality manager reported very good support from the human resources department at the acute hospital site.
- Medical leadership was less strong. The GP we spoke to was not aware of the developments planned for the service.
- The quality review of Trinity ward that had taken place in August/September 2015 identified that staff were frustrated about the lack of a sense of purpose of the ward. This still had not been fully addressed. The development of an information leaflet about the purpose of the ward for patients or visitors would help.
- Sharing information and learning from practice and incidents in particular, between hospital sites was taking place but not always being cascaded to staff.
- The consultant geriatrician from the acute hospital chaired the weekly MDT meeting but there was not an identified leader in the therapy team.

Leadership of this service

- The nursing leadership at ward level did not appear effective. There was a lack of direction and evidence that important tasks had not been completed to inform the service. For example there had been no ward based team meetings on Trinity ward in the six months prior to our inspection.
- Identified actions from the quality review in August/September 2015 had not taken place. For example no improvements to the ward environment for patients who were living with dementia.
- The matron visited the ward at least once a week. The ward were contacted every morning by a matron to establish numbers of patients, numbers of staff on duty and any risks or problems.

Culture within this service

- Staff were happy in their work and a number of the team had worked there for many years.
- Staff were confident and open to report incidents and share this information.
- Morale was good this seemed to be related to the recent appointment of new staff.

Public engagement

- There was a very supportive charitable organisation called the Friends of Ripon Hospital who have actively supported the hospital for 60 years. There were many

Are services well-led?

supporters of the organisation living in the local community who had raised many thousands of pounds and contributed to the provision of essential equipment for care delivery and patient comfort on Trinity ward.

- Plans for the future including the vanguard and the use of the community hospital site were to be consulted on widely. We were told by members of the public how much they valued the hospital and the services it currently provided.
- Volunteers were welcomed onto the ward and there are plans to increase the involvement and activities.
- There was information available for patients and visitors in a folder in the day room about the Carer's Resource who could provide support to carers in the community however the information may have been out of date as it should have been updated in November 2011.
- Thank you cards were on display on the ward.
- Friends and Family information was on display for December 2015.

Staff engagement

- Staff were aware of the "This is Us!" vision, mission and objectives set by the trust.
- Staff participated in the Friends and Family Test and the most recent results showed that 90% of staff would recommend the ward for care and treatment and 66% of staff would recommend the ward as a place to work out of 124 responses in December 2015.
- A recent review of the trust by an external organisation recommended that there should be an increase in the opportunities for engagement with staff working in community services.
- A quality review undertaken in August/September 2015 identified that the profile of quality of care and opportunities for staff to participate in this needed to improve in order to invigorate staff.
- Staff told us that they had regular communication with senior managers and received information through

regular emails. This included information about training sessions and information on preventing harm to patients. They also said that the matron was a regular presence at the hospital site. However some staff reported they felt the community hospital was isolated and neglected at times.

- A newly formed Quality of Care meeting at the hospital chaired by the matron had started meeting in November 2015.
- There was very out of date information on display or available for staff to read in the staff rest room and dining area. For example – nursing information from 2003 and NICE guidelines regarding prevention and treatment of pressure ulcers from 2005. The staff notice board contained a mix of professional and work related information such as training dates as well as personal and local advertisements.

Innovation, improvement and sustainability

- The "This is Me" tool had been devised by the Alzheimer's society for use with patients living with dementia to assist in the communication and understanding of a person's individual needs and preferences. We were told that this was used in the trust and the Butterfly scheme had also recently been implemented. This was a nationally recognised system of hospital care for people living with dementia.
- A number of items to improve the environment were planned such as the provision of televisions and wall art.
- The vanguard project was seen by staff to be an exciting development and most staff were looking forward to seeing how this will work in the future.
- The trust had a working group who were looking at the development and implementation of a single assessment tool and care plan across health and social care.