Northamptonshire Healthcare NHS Foundation Trust

RP1

Community health inpatient services

Quality Report

Sudborough House
St Mary's Hospital
77 London Road
Kettering
NN15 7PW
Tel: 01536 410141
Website: www.nht.nhs.uk

Date of inspection visit: 23 to 27 January 2017
Date of publication: 28/03/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RP1E1	Corby Community Hospital	Corby Community Hospital	NN17 2NU
RP1Y8	Danetre Hospital	Danetre Hospital	NN11 4DY
RP1F2	Isebrook Hospital	Hazelwood Ward	NN8 1LP
RP1F2	Isebrook Hospital	Beechwood Ward	NN8 1LP

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

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

Where applicable, we have reported on each core service provided by Northamptonshire Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Northamptonshire Healthcare 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?	Good

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

We rated community health inpatient services as requires improvement because:

- Vacancies existed throughout the service and bank and agency staff were required to fill gaps in service provision. Active recruitment was ongoing but staff shortages remained on the service risk register. From November 2015 to December 2016, staff reported 23 incidents, which related to staff shortages, with one categorised as moderate harm and six low harms.The moderate harm incident was not attributable to the trust.
- The environment and room layout on some wards meant not all patients were easily observed. Some wards had significant health and safety hazards including leaking roofs, heating failures and trip hazards. There was insufficient storage space to store equipment safely.
- Prescribed medicine was not always signed for and staff were unsure if patients had received medicine as prescribed.
- Staff did not report all medicine related incidents in line with trust policy. There was no agreed training and assessment protocol for staff to undergo when they had made drug errors. Individual wards made their own decisions regarding staff competence following a drug error.
- Staff did not always review patients' prescribed medicine at the correct time.
- Medicine was not always stored in line with best practice guidance or trust policy.
- The service did not partake in national audits and so there was no benchmarking against other similar services and improvements could not be measured and compared.
- There was a high number of delayed discharges. At the time of our inspection, 46% of all patients were medically fit to go home but were waiting for assessments by the NHS or waiting for care packages. On average, 30% of all discharges over the year were delayed.
- Stroke patients were treated on different wards despite an action plan from August 2016 to accommodate all stroke services on one site. Following our inspection, the trust provided evidence that it is was working with commissioners to move stroke services to one site only.

However:

- The service had a good safety record. There had been no reported serious incidents or never events from September 2015 to September 2016.
- The service met its target for mandatory staff training and staff appraisals.
- Additional training was available for therapy staff and healthcare assistants. These provided opportunities for staff to develop their role and take on more responsibility. This improved the staff skill mix on each shift.
- Quality of care was assessed and monitored through a quality dashboard. This involved several local audits and action plans. Audit results were discussed at governance meetings and action plans were in place to address issues identified.
- Multi-disciplinary working across the service was good. Therapy assistants worked seven days a week.
- Patients and their families were involved in planning care and setting rehabilitation goals and they told us that they were very happy with the care they received.
- Patients received a mental capacity assessment on admission. Patients living with dementia or other cognitive impairment were easily identifiable to staff. Some wards had adapted their environment to cater for patients with living dementia.
- A core group of doctors and GPs provided care during normal working hours. The doctors were visible and accessible to patients, relatives and staff.
- The service responded positively to our February 2015 inspection. Staff told us about the improvements made, and how they had addressed some of the issues we identified. Notice boards in public areas displayed the changes that had been made and highlighted work still in progress.
- There was visible leadership in each area. Staff we spoke with told us they knew who their service leaders were and that they were accessible to them. Staff said they felt supported in their roles.

Summary of findings

Background to the service

Information about the service

Northamptonshire Healthcare NHS Foundation Trust delivers adult community inpatient services across Northamptonshire. The geographical area covered is mainly urban and has high levels of deprivation, as well as pockets of relative affluence. The community division provided health services to adults, including stroke, and neurological and physical rehabilitation services.

During our inspection, we visited four adult community inpatient services. Corby Community Hospital, a 22 bedded inpatient ward and Danetre Hospital, a 29 bedded inpatient ward that both provided physical rehabilitation for adult patients following an acute illness or a deterioration of a long-term condition.

We also visited Isebrook Hospital, which had two inpatient wards. Hazelwood ward had 32 beds and provided physical rehabilitation for adult patients following an acute illness or a deterioration of a long-term condition. Beechwood ward was a 15 bedded unit, which provided specialist inpatient rehabilitation for younger adults with neurological and other long-term conditions including brain injury.

During our announced inspection we spoke with 27 patients, 47 members of staff, and we reviewed 38 sets of patient care records. We also attended four meetings, looked at 31 medication charts and observed 16 episodes of care. We spoke with seven patient relatives and friends.

The wards are supported in the day either by doctors from a local GP surgery, or doctors employed directly by Northamptonshire Healthcare NHS Foundation Trust. Out of hours, provision is via an on call medical facility or, between some hours, via the emergency services. Therapy input is available from rehabilitation specialists including physiotherapists, occupational therapists and rehabilitation assistants.

Our previous inspection was carried out in February 2015. During that inspection we rated the service as requires improvement overall. We rated safe, effective, responsive and well led as requires improvement and we rated caring as good.

CQC identified the following areas of improvement for community health inpatient services:

- Ensure there are sufficient staff are on duty at all times.
- Ensure all staff have the appropriate training, supervision and appraisal required, in order for them to safely carry out their role.
- Ensure all patients have been fully risk assessed on admission and that all assessments have been documented in patient records.

During this inspection, we found that patients had received an assessment on admission and this had been documented in their notes. However, there was still insufficient staff to cover all of the shifts and some staff had not completed all of their required training.

Our inspection team

Our inspection team was led by:

Chair: Mark Hindle, Chief Operating Officer, Mersey Care NHS Foundation Trust

Team Leader: Julie Meikle, Head of Hospital Inspection CQC

The team included, inspection managers, inspectors and a variety of specialists including, a medical doctor, a community matron and an occupational therapist.

Why we carried out this inspection

We inspected this core service as a follow up comprehensive inspection.

Summary of findings

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 hold about the core service and asked other organisations to share what they knew. We carried out an announced inspection on 24 to 27 January 2017. During the inspection we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

One patient told us that they had been in many acute and community hospitals but none were as good as Corby Community Hospital. Another patient said the staff at Corby Community Hospital were kind but there was nothing to do.

Patients on Beechwood ward told us they thought the facility was fantastic and that their friends and family were always made welcome on the ward.

A relative told us they were very happy with all the care provided at Danetre Hospital.

Patients at Hazelwood ward said the staff were lovely but always very busy. One patient told us it took 20 minutes for staff to respond to their call bell.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must ensure medication is administered in line with trust policy, best practice and national guidance. This includes correct documentation on prescription cards, risk assessments, single dose medication and authorisation of medication.
- The trust must ensure all medicines are stored and disposed of in line with trust policy and best practice.
- The trust must ensure staff receive the appropriate competency training following a medicine incident. Staff training must include the requirement to report all medication incidents on the electronic incident reporting system as per trust policy.

Action the provider SHOULD take to improve

- The trust should ensure patient outcomes for inpatients are monitored and reviewed to ensure services are meeting the needs of each patient.
- The provider should identify and partake in relevant national audits, which can be used to benchmark the quality of care it provides.
- The trust should use a pain monitoring tool for every patient. Patients should have the effectiveness of their analgesia monitored and recorded using a recognised pain scoring assessment tool.
- The trust should ensure staff receive training and supervision, and this is documented and monitored to ensure it meets the trust target.

Summary of findings

- The provider should ensure a programme of continued recruitment to minimise vacancies throughout the service.
- The provider should ensure that staff follow infection, prevention and control guidance as per trust policy.
- The provider should ensure the environment across all wards is safe.
- The provider should work closely with external agencies to try and reduce delays in patient discharges and ensure assessments are completed as soon as possible.
- The provider should ensure all risks have been added to the risk register and all identified risks are reviewed and updated.

Northamptonshire Healthcare 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 safe as requires improvement because:

- Nurse staffing was a concern for all senior nurse managers and was on the risk register. Vacancies existed throughout the service and there was a reliance on temporary nurses to fill shifts. Some risks were mitigated by scheduling extra health care assistants when nurse shifts could not be filled and by using regular temporary nurses wherever possible. The service was actively involved in recruitment, but not every shift was filled. From November 2015 to December 2016, staff reported 23 incidents, which related to staff shortages, with one categorised as moderate harm and six low harms.The moderate harm incident was not attributable to the trust.
- Some wards were in a poor state of repair and provided health and safety risks including trip hazards, leaking roofs and heating failures.
- Prescribed medicine was not always signed for and staff were unsure if patients had received medicine as prescribed.
- Not all medicine related incidents were reported in line with trust policy and there was no protocol to follow when staff made drug errors.
- Patients did not always have a timely review of their prescribed medicine.
- Medicine was not always stored in line with best practice guidance or trust policy.
- Not all wards had secure entrances and exits. Vulnerable patients could leave the wards and unauthorised personnel could gain access to the ward unnoticed.
- Staff did not always change their gloves and aprons between tasks and therefore opportunities for hand washing were missed.
- Compliance with annual immediate life support training was low, and ranged from 33% to 100%. This was on the service risk register. The risk was increased at night

when there were fewer registered nurses on duty. However, wherever possible the service tried to ensure there was a member of staff on each shift with in date resuscitation training.
- Some patients were transferred into the service inappropriately. This included patients that were too sick to be cared for by the service. Some patients had additional risks, for example, a risk of falling which had not been communicated prior to the patients transfer.
- There was a high number of falls reported in the service. The service had introduced a new falls training package but this was still in its infancy at the time of our inspection and its impact could not be measured.
- The layout of some wards and the use of pods for additional bed spaces meant it was difficult to observe all patients.

However:

- There was a positive incident reporting culture amongst staff, although not all medication incidents had been reported. Staff gave examples of where they had received feedback and lessons learnt from incidents.
- The community inpatient wards were visibly clean. There were adequate gloves and aprons and hand gel facilities were available throughout each ward.
- There was good equipment provision, which enabled staff to complete their jobs safely. Staff cleaned and stored reusable equipment appropriately after use.
- Staff assessed risks to patients individually. Deteriorating patients were escalated using an agreed escalation protocol.
- The service met its overall target for mandatory staff training and staff appraisals. Staff had access to online mandatory training and an electronic record was available which highlighted the training they were required to complete.
- Compliance with safeguarding training was above trust target and staff understood their responsibilities to keep vulnerable adults safe.
- Access to doctors and medical cover was goods across all four wards.
- The service had implemented its own quality dashboard that audited and monitored safety standards across each service.
- Staff were aware of local contingency plans and emergency procedures and we saw evidence of when they had been applied.

Safety performance

- The community inpatients services participated in the NHS Safety Thermometer programme. This is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free care' in the NHS. Data is collected on a specific day each month to indicate performance in four key safety areas. These are, new pressure ulcers, catheter associated urinary tract infections, venous thromboembolism (VTE) and falls.
- Safety thermometer data from December 2015 to December 2016 showed that most harms were recorded for pressure ulcers, although the annual data did not differentiate between new pressure ulcers and pressure ulcers patients had acquired before being admitted to the service. However, further evidence provided indicated that most pressure ulcers were inherited, that is, patients arrived on a ward already with a pressure ulcer. In December 2016, two new pressures ulcers were acquired at Danetre Hospital. Both of these were investigated and found to be unavoidable. This meant the patients had been fully assessed for their risk of developing a pressure ulcer on admission and all reasonable steps to prevent skin damage had been implemented. We saw evidence of these assessments and that turn charts had been completed regularly during our inspection.
- Between January and December 2016, the service reported two VTE harms.
- Senior nurses collected quality performance data each month. This was used to inform a quality dashboard. Information collected included details of falls, staffing, pressure ulcers and training figures. This data was not displayed publically but was available to staff electronically.

Incident reporting, learning and improvement

- There were 816 incidents reported in the service between October 2015 and September 2016. The majority of these were categorised as no harm.
- Incidents were reported using an electronic incident reporting system. Staff told us that they were encouraged to complete incident reports, and most staff told us that they had received feedback from the reports they had raised.

Requires improvement

Are services safe?

- Staff told us falls were the most common reason why they had completed an incident form. Trust data supported this and showed 252 (31%) incidents were raised as either 'fall on level', fall from height' 'found on the floor' or 'assisted fall'. Most falls were recorded as no harm or low harm. However, 16 patients experienced moderate harm as a result of a fall. All falls incidents were reviewed by the senior matron responsible for falls training who looked for common themes. Falls with harm were investigated by the patient safety team. Staff told us about the lessons learned from recent falls in their area and across the service. We saw a 'lessons learned' falls poster publically displayed on notice boards throughout the service. However, therapy staff across the service told us they did not always get feedback from the falls incidents they had reported.
- The service had an action plan to reduce the number of falls. This included renewed face-to-face training for all staff, the introduction of ward falls link nurses and falls information boards in each area. This was in its infancy at the time of our inspection and therefore its impact could not be measured.
- There were no serious incidents (SI) requiring investigation reported from. SIs are events in health care where there is potential for learning or the consequences are so significant that they warrant using additional resources to mount a comprehensive response. During our February 2015 inspection there were nine SIs reported from December 2013 to November 2014. Most of these incidents related to falls and pressure ulcers. Staff told us they had implemented various measures to improve patient safety following a SI and this included, auditing compliance to the accurate monitoring of sick patients, using the National Early Warning Score, and monthly skin damage audits to reduce the number of pressure ulcers.
- A review of all the clinical incidents reported by the trust fromshowed there was a grade three hospital acquired pressure ulcer at Danetre Hospital. All grade three pressure ulcers should be formally investigated. We asked to trust to provide us with evidence of their investigation into this pressure ulcer but they were unable to do so. The trust told us that the pressure ulcer was unavoidable because the patient was non-compliant with their treatment.However, we were not provided with any evidence regarding this and we did not see their investigation report.
- We were told about a new SI reported in January 2017 that was being investigated. Staff told us about the actions taken following the incident and we saw that they were in line with trust policy.
- Learning from serious incidents was shared with staff through the trust's monthly 'lessons learned bulletin'. We saw lessons learned posters displayed throughout the service and we looked at ward minutes where serious incidents had been discussed.
- There were no never events reported for this service from October 2015 to September 2016. Never events are serious incidents that are wholly preventable because guidance or safety recommendations exist that provide strong systemic protective barriers at a national level and should have been implemented by all healthcare providers.
- Agency staff had access to the electronic incident reporting system, which was provided on the trust intranet. Agency staff we spoke with told us they knew how to report an incident.
- Most staff told us incidents and any associated learning from them were discussed at ward meetings. We saw minutes from these meetings during our inspection, which supported this. However, therapy staff across the service told us they did not always get feedback from all of the incidents they had reported.

Duty of Candour

- NHS providers are required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and to provide reasonable support to the person.
- Staff told us the trust had an open and honest culture and they were aware of their responsibilities to be open and honest with patients about incidents. We saw

documented evidence in patient notes where patients and relatives had discussed incidents, for example, when a patient had a fall. We saw that letters of apology were sent following complaints.

- During out February 2015 inspection senior staff told us that they had not received any training regarding duty of candour and that they had not been following the trust policy. This had been recognised and training was provided. During this inspection, we found all grades of staff had completed on line duty of candour training. Staff we spoke with described duty of candour and when it would be required. Some staff gave examples of when they had been involved in applying duty of candour.

Safeguarding

- Staff we spoke with were confident in reporting safeguarding concerns and were aware how to escalate concerns to the safeguarding team. We saw evidence that safeguarding referrals had been made and we saw safeguarding policies displayed on staff notice boards.
- In September 2016, 97% of all staff in the service had received level 1 adult and children safeguarding and 92% had received level 2 safeguarding training. This was above the trust target of 90%. Level 3 safeguarding children training was not required in this service and no staff had received this level of training.
- Pressure ulcers and falls reported on the electronic incident reporting system were referred to the appropriate specialist team to assess if the incident was a safeguarding issue or not. For example, the tissue viability team would investigate if a category three or four pressure ulcer was avoidable or not and whether there were any safeguarding concerns about the patient.
- All staff we spoke with had a good understanding of what constituted abuse and the actions they would need to take if they suspected a patient required safeguarding. Staff told us about an incident when they had contacted the safeguarding team due to suspected financial abuse of a patient and that the safeguarding team had implemented actions as a result of their referral.
- All wards had information on what staff should do if they were concerned about a patient. Staff told us they were aware of whom to contact if they had concerns about patients.
- We saw information leaflets and posters in ward areas that highlighted the importance of safeguarding and contained details of external agencies for patients, relatives or staff to contact if they had concerns.
- The trust safeguarding team recorded the number of safeguarding referrals made. From October 2015 to September 2016, the trust made eight safeguarding referrals.

Medicines

- Pharmacy provision was provided by a local commercial pharmacy who supplied all of the drugs to the inpatient wards.
- A pharmacy technician visited each site once per week to check stocks and review patient medication charts and a qualified pharmacist visited weekly. Telephone pharmacy advice was available if required.
- The service used paper based medication charts. We reviewed 31 medication administration charts across the service and found medications were prescribed correctly. However, eight of these charts (25%) had a medication prescribed but not signed for. This included a time critical Parkinson's disease medication, insulin, an antibiotic and a drug used to help reduce blood clots. This was brought to the attention of staff during our inspection. Staff were unsure if some of the medications had been given but not signed for, or if the medication had not been given. Senior staff told us they were aware of medication incidents including some drugs prescribed not signed for and that a reason for omission was sometimes not documented. The service audited drug charts every week. We looked at an audit that had been carried out on Hazelwood ward in January 2017 and saw that drug omissions had been identified. These had been followed up with the staff involved and each case was discussed at ward meetings. We saw minutes from ward meetings on Hazelwood ward which including a discussion about two medication errors. Staff had implemented a drug chart check at every handover where the nurses from

the outgoing shift and incoming shift, reviewed the medication chart together. Although we observed this process during a handover on Hazelwood ward, errors and omissions still occurred.

- The service reported medication omissions in its quarterly dashboard. We saw from the December 2016 data, 20% of patients on Beechwood ward had unexplained drug omissions. This figure was 13% for Danetre Hospital and 9% for Hazelwood ward.
- Some medications were omitted due to stock not available.
- From September 2015 to September 2016, the service reported 55 incidents regarding medication. The majority, 44%, were reported at Corby Community Hospital. Not all medication omissions were reported as incidents and during our inspection, two incident reports were raised at our request following unsigned doses of critical medication.
- Patient medication charts included a list of drugs that a registered nurse could administer without a specific prescription, known as discretionary medications. This included medicines that could normally be bought over the counter, such as paracetamol or simple cough mixtures. There is a requirement that this form must be signed by a doctor before a nurse can administer against it. None of the medication charts we reviewed had been signed by a doctor, even though nurses had administered medications against the chart. This was brought to the attention of doctors and the lead pharmacist during our inspection. We revisited Danetre Hospital and reviewed 15 extra prescription charts, five had discretionary medications that were not signed by a doctor.
- A competency based training package was used to assess all newly registered nurses who were required to administer medication. New staff were also supervised on medication rounds. Intravenous therapy training was provided as an additional training session and included competency assessments. However, there was no specific retraining protocol to follow when staff made a drug error and each case was handled locally by ward managers. Medication errors were discussed at medicine management meetings and minutes were fed back to ward managers for further learning.
- Medicines were administered by registered nurses only. During scheduled medication rounds, the nurse conducting the round wore a 'do not disturb' tabard. These tabards were introduced to reduce interruptions and reduce the risk of medication errors. We saw staff wearing the tabards were not interrupted during medication rounds.
- Staff checked the identity of each patient prior to administering medication. This was done verbally whenever possible and patient's wristbands were checked to confirm patient identity. There was also a photograph of each patient attached to their medication chart, which helped ensure correct identification of patients.
- Controlled drug (CD) registers were checked twice a week. Checks showed the correct amount of stock was available at each location.
- On two wards, Danetre Hospital and Corby Community Hospital, we found patients' own CDs available in the CD cupboard after the patient had been discharged. Staff told us they were not allowed to destroy the medication and were waiting for a designated pharmacist to remove them. We spoke with a pharmacy technician on site who told us that registered nursing staff were permitted to destroy patients' own CDs. Therefore, staff were not clear who was responsible for destroying the medication.
- In Corby Community Hospital, we found out of date ward stock CDs stored in the CD cupboard. These had been marked as 'expired' and staff told us they were waiting for the official designated pharmacist to remove the drugs. Although staff we spoke with correctly identified that the medication was out of date, there was a risk that this medication could be administered in error.
- Danetre Hospital had used a single use vial of medication to administer multiple doses. A partially used vial of ketamine which was marked 'single use only' had been used daily from 16 January 2017 to provide "when required" doses of ketamine. This did not follow the trust policy and it was raised with staff during our inspection.
- We found an out of date bag of glucose intravenous fluid at Danetre Hospital. This was removed during our inspection.

Requires improvement

Are services safe?

- Medication prescription charts recorded information on patient allergies and patients with allergies wore red wristbands to highlight this. Patients without allergies had 'no know allergies' documented on their medication chart.
- We looked at the medication charts of 15 patients who were prescribed enoxaparin. Enoxaparin is a blood-thinning drug given to patients in hospital to help prevent blood clots. Patients prescribed this medication were required to have a review every seven days. Four patients did not have a review documented on their chart.
- Prescription medicines were appropriately stored in locked cupboards. At Corby Community Hospital, the medication room door lock was broken and this had been reported. All medications were locked inside cupboards within the medication room and were inaccessible without a key.
- Oxygen cylinders were stored securely attached to a wall to prevent accidental injury.
- All sites recorded the temperature of their medicine fridge. Records showed the temperature of the medicine fridge at Danetre Hospital was recorded as being regularly above the recommend temperature range of between 5 and 8°C. For example from 31 October 2016 to 28 November 2016, the maximum temperature was recorded as 12.8°C and from 24 December 2016 to 13 January 2017, the maximum temperature was 9.4°C. No action had been recorded to indicated what measures had been taken to ensure the medicine inside the fridge was safe to use. Staff at the hospital told us the temperature of all fridges was now monitored centrally and that the true temperature of the fridge had remained within accepted ranges for the whole of this period. However, this system was not set up yet and therefore we were not assured the medication kept in this fridge had been stored at the correct temperature.
- The temperature of clinical rooms where intravenous fluids and medications were stored was not recorded. Therefore, we were not assured the medicine was stored at the correct temperature.
- Danetre Hospital had their own fridge to store blood for patients requiring a transfusion. This service was monitored and maintained by the blood transfusion service at a local acute hospital. Access to the blood fridge was restricted to staff who had received the appropriate blood administration training.
- Open medication with a limited shelf life was not always annotated with a date of opening, for example, cough mixture and the pain relief medicine, Oramorph. There was a risk that medication could be used passed its expiry date and meant the medicines might not have been as effective, for example, in providing pain relief.
- Not all patients were allowed to self-administer their own medication. Some patients were unable to self-administer due to their clinical condition. Staff told us there was a process for assessing a patient's ability to self-administer medication but we did not see this during our inspection. Some patients told us they had not been given the opportunity to self-administer medication, even though they had normally done so at home. One patient told us they were allowed to self-administer their inhalers only. This is important because it helped rehabilitation patients to be as independent as possible.
- Patients who were identified as needing help with their medication at home were provided with Dossett boxes, tools to help organise medications. These were obtained in advance of discharge so staff could teach patients how to use them safely.
- Patients were given a 28-day supply of medication when they were discharged. At home medications were ordered in advance of a patient's discharge but could be obtained on the day if required.

Environment and equipment

- The layout of some wards meant staff had poor visibility of some patients. It was especially difficult to see patients in Corby Community Hospital and Hazelwood ward where 'pod' bedrooms had been added to provide additional capacity. Pod rooms were built in porta cabins attached by a corridor off the main ward. Staff told us they risk assessed each patient to ensure only low risk patients stayed in the pods. During our inspection, we spoke to two patients using the pod rooms and both told us they were aware of the risk of falling and would therefore only mobilise when staff came and provided assistance.

Requires improvement

Are services safe?

- Not all wards had secure entrances and exits, which meant vulnerable patients could leave the ward and unauthorised personnel could access the ward. We arrived on Hazelwood ward at 7.15am and found that the rear access doors were wide open and we were able to walk directly onto the ward. This was raised as a safety concern with senior staff during our inspection.
- Resuscitation equipment, for use in an emergency was checked daily in most clinical areas. The equipment on the trolleys we checked was in date, clean and ready for use.
- The resuscitation trolley was easily accessible for staff to collect in the event of an emergency and all staff we asked were able to identify where the trolley was stored.
- During our February 2015 inspection to Corby Community Hospital and Hazelwood wards we found there was limited storage space for large equipment, such as hoists. This remained the same during this inspection but the concern had been added to the service risk register. At Corby Community Hospital there were two corridors off the main ward that provided access to patient pod rooms. Both of these corridors had hoists stored alongside the wall, portable plug in heaters on the floor with loose electrical cables and freestanding fire extinguishers. The fire extinguishers were based on a plastic tray but the tray was not secured and the extinguishers wobbled when touched. These obstructions were trip hazards and provided an obstruction should an emergency evacuation be required.
- At Corby Community Hospital the floor was uneven in the corridors that accessed patient pod rooms. Staff told us it had been repaired and improved but that it was still uneven and some areas were on a slope. Patients and visitors using mobility aids, or who were partially sighted were particularly at risk of falls on this surface. This issue was on the service risk register but staff we spoke with were unaware of when the issue would be resolved.
- During our inspection at Corby Community Hospital, three sets of fire doors were continually alarming. This had been reported to the estates department. Staff told us several attempts to repair the alarms had failed or only worked for a short period. Although the alarm sound was relatively quiet, it could be disturbing for some patients, especially at night. We were told the faults with the alarms were due to battery faults only and had no impact on patient safety.
- There was insufficient provision of estates maintenance to keep the ward environments safe at all times. Beechwood ward, Hazelwood ward and Corby Community Hospital had all reported reoccurring heating failures and delays in carrying out repair work. Corby Community Hospital had several areas of damp and leaking roofs.
- The electrical equipment we inspected had been checked safety tested annually as per recommendations.
- Staff told us they had access to the right equipment they needed to do their jobs. Extra equipment could be ordered if required and we saw evidence of equipment loans on Hazelwood ward. We saw all areas had bariatric equipment available including commodes, hoists and slings. Bariatric is the medical term used for patients who are clinically obese.
- All wards had access to pressure sensor equipment that was used to detect movement in patients who were at high risk of falls.
- Slings and slide sheets inspected were visibly clean. Most areas used reusable slide sheets although on Beechwood ward we found a mixture of disposable and reusable slide sheets, both of which were red. This meant there was a risk staff would reuse a disposable slide sheet more than once.
- Domestic waste was correctly segregated and waste bins were compliant with health and safety waste regulations, including waste management guidance document Health Technical Memorandum (HTM) 07-01 safe management of healthcare waste and HTM 83. Bins were fire retardant, enclosed and foot operated. The management and disposal of sharps was completed in accordance with trust policy.
- Equipment including beds, hoists and wheelchairs was clean and in working order. Items were labelled with the last service date, and some equipment had labels that identified when the equipment was last cleaned.
- We found several equipment storerooms at Danetre Hospital were wedged open with blocks of wood. One

store contained sterile equipment including catheters, syringes and dressing packs and wound care items including silver dressings. These items were not stored safely and securely to prevent theft, damage or misuse. This issue was identified as a risk during our February 2015 inspection and had not been rectified.

- A medical devices team had responsibility for the stock inventory and for annual equipment checks. Ward managers kept a database of staff that had completed equipment training and this was updated regularly. Following initial face-to-face equipment training, all staff completed online self-assessments. We saw evidence of these assessments on Beechwood ward.

Quality of records

- Staff recorded in patient records using an electronic records system which was also used across the community trust and by some local GPs. This meant that information was shared with staff that needed access to patient care plans and treatments. Staff told us patients were asked for consent to share their information electronically. Regular bank and agency staff were permitted access to this system but managers told us that very few agency nurses had access to the electronic reporting system. Reasons for this included, the length of time to obtain passwords, difficulties with agency nurses providing adequate personal identification, and difficulties in arranging suitable training dates. We were told that there was always at least one member of staff on duty who could access the electronic records system.
- Agency nurses recorded the care they provided on paper, which was later scanned into the patient's electronic record. Paper records included patient identification information and agency staff nurse details.
- We looked at 38 patient records and found that they were comprehensively completed including information on patient ethnicity and consent. In addition to electronic notes, patients had a paper-based folder where staff recorded daily ongoing care, such as food diaries, fluid balance records and turn charts.
- The service carried out local documentation audits, which showed most patient assessments had been carried out in line with trust guidelines.
- Daily progression notes were recorded electronically by members of the multidisciplinary team including doctors, dietitians and therapists. This ensured all staff had access to all of the patient's assessments and referrals which had been carried out.

Cleanliness, infection control and hygiene

- All wards we inspected were visibly clean at the time of our inspection.
- The Health and Social Care Information Centre Patient Led Assessments of the Care Environment data showed that in 2016, all inpatient services scored better for cleanliness than the national average for small community services. Danetre Hospital and Corby Community hospital both scored 100% compared to the national average of 98%.
- All wards carried out regular infection control audits. This included hand hygiene audits, 'hot spot' infection control audits and matron's observational tool audits. Trust data showed that between April and September 2016, compliance to these audits ranged from 89% to 100%. Hand hygiene on all wards was reported as 100% in each audit.
- In September 2016,infection control training compliance for clinical staff was 87% or above for all community inpatient locations except for Danetre Hospital, where compliance was 79%. Although this had improved since our February 2015 inspection where it was 58%, it still did not meet the trust target of 90%. A manager told us infection training compliance was low because it had recently changed from three yearly update training to yearly update training and as a result of this, some staff were out of date. However, we saw there was a plan to address this and staff had been booked to receive an update in infection control training.
- Most non-clinical staff in community inpatient locations had received the three yearly infection control update training. In Isebrook Hospital, 94% of staff had received training and all other areas achieved 100% compliance.
- The clinical areas had adequate hand washing facilities and we observed staff washing their hands or using hand-cleansing gel between patients and when leaving or entering different areas. However, at Corby Community Hospital there was one hand hygiene sink in each bay of four patients. This sink was located inside a

patient bed space. If the bedside curtains were closed, staff could not access the sink to wash their hands. There was a sink in the corridor outside the bay but staff would have to touch door handles in order to access it.

- The dirty utility room at Corby Community Hospital did not have a dedicated hand hygiene sink which was compliant with Health Building Note 00-09. Dedicated hand hygiene sinks do Access to this sink was blocked by stored commodes. We did not observe staff working in this room so we were unable to assess how staff cleaned their hands when disposing of bodily fluids.
- Personal protective equipment (PPE), such as gloves and aprons, was readily available in the wards but we saw that its use did not always comply with the trust's PPE policy. Some staff wore the same gloves and aprons to carry out multiple tasks. We raised this with staff during our inspection. We were told additional hand hygiene and PPE use training would be provided.
- Staff followed the trust policy of being arms bare below the elbows, which facilitated thorough handwashing.
- The cleaning of inpatient areas was completed by an in-house serviceand cleaning schedules were displayed on all of the wards.
- Routine water testing was carried out by a member of the estates team in conjunction with a third party water safety company. Housekeeping staff were responsible for the daily flushing of water systems to prevent water borne microorganisms (bugs) such as Legionella.
- The service had an MRSA screening policy. Only new patients who had a wound, a catheter or another device, for example a feeding tube, were screened. Compliance to this screening policy was not audited.
- From April to September 2016 there were no cases of MRSA bacteraemia. MRSA is a bacterium that is resistant to a number of widely used antibiotics.
- From April to September 2016 there was one case of trust apportioned Clostridium difficile infection. This was investigated by the infection prevention and control team and antimicrobial prescribing in an acute hospital was found to be the cause in this case.
- During our inspection, one patient was isolated because they had previously been confirmed as having Clostridium difficile. Staff were able to tell us how they were monitoring the patient for signs of reinfection and relapse and we saw evidence of this in the patient's notes.
- Diagnostic specimens to be sent for investigation were stored and packaged in containers with cushioning pads and outer packaging and were compliant with transport regulations.

Mandatory training

- Staff completed most mandatory training using an online electronic training system. Training dates and pass rates were recorded and available to staff and managers to view at any time.
- Staff told us they were given time to complete mandatory training. Some staff said they did this during work time when it was quiet on the wards.
- Information about how to access mandatory training was displayed across staff noticed boards at each service. There were 14 courses that the trust classed as mandatory training. This included fire awareness, safeguarding, information governance, and health and safety training.
- In December 2016, all wards had achieved the trust target of 90% for average compliance to mandatory training, and figures ranged 91% to 100%. However, some individual training did not meet the trust target and this included clinical infection control training, which in January 2017, was 78% compliant on Hazelwood ward and manual handling training which was 87% compliant. Compliance to role specific training ranged from 83% at Danetre Hospital to 96% on Beechwood ward.
- During our February 2015 inspection, we reported that insufficient numbers of staff had received training in basic life support, level 2 and level 3 resuscitation training and immediate life support, (ILS). The trust implemented actions to rectify this. However, during this inspection we found some staff were still not compliant with appropriate training in life support. At Corby Community Hospital, 79% of eligible staff had the appropriate level of ILS. At Hazelwood ward, this figure was 67% and at Danetre Hospital, 33% of staff had the appropriate level of life support training.

- Managers told us sepsis training was delivered as part of ILS training. Not all staff received ILS training therefore, we were not assured that all staff were able to adequately respond to a patient showing signs of sepsis. However, we saw that there was a sepsis recognition flow chart incorporated into the recording of observations chart.
- Not all eligible staff were compliant with their anaphylaxis training. Although this training was role specific and not deemed mandatory for every member of staff, in September 2016 only 74% of eligible staff were compliant. This meant that staff might not be able to respond appropriately in the event of an anaphylaxis event.
- In addition to mandatory training, staff completed role specific training. Not all staff were compliant with their role specific training. For example, 79% of relevant staff had training in pressure ulcer prevention and 82% of relevant staff had manual handling training.

Assessing and responding to patient risk

- Clinical risk assessments and care plans were completed and followed for each patient. These included assessments for pressure ulcers, falls risk and nutrition scores.
- Staff used the National Early Warning Score (NEWS) in accordance with National Institute for Health and Care Excellence (NICE) clinical guidance CG50, to record routine physiological observations including blood pressure, temperature, and heart rate. There were clear directions for actions to be taken when NEWS scores increased and indicated a patient was deteriorating. We saw staff had escalated NEWS appropriately.
- The service carried out quarterly NEWS audits and had a target of 100% compliance. Audit results for August 2016 showed 99% of patients had their observations recorded on the NEWS chart within 24 hours of admission. Furthermore, 93% of patients had their observations completed in line with the required frequency. However, only 83% of patients had been appropriately referred for a medical review where NEWS had been triggered due to a deteriorating patient.
- Actions to improve compliance included provision of training and weekly NEWS audits in each area. In addition, the service adapted the NEWS chart to ensure it met the needs of patients in a community hospital setting, rather than an acute hospital. During our inspection, we saw four patients' charts where NEWS had been triggered and each had been appropriately assessed and reviewed.
- Each patient had a risk assessment for malnutrition. This was done using the Malnutrition Universal Screening Tool (MUST). However, an audit carried out in December 2016, showed 38% of patients at Danetre Hospital did not have an assessment carried out in line with trust policy for nutritional screening. At Hazelwood ward, 50% of patients who were identified as being at risk of malnutrition, did not have a care plan in place which identified that the care requirements had been delivered.
- Patients were assessed for their risk of developing a venous thromboembolism (VTE) on admission as per NICE guidelines: VTE: reducing the risk for patients in hospital (2015). In September 2016, the service carried out an audit of compliance with their policy to prescribe VTE: Policy for Primary Thromboprophylaxis. Results showed that 84% of patients had a VTE assessment documented and of these 87% were completed within 24 hours of the patient being admitted. We saw initial VTE assessments had been recorded in the electronic notes of the patients we reviewed. However, at Danetre Hospital, we looked at 15 medication charts for evidence of weekly VTE follow up reviews and found that four had not had a weekly review as per trust policy.
- The service monitored the number of sick patients who required transfer back to the acute hospital within three days of admission. From September 2015 to September 2016, 21 patients were returned to an acute hospital and three were reported in one month for September 2016. We were told, some patients arrived from acute hospitals that were not medically fit for the community service and we spoke to one patient who told us they were sent back to the acute hospital immediately after their arrival. Each case was investigated and lessons learned were identified. This included better handover information between hospitals, doctor to doctor discussions, access to patient blood results and thorough patient observation checks immediately prior to discharge. Patients with a NEWS of more than two were not accepted for transfer.

Requires improvement

Are services safe?

- Some staff had received sepsis training and said they felt confident in identifying a patient who was becoming septic. There was a sepsis guide included on the NEWS observation chart. Sepsis training was being rolled out and not all staff confirmed they had received it. Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs.
- Blood transfusions were given to patients who required them. Transfusions were carried out in daytime hours only, to ensure the safety of the patient. Patients who required an urgent transfusion, were transferred to a local acute hospital. Danetre Hospital had their own blood refrigerator to store blood, which had key code access for trained staff only.
- Patient's fundamental care needs were checked at regular intervals. The frequency of checks was structured and reflected the level of risk to each patient. For example, patients who could not reposition themselves in bed without assistance were on hourly turn charts, and patients who were mobilising around the ward independently did not require this.
- Wards cohorted (grouped) patients who were at high risk of falls in bays. Each bay had an allocated member of staff who remained in the bay to observe patients. Patients also had equipment provided for them that reduced the risk of falling or reduced the impact if they fell. This included sensor cushions, which alarmed if patients moved; beds that could be lowered to the floor and crash mats placed around the bed.
- Staff assessed each patient's mobility on admission and regularly throughout their stay. Manual handling assessments were carried out by the therapy team. Requirements were recorded on boards behind the patient's bed so all staff were aware of the level of assistance each patient required. This enabled safe mobilisation and reduced the risk of patient falls.
- White boards by each patient were used to identify a variety of patient needs in addition to mobility assistance. Dietary requirements and likes and dislikes were also recorded on the board alongside the patients preferred name.

Staffing levels and caseload

- During our previous inspection in February 2015, there were insufficient numbers of suitably qualified staff to fill all shifts in the inpatient wards. This remained the case during this inspection and safe staffing had been reported on the risk register since September 2014.
- Senior staff used recognised national safer nursing staffing tools to identify the number of nurses required to care for patients on each shift. These were reviewed regularly.
- Staff fill rates compare the proportion of planned hours worked by nursing and healthcare assistant staff (HCA) to actual hours worked. All NHS hospitals are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review in order to ensure adequate staffing levels for patient safety. In September 2016, the trained nurse fill rate on Hazelwood ward was 89%, while Corby Community Hospital reported a fill rate of 90%. However, the service had mitigated some of the risks by increasing the number of HCAs on duty to 111% and 107%, respectively.
- The average number of vacancies across the community hospitals from September 2015 to September 2016 was 37 whole time equivalent, which was 23% of the workforce. In September 2016, there were 9 full time HCA vacancies and 15 registered nurse vacancies across the service.
- Corby Community Hospital had the highest percentage of shifts covered by bank staff from September 2015 to September 2016 for both registered nurses and HCAs. Hazelwood ward and Danetre Hospital had similar usage of agency nurse staff (58 to 60%).
- Managers told us that they had developed the role for some HCA staff and had utilised the band three therapy staff to help with nursing care. Band four nursing assistants were also introduced and carried out many of the nurse roles including wound care and ward co-ordination plus overseeing admissions and discharges.
- During our inspection, we saw there were some gaps in the rota. For example, on 25 January 2016, Hazelwood ward had one registered nurse short on the morning shift and an HCA short on the afternoon shift. Both of these gaps were due to staff sickness at short notice and cover was not available. However, we saw that the ward manager was available to assist clinically on the morning shift.

Requires improvement

Are services safe?

- Staff sickness rates on all wards were 7%, except on Hazelwood ward where it was 4.7%. This was worse than the England average for similar trusts, which was 4.6%. However, the sickness rate had improved since our February 2015 inspection when it was 9%. Managers told us that they had several members of staff on long-term sickness and this affected their overall rate.
- From November 2015 to December 2016, staff reported 23 incidents, which related to staff shortages, and 11 of these were reported at Corby Community Hospital. Most incidents were recorded as no harm or a near miss. There was one moderate harm and six low harms reported because of staff shortages.The moderate harm incident was not attributable to the trust.
- The service carried out a risk assessment when actual staff levels fell below planned staff levels. The nurse in charge of each shift carried out this assessment and escalated risks to the on call manager. Staff showed us the risk assessments that they had undertaken when the number of actual staff was shorter than the planned number of staff. We saw clear documentation of the escalation process.
- Each ward displayed the number of nursing staff required for the day and the number of nursing staff actually on duty. The number of therapists was not highlighted to visitors or patients.
- Some nurses and HCA staff said they were short-staffed. However, most staff told us most shifts were filled using bank or agency staff. Therapy staff told us there was sufficient therapy staff to carry out the therapist's role. However, band three therapists were required to undertake nursing roles from 7am to 10am every day. After this time, the therapy staff returned to their traditional role. Some therapy staff told us they often had to stay in the nursing role for the whole of their shift due to nursing shortages. One patient told us they felt more staff was needed because the nurses were always very busy.
- Bank and agency staff were inducted to each ward area. This included a ward orientation, familiarisation with emergency procedures and equipment, documentation, and medication administrations. Whenever possible, regular bank and agency nurses were used. Block bookings were made wherever possible to cover planned sickness. This helped with continuity of patient care.
- Ward managers were additional to clinical staff each day on most wards. This allowed them to help clinically and cover last minute staff shortages if required. Staff also moved across sites to cover any gaps in the rota.
- There was a senior nurse on call during the night and at weekends for the community hospitals. All staff were aware of who this was and how to contact themStaff told us, the ward manager on call rang each day to ensure wards were staffed and to identify any concerns.
- Medical cover varied across all four wards. Consultant medical cover was available on Beechwood ward and Hazelwood ward from Monday to Friday between 9am and 5pm. There was also two speciality grade doctors during the day. Out of hours and at weekends, cover was provided on an on call basis by consultants and speciality grade doctors employed by the service.
- Corby Community Hospital had access to a consultant medical doctor although this was limited. A speciality grade doctor was available from Monday to Friday between 9am and 6pm. From 6pm to 8pm Monday to Friday and 8am to 8pm at weekends and bank holidays, a GP consortium provided an on-call service. All other out of hours cover was provided by a countywide out of hour's service. At Danetre Hospital GP's provided medical cover from Monday to Friday and out of hours from 8pm to 8am cover was provided by a countywide out of hour's service.
- Emergency cover was provided by the ambulance service across all services.

Managing anticipated risks

- Staff were aware of the business continuity plan for incidents that occurred and affected the service, for example, power cuts, water leaks and bad weather. We were told about a recent overnight power cut and the actions staff had implemented to keep patients safe.
- Each ward had a quick access guide called ''what ifs''. This reminded staff what to do in an emergency, for example if there was a power cut or the medicine cupboard keys were lost.
- There was a procedure for transferring sick patients out of the ward when they had been identified as deteriorating in their condition. Staff we spoke with were aware of the procedure.

Requires improvement

Are services safe?

- Manual handling equipment and information on the number of staff required to safely support a patient was available on boards by patient beds.
- All services had a handover at the beginning and end of each shift. We observed nursing handovers on Beechwood ward and Hazelwood ward. Nurses starting their shift were given information about the medical needs of each patient. This included any clinical risks which had been identified and any discharge arrangements which had been made. Handover sheets were used to provide staff with brief details of each patient's needs. These were also shared with the therapy teams.
- Staff were aware of the risks associated with using the extra bedrooms in the porta cabin style pods at Corby Community Hospital and on Hazelwood ward. All patients accommodated in these pods were risk assessed for their suitability to be isolated and out of sight. Patients identified with additional risk factors were not nursed in a pod.

Major incident awareness and training

- Clinical leads were aware of the trust's major incident policy but had not received training on their roles and responsibilities in the community in the light of a major incident occurring. However, staff were aware of local contingency plans and emergency procedures and we saw evidence of when they had been applied.

Requires improvement

Are services effective?

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

Summary

We rated effective as requires improvement because:

- There was a lack of benchmarking with national standards to outcomes for patients undergoing rehabilitation programmes.
- The service did not participate in national audits, for example the Sentinel Stroke National Audit Programme.
- Nursing staff did not use a pain assessment scoring tool to assess pain regularly. However, patients were assessed for pain on admission. We saw pain relief was prescribed and administered but staff did not always check the effectiveness of this.
- Stroke patients were accommodated across the service despite an action plan from August 2016 consolidate stroke services in one area. Following our inspection, the trust provided evidence that it is working with commissioners to move stroke services to one site only.
- Staff had access to regular clinical supervision. However, this was not recorded formally for all staff and so it did not meet the trust target.
- There was a high number of delayed discharges. At the time of our inspection, 46% of all patients across the service were medically fit to be discharged home but remained in hospital because there were no care packages available or the patient was waiting to be assessed for care. On average, throughout the year, 30% of all discharges were delayed.

However:

- Most staff had received an appraisal and told us about their objectives.
- Local audits to assess the effectiveness of care were carried out and we saw action plans to address some of the issues identified.
- There was an innovative use of skill mixes and staff grades throughout the service which offered opportunities for continued staff development. Preceptorship programmes were available for new nursing staff and leadership courses were available for band six staff grades and above.
- Doctors had access to training and development through consultant led revalidation and weekly continued professional development sessions.
- Care and treatment was planned and delivered in line with current evidence based guidance and best practice.
- Mental capacity assessments were completed on patients during their admission. Staff had a good awareness of Deprivation of Liberty Safeguards and understood their role in protecting patients.
- The was evidence of good multi-disciplinary working across the service. This included with the nurses and doctors, therapist and clinical nurse specialists.
- Clinical assessments were carried out on admission to the service.

Evidence based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines were used in many areas across the service. For example, NICE guidance for falls in older people; guidance for chronic obstructive pulmonary disease and guidance for patients with type two diabetes.
- Trust policies were current and we saw that there were systems in place to provide care in line with best practice guidelines. For example, an early warning score was used to alert staff when a patient's condition deteriorated, in line with NICE CG50 Acutely ill patients: recognition of and response to acute illness in adults in hospital, 2007.
- We saw evidence of comprehensive patient assessments using recognised risk assessment tools for patients on admission. Assessments covered most health needs including physical, mental, emotional and spiritual health as well as clinical needs. These risk assessments formed the basis for individualised care plans which were regularly reviewed, for example, the Waterlow score was recorded to identify patients at risk of pressure ulcers.

Requires improvement

Are services effective?

- Physiotherapists used evidence based assessments including the elderly mobility scale (EMS). EMS assesses mobility in frail elderly patients and enabled physiotherapists to plan patient care according to individual patient needs.
- Occupational therapists (OT) assessed stroke patients using the Barthel Index. This is a widely used measure of functional disability. This allowed OT staff to plan appropriate interventions for stroke patients.

Pain relief

- Patients were assessed for pain on admission and this was recorded electronically and updated as required. Patients who confirmed they had pain on admission were commenced on a pain care plan. However, patients who reported having no pain, did not usually have a pain care plan and nursing staff did not use a visual pain score system to regularly assess any changes in patient pain.During our inspection we saw analgesia was administered but we did not observe staff checking or recording its effectiveness. Using a recognised pain-scoring tool also allows the adequacy of pain relief medication to be assessed. Therapy staff used a visual scoring tool assessment tool.
- Patients told us staff provided pain relief on request and we saw pain relief was prescribed for some patients regularly on prescription charts.
- Physiotherapy staff asked patients if they required pain relief before starting their therapy session.
- Patient pain was discussed at handover and during board rounds. We heard a nurse request topical analgesia for a patient who did not like to take oral medication.

Nutrition and hydration

- Patient Led Assessments of the Care Environment (PLACE) 2016, data showed that all of the inpatient services scored the same or better than the national average of 92% for the quality and availability of food and drink. Corby Community Hospital scored 99% and Danetre Hospital scored 96%.
- Patient's nutrition and hydration status was assessed and recorded using the **Malnutrition Universal Screening Tool** (MUST). During our inspection, we found patients had MUST assessments which had been updated at least weekly.
- Specific dietary requirements or assistance with eating was recorded on boards at patient bedsides, for example, patients who required thickened fluids.
- Patients who were identified as being at risk of malnutrition had a food diary to record their daily intake. Most food diaries we looked at were fully completed. We saw a few charts where a meal record was missing.
- Fluid charts were completed for patients at risk of dehydration or where there was another medical need. We found fluid charts were not always completed regularly and we saw four fluid charts that did not have a total balance calculated at the end of each day.
- Patients were weighed weekly or as required following their nutritional assessment. Patients who were losing weight or who had specific dietary requirements were referred to a dietitian. We saw evidence of dietetic reviews in notes. A dietitian was available on the wards at least twice per week and additional advice was available by telephone if required
- Meal times were protected to allow patients time to eat their food. Most clinical tasks were avoided at this time although the medication rounds occurred at meal times. Some wards told us they did not allow visitors during meal times although they did allow relatives to help with feeding if this was required.
- Patients were offered drinks regularly during our inspection and water jugs were full and within reach of patients.
- Patients who required assistance with eating and drinking used red meal trays to identify them to staff. Patients who had required their food intake monitoring also used a red tray.
- Patients were encouraged to eat together at dining tables for their daytime meals. Patients at Beechwood ward said they enjoyed this opportunity to socialise.

Requires improvement

Are services effective?

- Patients had access to information about healthy eating so they could make informed decisions about the food they chose from the menu. We reviewed a selection of menus and found they offered patients a varied diet which included a selection of modified texture diets.
- Patients had a choice of meals and meals to meet cultural and clinical requirements were available, such as Halal or gluten free food. Cold snacks were available for patients outside of meal times and relatives were able to bring food in for patients and store in a fridge.
- Pictorial menus were available to help patients choose their meals.
- Most patients we spoke with said they enjoyed the food however, one patient said it was repetitive because they had been in so long and another patient said the portions were too small for younger, healthier patients. Main meals arrived at each ward pre-packaged and there was no opportunity to request larger or smaller portions. However, staff told us snacks were always available for hungry patients.

Patient outcomes

- There was a defined admission criterion for the community wards. This included step up care for people at home requiring non acute medical care and step down care for patients leaving an acute hospital but requiring rehabilitation. All patients were required to have the physical ability, mental cognition and motivation to participate in active rehabilitation. This did not apply to patients admitted for palliative care. Patient rehabilitation goals were agreed on admission.
- The service did not participate in the Sentinel Stroke National Audit Programme (SSNAP). SSNAP aims to improve the quality of stroke care by auditing stroke services against evidence-based standards and national and local benchmarks. Local acute hospitals started patients on the audit pathway but this was discontinued once patients were admitted to the community. This meant the effectiveness of the stroke treatment provided by the service was not measured. The trust told us it was currently unable to supply data to SSNAP due to logistical issues following the reconfiguration of local services. However, the service was working with the acute sector to resolve these issues and hoped to take part in the audit in the future.
- Stroke patients received care across the service with dedicated stroke beds at Danetre Hospital and Hazelwood ward. During our inspection, we saw stroke patients were being cared for across all sites. A previous review of stroke services recommended all stroke patients were cared for on the same ward to ensure they received the best care possible in line with national guidance. An action plan provided by the trust dated August 2016 included an action that all stroke patients be located on Hazelwood ward only. This had not been actioned. In response to our information request, the service told us it was waiting for the clinical commissioning groups to provide them with assurance that it has carried out all of the appropriate public consultation processes before it actively moves stroke beds to one location.Information provided after our inspection indicated the trust was working with clinical commissioning groups on plans to move all stroke beds to one site.
- Therapy services on Beechwood ward conducted a local audit to assess improvements patients had made from their admission to discharge. The audit was carried out over six months in 2016 and used the Rivermead Outcome Measures to assess patients. Results showed an improvement in functionality of 26%. However, there were no formal audits of patient outcomes performed by therapy staff and therefore there was no benchmarking against other similar organisations.
- Physiotherapy and occupational therapy staff used an integrated patient assessment and management plan to record their interventions. This encouraged consistent rehabilitation therapy goals for patients and promoted multidisciplinary team (MDT) working.
- The community in-patient services all participated in the National Patient Safety Thermometer scheme, which monitored patient harms.
- The average length of stay (LOS) from October 2015 to September 2016 in the service was 45 days. Beechwood ward had the highest LOS with an average of 55 days and Danetre Hospital ward had the lowest with an average LOS of 32 days.

Requires improvement

Are services effective?

- From November 2015 to September 2016, the service reported 14 readmissions. Staff told us some patients regularly returned to the service, for example, following a fall at home. Where possible, patients were readmitted back into the same ward from which they were discharged.

Competent staff

- Appraisal rates for permanent non-medical staff in the service from October 2015 to September 2016 were 95%. Staff we spoke with told us their appraisal had been worthwhile and had provided them with additional training opportunities or personal development plans
- The trust target for clinical supervision was 90%. From October 2015 to September 2016, medical staff exceeded this target. However, clinical supervision for non-medical staff was 77%. No data was provided from April to August 2016. During our February 2015 inspection, we identified that clinical supervision was not routinely recorded for nursing staff and this remained the same during this inspection. However, nursing staff told us they did have ongoing clinical supervision as well as formal training sessions and one to one discussions with their team manager. Therapy staff had a more structured clinical supervision process which was recorded and conducted formally every three months.
- Nursing staff told us about some clinical supervision which involved exploring different responses to unhappy relatives. At Corby Community Hospital we saw an advertisement for a 'clinical supervision session' on wound care. This type of session is regarded as informal training rather than clinical supervision.
- Training and support was provided for registered nursing staff requiring revalidation with the Nursing and Midwifery Council. Revalidation is the process all nurses have to complete in order to continue nursing.
- Preceptorships were provided for newly qualified nurses. Preceptorship is a structured period of transition and learning for registered nurses when they first start nursing. This ensured new staff were provided with adequate opportunities for support, supervision and training.
- Registered nursing staff completed mentorship programmes at a local university. This allowed the service to access student nurses who could work alongside trained staff on placements. We spoke to a student nurse who told us their placement had been a 'great learning opportunity' and had allowed them to learn essential nursing skills.
- All new unregistered staff completed the care certificate. The care certificate was introduced following the Francis Report and Cavendish Review, and assessed individuals against 15 required standards. This provided assurance that unregistered staff had received training to a specific standard.
- The inpatient services had champions or link nurses, for specific services. These included infection prevention and control, tissue viability, dementia, and falls. These champions received extra in-house training to develop their knowledge in a specific area. Champions were responsible for cascading information to the rest of the department.
- All staff groups told us they had good access to further training opportunities, both internally and externally. Examples of courses included, leadership courses, nail care, diabetes care and stroke care pathways. Some courses were taught online, for example blood transfusion training. Skills courses were also provided for example, in catheter insertion and cannulation.
- There was a process in place to manage underperforming staff. Ward managers said they felt supported to do this by their matrons and through the human resource department.

Multi-disciplinary working and coordinated care pathways

- There was good MDT working throughout the inpatient services. Board rounds were conducted on all wards and were attended by the MDT. Some MDT meetings included social service care managers
- We observed a MDT ward round at Danetre Hospital. A doctor from the local GP services facilitated the ward round which included nurses and therapists. Staff discussed patient care and progress with each patient. Concerns and problems were identified and discussed together.

- Relatives were invited to MDT meetings. Relatives were also invited to therapy sessions where staff demonstrated how to help patients move and function safely.
- All wards had an allocated care worker. The care worker ensured social services were aware of every patient who required additional support on discharge. Care workers ensured delays in discharge were kept to a minimum by managing all the necessary referrals and collecting completed assessments.
- The service manager met with local providers to ensure pathways into and out of the service were open as much as possible.
- An intermediate care team was available to support some patients at home. The intermediate care team assessed patients within 48hours of a referral and if suitable, provided support for the patient following discharge. This ensured continuity of care and allowed patients to go home as soon as possible.
- Therapy staff told us their role was embraced by the community services and that they all worked together for the benefit of each patient. For example, we saw how a therapist referred a patient to the speech and language therapy (SLT) team. Following SLT advice, the therapist was able to communicate effectively with the patient, which helped achieve the patient's rehabilitation goals.

Referral, transfer, discharge and transition

- Patients were referred into the service by acute hospitals or GPs. Priority of admission was based on clinical need. Some patient referrals came through the single point of access centre which had oversite of all beds countywide. GP referrals came directly into the service.
- Admission criteria and pathways were in place and patients were mostly admitted appropriately to the service. However, some patients admitted from an acute hospital were found to be medically unfit for admission to a community hospital and had to be readmitted into an acute hospital. Staff told us they completed incident reports for all patients returned to an acute hospital. From September 2015 to September 2016, 21 incidents had been reported for patients returned to an acute hospital. Lessons learned from these included ensuring a set of patient observations were carried out prior to transfer and reviewing the patients' blood results. One patient told us how distressing it had been when they arrived in an ambulance from an acute hospital and had to go straight back again due to their medical condition.
- Staff told us there was a waiting list of approximately two weeks to access the service and approximately 20 patients were currently waiting.
- Discharges from the service were completed any day of the week once the patient was fit enough and had any relevant care packages in placeDischarge letters and medications were prepared in advance of the actual discharge date. GPs were sent discharge letters electronically if they used the same electronic system or posted to the surgery if required.
- Transfers from acute hospitals were planned to occur during the day and ideally before 8pm. However, patients often arrived later than this due to issues with patient transport. Arrivals after 11pm were deemed unacceptable and staff said they would raise an incident report in these circumstances.
- Patients who required care and treatment that could not be provided by the service, for example, because the patient's condition deteriorated, were transferred to an acute hospital. There was an established procedure to follow for this which staff were aware of.
- All wards reported high numbers of delayed discharges. These had reduced over the previous 12 months. From September 2015 to September 2016, 30% (249) of all discharges across the service were delayed. We were told most delays were due to patients waiting for packages of care at home or for placements in care homes. We found that 20% of delayed discharges in the service were due to delays in assessments for care and this compared with the England average of 18% delayed discharges due to assessments.
- Several measures had been introduced to discharge patients as quickly as possible once they were fit. This included, MDT board rounds, which highlighted any barriers to discharge early, provision of estimated discharge dates on admission, therapy assessment with goals, twice-weekly tracking telephone conferences and

the allocation of a dedicated care manager in charge of each discharge. In addition, daily discussions took place with the integrated discharge team and the single point of access cross county flow centre.

- We attended a tracking meeting and heard in depth reviews of each patient's current ability and plans for their discharge. Staff told us most patients were happy with their discharge options. There was a system in place if patients or relatives refused all care packages offered.
- We spoke to several patients across the service who were deemed fit for discharge. Some had been waiting for several weeks and expressed frustration that care in the community had not been found sooner.
- All patients were offered family planning meetings to discuss their discharge options with the MDT and care managers.

Access to information

- Information about patients was stored electronically and on paper. Staff told us paper records were scanned into the electronic system at a later date. Admissions assessments and care plans were completed electronically. Ongoing daily checks such as diet sheets and NEWS charts were written on paper and kept beside the patient's bed. This meant staff had easy access to relevant information about patients.
- Agency staff were permitted to use the electronic records but they required a password and training in order to do so. Very few agency staff had these and so access to electronic patient information was limited for them. Permanent staff told us they logged on and shared electronic information with agency staff when required.
- Information boards across the wards provided information regarding dementia, safeguarding, tissue viability and mandatory training dates.
- All staff could access clinical guidelines and pathways via the trust intranet.
- There was a trust email system and staff told us they regularly accessed this.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Nursing and therapy staff told us they had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) although this training was not mandatory. There was no compliance target for MCA training but in September 2016, 85% of staff were compliant.
- In January 2016 the service carried out a MCA training and knowledge audit. The results showed an improvement in staff knowledge and awareness of MCA and DoLS. Staff that we spoke to were able to describe the relevant consent and decision-making requirements relating to the MCA and DoLS to protect patients.
- We saw evidence that DoLS applications had been made by the service. We reviewed the assessments of a patient subject to a DoLS application and found them to be comprehensively completed. Nursing staff told us DoLS applications were rarely required by the service because most patients wanted rehabilitation. We were told the admission criteria was for patients who had 'the motivation to participate in rehabilitation'.
- All patients had a mini mental capacity assessment using the abbreviated mental test (AMT) on admission. The AMT uses 10 simple questions to highlight any cognitive impairment. Doctors carried out further assessments and tests on patients they were concerned about following the AMT. This helped establish if the impairment affected the patient's ability to consent to treatment.
- Where a patient lacked the capacity to make their own decisions, staff told us that they made decisions about care and treatment in the best interests of the patient and involved the patient's representatives, family, friends, and other appropriate healthcare professionals.
- Consent to treatment was documented electronically on the admission document. We saw further ongoing daily consent had been recorded by selecting from a drop down tick box on the electronic record.
- Therapy staff documented that they had obtained verbal consent prior to treating patients. However, verbal consent was not recorded by all staff groups. We saw nursing staff taking a patient's blood pressure who asked for their permission first and a patient being fed

was also asked first but this consent was not documented anywhere. Patients told us staff usually asked first, or at least 'told them what they were going to do' before they did anything with them.

- A patient information leaflet was available on bed rails. Staff discussed the use of bed rails with patients, and relatives if required, before attaching them to a bed. During our February 2015 inspection we reported that staff referred to bed rails as 'cot sides' and that this term was considered derogatory. During this inspection, we found most staff had used the correct term. We found one record which referred to bed rails as 'cot sides', and so we were not assured that all staff were aware of the derogatory nature of this term.
- Staff we spoke with knew how to raise concerns regarding DoLS. We saw evidence of a DoLS application escalated appropriately at Corby Community Hospital.
- Patients who had dementia or a learning disability were identified on a patient whiteboard using a butterfly symbol. This symbol is used in healthcare to ensure staff can identify patients who require additional support.

Good

Are services caring?

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

Summary

We rated caring as good because:

- All of the patients we spoke to told us they were happy with their care. Patients told us staff treated them with dignity and respect and praised them for being kind and patient. We observed staff behaving this way during our inspection. Staff were described by patients as being 'marvellous' and 'wonderful'.
- Relatives told us that they were invited to care planning meetings and that staff had provided them with emotional support when required. We saw self-care was promoted where appropriate.
- Friends and Family Test (FFT) results were similar to the England average

However:

- The inpatient services scored worse than the national average for privacy and dignity in the Patient-Led Assessments of the Care Environment (PLACE) assessment, 2016.

Compassionate care

- Patients reported positive experiences about their care and told us they were very happy with the way staff treated them. Some patients said staff were very busy but that they made time to attend to their needs. Patients described staff as 'very kind', 'wonderful', and 'marvellous'. We had no negative comments about any of the staff or the care provided.
- We saw staff speak with patients and relatives in a respectful way. Staff were engaged with their patients, were talkative and encouraging and we saw groups of patients laughing with staff.
- Patients said staff respected their privacy and dignity during personal care. Patients said staff always spoke to them as quietly as possible when discussing personal or private matters and ensured the curtains were closed for washing and dressing. We observed this during our inspection. However, PLACE audits carried out in 2016 relating to privacy and dignity and wellbeing showed the service scored worse than both the England average of 90% and the trust average as a whole. Isebrook Hospital and Corby Community Hospital both scored 83%. Danetre Hospital scored the highest at 88% but this had fallen since 2015 when it was 94%.The trust told us it had implemented several measures to improve patient privacy and dignity across all wards. For example, wards were painted different colour zones and new blinds had been obtained.
- The trust used the NHS FFT to obtain feedback from patients. The FFT is a single question survey which asks patients whether they would recommend the NHS service to their friends and family. The most recent published data for the whole trust, showed for December 2016, 97% of patients who responded to the survey said they would recommend the service. This was similar to the England average, which was 95%.
- The service gathered patient feedback and satisfaction using an electronic system called 'I want great care'. All patients were encouraged to provide comments on the care they had received. From April to September 2016, 100% of patients at Corby Community Hospital said they would recommend the service to friends and family. Patients at Beechwood ward were 96% likely to recommend the service and at Danetre Hospital, 94% recommended it. At Hazelwood ward, 84% of patients recommended the service. We reviewed some of the feedback provided in the survey and saw comments had included 'sometimes care is good, sometimes care is bad'; 'not enough staff' and 'left on the toilet too long'. Staff told us that since September 2016, feedback from this survey had improved. Published data for January 2017 showed 100% of patients across all four wards would recommend the service.
- The service received 218 compliments from October 2015 to September 2016. Hazelwood Ward received the most compliments at 73, followed by Beechwood which received 65 compliments.
- All wards displayed a large number of 'thank you' cards, which patients and relatives had given to the staff for the care they had provided. Comments inside the cards indicated that relatives had also felt cared for, as well as the patients.

Good

Are services caring?

- Patients told us that staff encouraged them to be independent and were very patient with them. One patient told us that staff never rushed them and always allowed them as much time as necessary.
- We saw evidence that staff respected the individual social needs of patients. Where possible, patients were encouraged to eat meals together. However, if patients would rather eat in their room, they were allowed to do this. Patients on Beechwood ward told us about the shared activities available, including a video game, and board games and said patients could sit and watch if they did not want to join in.
- During our inspection, we saw that call bells were answered promptly. One patient at Hazelwood ward told us they had waited 20mins for their call bell to be answered.

Understanding and involvement of patients and those close to them

- Staff told us that patients were offered a copy of their care plan. This was recorded on electronically. Most patients we spoke with said they were aware of what their treatment goals were.
- Patients had a multi-disciplinary team (MDT) meeting on admission to discuss their individual care needs. Families also attended these meetings if they wished. Further MDT meetings are arranged if the patient's recovery or discharge plans had to be altered in any way.
- Therapy staff told us they regularly met with families to demonstrate safe ways patients could move when they are discharged. This allowed families the opportunity to ask questions as to how they could assist the patient with everyday tasks.
- Patients and relatives said they would ask staff questions if they wanted more information about anything. During our inspection, family members requested to see a doctor about their relative. This was arranged for later on the same morning.
- Relatives on Beechwood ward were encouraged to join patients during meal times and help them with their meals if necessary.
- Most patients said they knew when they were likely to be discharged, although some said they did not know when they would actually get out because they were waiting for ongoing care packages.
- All patients had a named team lead nurse and doctor who was responsible for their care. Patients and relatives knew who to ask to speak to if they had any questions.
- Patients were encouraged to go out for day trips and visits home when able. This encouraged them to be as independent as possible and allowed them to spend time privately with their families. On Beechwood ward, some patients had 'flats' rather than 'rooms' with individual kitchens, living and bathroom areas. This helped patients gain confidence in their ability to cope once discharged. Relatives could visit patients in the flats and see how they coped with basic tasks such as making hot drinks.

Emotional support

- Pet therapy, via pat dogs, was used on all of the wards except at Corby Community Hospital. The pets were dogs which belonged to staff or volunteers. We saw pictures of these pat dogs at the entrance to each ward. Patients told us they 'loved seeing the dog' and that they always looked forward to the dog visiting them. Pet therapy has been proven to calm patients with dementia. Relatives and friends could also bring in a patient's own pet during visiting hours.
- There was a relative's room at Danetre Hospital, which had been funded by the 'Friends of Danetre Hospital' charity. The room provided a private space where families could be together and contained soft furnishings, drink making facilities and a television.
- Staff told us they referred patients to a psychologist if required. Relatives told us that the nursing staff provided them with emotional support. A chaplain was also available.
- A member of staff at Beechwood ward wrote to previous head injury patients and invited them and their families to a ward coffee morning along with all of the current patients and their families. The previous patients were invited to give a talk on how it felt to be back home and

they discussed the difficulties they had encountered. This allowed current patients the opportunity to ask questions and plan emotionally for going home after being in hospital for several months.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Information about the needs of the local population was used to inform how services were planned and delivered.
- Services were planned and delivered to take into account the individual needs of its patients, for example, age, disability, gender, religion or belief.
- Patients had timely access to initial assessment, diagnosis or urgent treatment and could access services at a time to suit them.
- Information on how to raise complaints and concerns was displayed in the areas we inspected. Staff told us information about complaints was discussed at team meetings to raise awareness and aid future learning.
- Patients were admitted from home when they required a step up in their care as well as being admitted from acute hospitals as a step down in care. Patients requiring admission from home took priority over patients being discharged from hospital. This helped avoid unnecessary admissions into the acute sector.
- The service adapted the care and treatment delivered to meet the needs of individual patients, for example those living with dementia.
- There was good access to multi-disciplinary care across the service.
- Patient and family preference was taken into account when admitting patients. Where possible, patients were moved to the most local hospital that had a suitable bed, in order to reduce travelling times for relatives.

However:

- Bed occupancy was high in all wards and there was a waiting list for admissions.
- Patients who required an urgent swallowing assessment waited up to 10 working days for an assessment. Some patients awaiting discharge had delays in their assessments.
- Corby Community Hospital had bright blue flooring. This could be confusing for patients with a cognitive impairment or dementia because it looked like water. Staff told us some patients did not want to step on the blue floor because it looked like water.

Planning and delivering services which meet people's needs

- The trust worked with Nene and Corby clinical commissioning groups (CCGs) to plan and deliver services to meet the needs of the population.
- Senior representatives from the service met regularly with local CCGs, social services, county councils and acute hospital providers to discuss ways of meeting the health needs of patients in the local area. Where needs could not be met, actions were discussed to provide suitable alternative care and treatment options. For example, there was insufficient care available in the community to fulfil all requirements. In order to discharge patients sooner, the service provided care in the patients home for up to 19 days following discharge. This allowed the patient to go home as soon as possible and freed up the hospital bed for another patient.
- There was a clearly defined admissions criteria for patients wanting to use the service.
- Kettering General Hospital and Northampton General Hospital, both local acute hospitals, fed directly into the service. Patients were also admitted from other acute regional hospitals when required. The services were also aligned with the intermediate care team, the community palliative care team, and the community stroke team.
- Admission to the service was via a central single point of access (SPA) patient centre. Patients who required continued care after discharge from the community hospitals were also referred to the SPA. The SPA had oversight of all available beds at each care facility across the county and ensured patients with the most need were allocated to the most suitable bed. Community hospital patients were referred to the SPA when their estimated day of discharge was 10 days away. This allowed the SPA to begin the process of finding an appropriate package to suit the patient's needs.
- Patients rarely had to move beds once they were admitted to a unit, unless it was necessary to ensure

male and female beds were separated. However, staff told us they had moved patients between hospitals when requested by patients and families to ensure they were treated as locally to home as possible.

- The service provided a step up facility for patients who became ill at home. This prevented them from being admitted to an acute hospital. The service offered a step down to patients who required nursing care and rehabilitation following a stay in an acute hospital. Admission for step up patients took priority over patients who were waiting to leave an acute hospital bed.
- End of life care facilities were provided at Danetre Hospital where beds were specifically reserved for patients on an end of life pathway.
- Rehabilitation was the main focus for care but sub-acute care was also provided. Additionally, day case administration of intravenous medication (through a vein) and blood transfusion services were provided at Danetre Hospital. This avoided medically fit patients who required long-term intravenous medication or blood, from being admitted into a hospital bed.
- Beechwood ward provided neurological rehabilitation services specifically for younger adult patients.
- Beechwood ward provided the most activities for patients. This included video games, Zumba exercise classes and a selection of board games. Patients told us activities were adapted to the needs of each patient and told us about events where family and friends attended. There was an easily accessible garden for patient use. However, patients at Corby Community Hospital told us they had not been involved in group activities and that their only entertainment was a shared television. Therapy staff told us the group activities were new at Corby Community Hospital but included movie nights, mindfulness sessions and exercise classes.
- Patients were provided with a welcome pack on admission to each hospital. Information in the pack included an explanation of the different staff uniforms, mealtimes and who to contact if patients had any concerns.
- Stroke patients were referred to a speech and language therapists (SLT) for a swallowing assessment. However, access to SLT involved long delays for non-stroke patients using the service. The trust told us this was because there was no SLT funding budgeted for community inpatients.

Equality and diversity

- Policies were in place to ensure that the equality and diversity of staff and patients was respected.
- Translation services were available when required and staff we spoke with said they knew how to access these. Staff told us the majority of patients using the service were of white/European ethnicity and this reflected the demography of the area.
- Equality and diversity training was mandatory training for all staff and 100% of staff in the inpatient services had completed their three yearly update.
- Disabled parking was available at all sites and lifts were available at Danetre Hospital, which provided a service above the ground floor. All sites were accessible for people who used a wheelchair or other mobility aid.
- There was no access to multi faith centres at any of the hospitals.

Meeting the needs of people in vulnerable circumstances

- Results from the Patient-Led Assessments of the Care Environment (PLACE) 2016, relating to dementia, were above the national average. This assessment looked at how the environment met the requirements of patients living with dementia. Corby Community Hospital scored 97% and Isebrook Hospital scored 92%. Danetre Hospital had the lowest score at 89% but this was still better than the England average of 75%.
- Patients over 75years old were screened for dementia on admission. Audits carried out by the service in 2016, showed 100% of patients were screened on Hazelwood ward and Beechwood ward and that 85% were screened at Corby Community Hospital and Danetre Hospital.
- Patients living with dementia had an individual 'all about me' care booklet, which provided information for staff on the individual needs of the patient. This included information on what they liked to be called,

how they liked to drink their tea and any help they required getting dressed. Relatives helped to complete the booklet as soon as possible after a patient was admitted.

- White boards were available at each bedside and were used to highlight the individual requirements for each patient. For example, patients who used a hearing device during the day or who were at risk of falling. This helped staff tailor the care they provided to individuals.
- Adaptive cutlery was available for patients with who found it difficult to hold traditional knives and forks.
- Training records showed 81% of service staff had undertaken training in learning disabilities and 87% had dementia awareness training. This helped staff meet the specific needs of patients.
- Hazelwood ward employed a mental health trained nurse who had training and experience of working specifically with mental health patients. This nurse provided local training to other staff on the ward.
- Special clocks were available for patients living with dementia to help orientate them on the wards. Some toilet and bathroom signs included a picture to help patients find the right room. The wards had been painted 'dementia friendly' colours. On Hazelwood ward, this included segregating different bays by using different colour paint for the walls. However, at Corby Community Hospital the floor was painted bright blue. Staff told us some patients were confused by this and did not want to walk on the floor because they thought it was water.
- All wards had an area or room patients and their relatives could speak with staff in private.
- There was a variety of bedroom options available in the service. Single side rooms with bathrooms were available on all wards alongside small bays for up to six patients. Beechwood had some flats, which included a living space and kitchenette. Some of the patients we spoke with enjoyed having their own room and others said they enjoyed being on a ward where they could see other people. Where possible, staff tried to allocate beds according patient preferences but they said this was not always possible for clinical reasons.
- The service reported no mixed sex breaches from September 2015 to September 2016. Consideration was given to the location of toilet facilities when allocating patients to beds to ensure compliance with single sex facilities.

Access to the right care at the right time

- Patients throughout the county were admitted from a single point of access centre following an assessment of needs. There was a waiting list for admission to the service. Approximately 20 patients were waiting for a bed at each hospital at any one time. Delays in patient admissions were due to lack of available beds. However, there were patients on all wards who were medically fit for discharge but required further assessments or packages of care before they could go home.
- There were high levels of bed occupancy within the service and staff told us they rarely had an empty bed on their ward. From October 2015 to September 2016, the trust's average bed occupancy rate was 97%. High bed occupancy was highlighted during our last inspection in 2015 when it was 94%. Hazelwood ward had the highest bed occupancy rate for the 12-month period at 100%. Bed occupancy rates above 85% can affect the quality of care given to patients and can increase the number of infections in a hospital.
- Patients requiring rehabilitation following a stroke were referred to specialist stroke beds based in Danetre Hospital and Hazelwood ward. However, during our inspection, stroke patients were on all wards. The trust told us patients were always offered a specialist stroke bed but they were given a choice and could elect to go to a general rehabilitation bed if they preferred. Patients often chose to be placed in whichever bed was nearest their home so friends and family could visit easily.
- Danetre Hospital provided six beds for patients requiring end of life care. It reserved two beds at all times for patients with palliative care needs. This ensured a bed appropriate for patients requiring this care was available when required.
- Most patients were admitted to the service during the daytime. Out of hours, admissions were avoided because of the increased safety risk associated with being in an unfamiliar environment at night time and there was reduced doctor availability out of hours. Patients who were admitted in the day received a

thorough assessment to ensure staff understood all of their needs. However, some out of hour's admissions did occur, mainly due to delays in transport when patients were admitted direct from an acute hospital.

- Therapy services were available seven days per week. New therapy assistant roles had been created to allow weekend rehabilitation and reduce patient length of stay. Patients told us they had regular physiotherapy and went to the gym frequently. One patient told us they went to the gym four times a week and sometimes even more.
- Therapy staff had a target to assess patients within 72hour of a referral. Therapy staff told us most patients had an initial assessment within 24hours of their admission. Further on-going assessments were scheduled according to individual patient need.
- There was a service level agreement in place for stroke patients to receive speech and language therapy (SLT) and dietetic care.
- Patients using the service and who were in a stroke bed were seen by a SLT therapist within a week of their admission. However, there was a waiting time of 13 weeks for patients in community beds. Urgent swallowing assessment referrals were seen as quickly as possible within 10 working days of their referral.
- During our February 2015 inspection, we reported patients waited an average of six days to see a dietitian. During this inspection, most patients were assessed by a dietitian within four days. Nurses told us they followed malnutrition universal screening tool (MUST) guidance and started patients on nutritional supplements until the dietitian assessed the patient. We looked at the notes of a patient who was waiting to see a dietitian and saw that nutritional supplements had been prescribed. This meant that patients were still receiving first line care and treatment despite the delays in dietetic assessments.

Learning from complaints and concerns

- The service had three formal complaints reported from October 2015 to September 2016. One complaint involved medication omissions and was upheld. Two complaints were not upheld and involved staff attitude. In all cases, an apology was provided by the trust and action plans were put in place and monitored by managers.
- Managers told us they tried to resolve informal complaints locally, but if this was not possible, patients and their relatives were referred to the trust's complaints process. Nursing and therapy staff told us they were aware of the complaints process. Staff said they tried to resolve issues at the time directly with patients and escalated anything to their managers that they were unable to resolve themselves. Nursing and therapy staff received feedback about complaints during their team meetings. Issues and complaints raised were discussed and lessons learnt were shared across the services. A nurse told us about a recent informal complaint and the measures which had been implemented to prevent similar concerns arising in the future.
- Posters were available on ward information boards which provided information on the complaints process and provided contact telephone details for patients. Patients we spoke with told us they would speak to the staff if they had any complaints.
- Ward notice boards included a section to display patient feedback. This was in the form of 'you said, we did'. However, some of the boards had staff comments rather than patient feedback. For example, the board on Hazelwood ward included 'a new reception area' and 'falls training' as a list of improvements they had made.

Good

Are services well-led?

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

Summary

We rated well-led as good because:

- There were effective governance arrangements in place to monitor quality, performance and patient safety. There was evidence that information from meetings was shared with staff.
- Local leaders were visible and staff told us they felt supported and valued and that their managers were approachable. There was an open culture with local management and staff said they would be able to raise any concerns with them.
- Matrons told us they had the autonomy to manage their own services.
- Staff were encouraged to approach their managers with ideas for service improvement or innovation.
- The service had taken a positive approach to the findings from our February 2015 inspection. Information about the improvements that had been made was available on notice boards in public corridors.

However:

- Some risks on the risk register remained the same as during our February 2015 inspection. These included, estates issues at Corby Community Hospital, staffing numbers, and low compliance to immediate life support training. Although these risks had been reviewed, there was little evidence of change or improvement.
- Vacancy rates and high sickness levels put additional pressure on substantive staff.
- The strategy to move all stroke patients to one hospital site was delayed. Plans started in August 2016 had not been completed. However, the trust provided evidence that they are now working on this strategy.

Governance, risk management and quality measurement

Leadership of this service

- A service manager for community hospitals represented the service at board level. A senior matron had responsibility for all four hospital wards and reported directly to the service manager.
- Each ward had a matron who provided local leadership and reported directly to the senior matron. The senior matron visited sites throughout the week to ensure staff had access to senior leaders as much as possible. Staff working on the wards told us they regularly saw both the senior matron and the service manager.
- Members of the executive team conducted regular board walks (informal visits) to the wards and services they were responsible for. These were opportunities to meet staff and to speak to patients and gain feedback about service provision. Staff spoke positively about the visits.
- Information was available to staff and visitors about how the service was making improvements following our February 2015 inspection. Staff saw our inspection as part of their continuous journey to improve. Managers carried out their own self-assessments that followed a CQC assessment style.
- Staff spoke highly about the support their immediate managers gave them. Staff told us their managers were approachable and they felt comfortable approaching them with any problems.
- Leadership was recognised by the trust as being essential for success. Leadership training was available to nursing and therapy staff.
- Clinical managers worked on the wards and delivered direct patient care when required to cover staff absences. This supported staff and provided opportunities for role modelling
- During our February 2015 inspection, we reported that there was a lack of shared learning between the services. However, during this inspection we found the

Good

Are services well-led?

wards were working together closely and that there were increased opportunities for sharing ideas. This included monthly ward team meetings which included both nursing and therapy staff.

- Therapy staff told us that they felt very much part of the service and that the teamwork between nursing and therapies was excellent. Staff said the introduction of new therapy roles had improved joint working.

Service Vision and strategy

- Managers told us there was a strategy for the service. The strategy had recently changed following the reconfiguration of health services across the county. The strategy included providing sub-acute care for patients with a focus on managing complex rehabilitation needs.
- The vision and values of the trust were displayed throughout the service. These had recently been changed but most staff told us about the values of their organisation.
- Values included, putting patients first, and respect, dignity and compassion. The service was also dedicated to treating everyone equally and providing a quality service to improve the health of people who used its hospitals. We saw these displayed on ward notice boards.
- Staff told us they felt listened to and that the welfare of the patients and wellbeing of the staff were very important to the organisation.

Governance, risk management and quality measurement

- Governance arrangements to monitor quality, performance and safety were in place and provided assurance to the trust board. Governance meetings were held at all levels regularly and discussed key performance issues including incidents, complaints, risks, best practice guidance, audits and lessons learned. These meetings were minuted and there shared with all relevant staff.
- Each ward held regular ward meetings where information from board level was discussed. We saw minutes from these meetings which demonstrated information was passed down from senior level to ward level.
- The service held their own risk register which was reviewed regularly. Risks were classified as red, amber, green (RAG) rated according to severity. High risks recorded included staffing levels, inappropriate admission of sick patients from acute hospitals, and uneven floors at Corby Community Hospital. Other risks were rated as moderate or low risk. Each risk had named staff responsible for carrying out mitigating actions by set review dates. Although actions from the risk register had been updated, there was little evidence of change or improvement.
- All ward managers acknowledged concerns about staffing levels. Staff used a risk assessment tool to guide actions when they had concerns about the number of staff on duty.
- Local quality auditing was important to the service and we saw this in governance meeting minutes where local audits were discussed. However, there was no evidence of participation in national benchmarking audits. This meant the service could not make comparisons in the quality of care it provided compared to other providers. There was also no data collected on patient outcomes from a therapy perspective indicating no ability to formally identify the effectiveness of their clinical input and assuring they met patient needs.
- Performance monitoring was done via a quality dashboard using information gathered by matrons on the safe delivery of care. The quality dashboard results were shared at team meetings and at governance meetings to ensure local actions were undertaken whenever issues with quality had been identified.
- An information governance audit was carried out in 2016 in response to concerns about the security of confidential patient information on Hazelwood ward. Concerns included the privacy of telephone calls received at reception and a fax machine was located in a public area plus access to medical records was unrestricted. This had been listed on the divisional risk register. During our inspection, we saw that these concerns had been addressed and that confidential information was now handled securely. A new reception desk had been created and the fax machine had been relocated into an office alongside patient records.

Good

Are services well-led?

Culture within this service

- Staff we spoke with reported a positive, supportive culture amongst the team. When staff required help or advice, they said they contacted their colleagues, even if they were not on shift, and always got the help they needed.
- There was an open door culture for staff with their managers. Managers said staff could arrange to see them or just drop in anytime. Staff told us they felt comfortable with their managers and would raise concerns with them if required.
- Staff told us they took pride in their work and that they were happy to work hard to improve patient care. Morale across the service appeared good with staff saying they enjoyed working for the trust. Staff told us the things they were most proud of was the high standard of patient centred care they provided and the working relationships they had with their colleagues.
- Staff in the service were aware of the whistle blowing policy and said they would know who to contact if they had any concerns in their area.

Public engagement

- There was an active charity, 'Friends of Danetre Hospital' that provided financial support to purchase equipment and improved facilities. Staff said the charity was very involved with the ward and told us about new plans to develop a garden for patients at Danetre Hospital.
- There were 'You said, we did' comments on display boards on each ward. For example, water dispensers had been provided following feedback from patients.
- On Beechwood ward we saw an information board which a previous patient had designed about the care they wanted during their stay.
- Information was available to the public about the services provided in the community hospitals via a web page on the internet.

Staff engagement

- The staff Friends and Family Test was launched in April 2014 in all NHS trusts. Staff are asked if they would recommend their service as a place to receive care, and whether they would recommend their service as a place of work. The percentage of staff in the trust as a whole who recommended the organisation as a place to work was 66% which was better than the national average of 64% (NHS England, Friends and Family Test, 2016 to 2017, quarter two). The response rate to this test was 34%, which was considerably better than the England average of 13%.
- Information for staff on current developments and news was available on the trust intranet. This included a section called 'the staff room', which highlighted new trust policies that had been released and any new training available for staff.
- The trust held 'recognition of achievement' awards for staff and services. Staff at Corby Community Hospital won a recent Trust Ambassador Award for their implementation of the SAFER patient flow bundle. The trust promoted health and wellbeing for staff. On the trust intranet there was a section called 'Your health: Your wellbeing' which promoted staff health, including exercise sessions and dietary advice.

Innovation, improvement and sustainability

- During our February 2015 inspection staff said there was a lack of innovation throughout community inpatient services because staff were always too busy doing their day jobs to be innovative. During this inspection staff told us of some changes they had made to improve the service. This included the implemented a patient flow bundle called SAFER across all of the community hospitals. The SAFER bundle was originally developed as a tool to help patient flow for acute hospitals but the service had made adaptations to the model to make it useful in a community hospital. SAFER has improved the focus of weekly multi-disciplinary meetings and communication with patients and their families.
- Danetre Hospital had been redecorated to make it more dementia friendly, signs had been updated to include pictures of baths and toilets.
- There was an ongoing programme of staff development and skill mix changes which supported the provision of seven day therapy for patients.
- A modified National Early Warning Score chart had been developed. This ensured specific triggers made it more responsive to the needs of community patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The trust did not ensure medication was administered in line with trust policy, best practice and national guidance. This included correct documentation on prescription cards, risk assessments, single dose medication and authorisation of medication. • The trust did not ensure all medicines are stored and disposed of in line with trust policy and best practice. • The trust did not ensure staff received the appropriate competency training following a medicine incident. Staff training must include the requirement to report all medication incidents on the electronic incident reporting system as per trust policy.