Tarporley War Memorial Hospital

Quality Report

Tarporley War Memorial Hospital
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Tarporley War Memorial Hospital was founded in 1919 by local subscription; it is funded by a small NHS grant which covers one third of its operating costs. The remaining funding is achieved through private self-paying patients, one off payments from NHS commissioners and charity fundraising. The hospitals registered charity fundraises through a local charity shop and other charitable initiatives. The in-patient unit specialises in the rehabilitation of the elderly, intermediate care and supporting terminally ill and palliative patients. The hospital also has a mini-minor injuries unit, where adults and children can be treated.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury.

The hospital director is the registered manager. This inspection was carried out as part of our ongoing programme of comprehensive independent health care inspections. We inspected the hospital on 1 and 2 February 2017 as an announced visit.

We inspected all areas of the hospital:

Are services safe at this hospital

- Although there was an incident reporting system in place, we found there was limited assurance that all incidents were reported and that learning took place following incidents that were reported.
- At the time of the inspection, three inspectors observed that a room occasionally used as a mortuary, was being utilised for storing equipment and was not fit for the use as a mortuary.
- Ten out of 13 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were incorrectly completed.
- Patients deemed at risk of pressure ulcers were not provided with the correct control measures to mitigate the risk of pressure damage such as monitoring and implementing a repositioning regime.
- The acuity tool used to determine staffing levels did not provide a measurable level that would indicate when extra staff were required. It did not effectively assist in determining appropriate staffing levels.
- Archived patient records were not stored appropriately; loose papers were not secured together meaning there was a risk that information may be lost.
- Staff treating children and young people for minor injuries were not trained to level 3 safeguarding.
- The hospital policy for the use of bed rails, by gaining consent from a relative rather than assessing if the patient had capacity, was contrary to the Mental Capacity Act 2015.
- Tarporley War Memorial hospital recorded safety thermometer information to enable them to determine their levels of harm free care.
- The hospital reported no serious incidents to patients during the reporting period February 2016 to January 2017.
- The hospital understood their responsibilities regarding safeguarding vulnerable adults, 85% of staff had completed training on safeguarding to level two. Staff knew how and when to make a safeguarding referral. The hospital reported they had not had cause to make any referrals during the reporting period February 2016 to January 2017.
- Medicines were stored securely and there were processes in place to ensure they remained suitable for use.
- Resuscitation equipment was in place and records indicated this was consistently checked.
- Other equipment was serviced and maintained regularly and appropriate records kept.
- Satisfactory minimum levels of staff were on duty to maintain patient safety.
- Ninety two percent of staff were up to date with their mandatory training.

Are services effective at this hospital

Summary of findings

- The hospital did not always follow evidence based care and treatment guidance and the National Institute for Health and Care Excellence (NICE) guidance such as NICE guidance on the prevention of pressure ulcers.
- The hospital did not have a system in place determine which NICE guidance applied to their scope of practice.
- There was limited assurance of an adequate and effective auditing programme.
- We identified a lack of understanding and incorrect application of the Mental Capacity Act legislation. Some patients did not have satisfactory evidence of the two stage mental capacity assessment documented.
- We saw limited assurance that the competency of health care assistants was assessed and recorded when acting as second checker for medicines administered in the absence of a second registered nurse.
- The hospital followed evidence based guidance in connection with wound care and risk assessments.
- Rehabilitation patients received assessments and input around their activities of daily living from occupational therapists and physiotherapists.
- Patients stated they were asked about pain and were satisfied with their pain relief.
- Nutrition and hydration needs were assessed and recorded; food provision was both appetising and nutritious.
- There was evidence of multidisciplinary input and involvement from all professionals in patient care.

Are services caring at this hospital

- Patients we spoke to were extremely positive about the care provided by staff.
- We saw that patients were treated with care and compassion and that their privacy and dignity was maintained.
- The hospital received very positive feedback on patient satisfaction surveys.
- We found many positive examples that demonstrated the kindness and thoughtfulness of staff towards their patients.
- Patients and those close to them were involved and consulted in their care and treatment.
- Provision was made for the emotional and psychological support of patients during their stay at the hospital

Are services responsive at this hospital

- The hospital did not gather information to identify the types of people who used the service. For example, the number of children who used the mini minor injuries service or the number of people living with dementia who used the hospital was not monitored. Trends in the reasons why people were admitted for respite care were not identified. This meant plans to develop the hospital were not informed by information about the types of people who became patients.More consideration was needed in relation to responding to people
- living with dementia or in vulnerable circumstances such as better signage throughout the hospital; large print leaflets readily available or a colour scheme in the public areas which separated private from public areas.
- Equality and diversity needs of patients and their families were not addressed by the service.
- The criteria for admission and the admission processes were not robust which meant people could be admitted to the service whose needs could not be met.
- Patients' who were known to the service did not have their care needs before each admission for respite care. This meant the service did not know prior to admission whether person's needs could be met.
- The complaints policy did not provide correct information and was not accessible to patients.
- Complaints received were fully investigated and independent specialists were involved when appropriate. Findings were discussed with the complainant and the outcomes shared with staff involved, but we found not all reported incidents were shared with the wider staff team.
- Patients were able to get involved with planning and providing a service through involvement in the fundraising initiatives and volunteer schemes.
- Patients were able to access the service in a timely manner and care and treatment was co-ordinated with other providers.
- Bed occupancy rates for 2015/16 was 62% which meant people had ready access to the service if required.
- The service worked with a clinical commissioning group (CCG) to plan and deliver step down bed for patients who did not need to be in acute hospitals.

Summary of findings

- Systems were in place to inform the local hospitals, GPs and others about beds available at the hospital.

Are services well led at this hospital

- There was no central vision shared by managers and staff concerning the care and treatment of patients.
- Governance arrangements were not embedded and were not robust enough to fully monitor quality, performance and patient safety.
- The hospital did not participate in national audits, but they undertook some local audits. We saw a hospital audit programme, however there was no actual analysis of audit findings, improvement actions or monitoring. We saw one audit completed by the previous hospital manager, but there was no analysis or learning points.
- The risk register was not robust and did not identify clear processes for mitigating risks and ongoing monitoring with given time scales.
- The process for staff to escalate local level ideas and risks was unclear.
- There was clear evidence that information from meetings was shared so all staff were aware. The Hospital Director was visible and staff told us they felt supported and valued by their peers and direct line managers.
- There was an open culture and staff felt they would be able to raise any concerns however they did not always receive feedback.
- There was a turnaround plan which identified areas that needed to be developed and improved in all aspects of managing the hospital.

Due to concerns and issues found on inspection we have taken enforcement action. The following regulations were breached;

Failure to comply with the relevant requirements of Regulation12 (1)(2)(a) Safe Care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Failure to comply with Regulation 17 (1)(2)(a)(b)(c), Good governance, of The Health and Social Care Act 2008(Regulated Activities) Regulation 2014

The hospital was given a compliance date and we will follow this up to check compliance with the regulations.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

Tarporley War Memorial Hospital was rated 'Requires Improvement'. The regulated activities we inspected were; diagnostic and screening procedures, treatment of disease, disorder or injury.

Our findings were as follows:

we found the following issues that the service provider needs to improve:

- Although there was an incident reporting system in place, we found that there was limited assurance that all incidents were reported and that learning took place following incidents that were reported.
- The main incidents reported were medicine errors and patient falls, we saw some evidence that these had been analysed for trends and patterns. However, in response to medication incidents we saw that the hospital advised 'we will remind staff to take extra care when administering medicines', as opposed to reviewing practices and competencies of staff.
- Information provided by the hospital showed that there had been no cases of MRSA and clostridium difficile (c.difficile) for the period April 2016 to

Summary of findings

December 2016. An audit for infection control was undertaken in November 2015, the audit showed good compliance with standards, however further audits have not since been completed.

- The risk register was not robust and did not identify clear processes for mitigating risks and ongoing monitoring with given time scales. The process for staff to escalate local level ideas and risks was unclear.
- The hospital did not always follow evidence based care and treatment guidance and the National Institute for Health and Care Excellence (NICE) guidance. The hospital did not participate in national audits, but they undertook some local audits. They have recently started following aspects of the safety thermometer which was submitted to the Quality advisory group and Trustee board.
- There was evidence of multidisciplinary input and involvement in patient care. A multidisciplinary meeting was undertaken every Monday to discuss the plan of care for each patient. This involved occupational therapists, physiotherapists and registered nurses.
- We spoke to trustees of the hospital who had strong ideas on the vision for the future of the hospital; however, the hospital staff could not describe the overarching vision or stated values. There was no quality strategy or clearly articulated quality priorities.

We found the following areas of good practice:

- Data provided by the hospital showed that 85% of staff had received an appraisal in the last twelve months.
- Patients were extremely positive about the care provided by staff. We saw that patients were treated with care and compassion and that their privacy and dignity was maintained. The hospital had very good patient feedback and positive feedback on their patient satisfaction surveys.
- Patients who were suitable for rehabilitation were assessed by physiotherapists and occupational therapist within 48 hours of admission. Individualised rehabilitation care plan were implemented.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, to help it move to a higher rating. Details are at the end of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Summary of findings

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Summary of this inspection

Background to Tarporley War Memorial Hospital

Tarporley War Memorial Hospital was founded in 1919 by local subscription; it is funded by a small NHS grant which covers one third of its operating costs. The remaining funding is achieved through private self-paying patients, one off payments from NHS commissioners and charity fundraising. The hospitals registered charity fundraises through a local charity shop and other charitable initiatives.

The hospital has 16 inpatient beds (separate male and female wards; five private side rooms and one double room). The hospital mainly caters for NHS 'step-down' patients who do not require acute care, (e.g. a fall, but no fracture) and patients transferred from an acute hospital who are waiting for a package of care to return home. We looked at all wards during the inspection.

The hospital provides a 'step up' service for people who needed extra care and help and 'step

down' services for those who no longer required an acute hospital bed. They also provide rehabilitation, respite care and palliative care.

The hospital also manage a "mini minor injuries" drop in service and have an outpatient's service which is operated by external providers, but using hospital facilities and nursing staff.

In 2016 the hospital had 208 inpatients comprising 54 step up, 62 step down, 79 respite care and 13 palliative care patients. The dressing's clinic saw 1625 patients which was an average of 135 a month; the mini - minor injuries clinic saw 192 patients, an average of 16 patients per month.

The hospital has a registered manager, who is also the director of the hospital. The hospital is registered with CQC for regulatory activities; diagnostics and screening procedures, treatment of disease and disorder and surgical procedures.

During our inspection; We spoke with 14 patients and relatives, 12 members of staff and three trustees and the (honorary) medical director. We reviewed 22 sets of patient records from current and past patients.

Tarporley War Memorial hospital was last inspected January 2014 and prior to this in November 2012 and was found to be compliant in all areas on both inspections.

Our inspection team

The team that inspected the service comprised of an Inspection Manager, three CQC inspectors, specialist advisors including a rehabilitation nurse and a manager with experience in governance and healthcare management.

Why we carried out this inspection

The inspection was carried out as part of our ongoing programme of comprehensive independent health care inspections

Summary of this inspection

How we carried out this inspection

To get to the heart of patients' experiences 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?

The hospital provided us with comprehensive information and data before and during the inspection We looked at information from Healthwatch and from the commissioners of the services.

During the announced inspection on the 1 and 2 February 2017 and the unannounced inspection on 13 February 2017 we spoke with a range of staff including senior managers, nurses, trustees, administrators and health care assistants who worked at the hospital.

We spoke with patients and relatives who were attending the hospital at the time of our inspection. We gathered feedback from questionnaires and received comments from people who contacted us to tell us about their experiences. We also reviewed patient records.

We viewed policies and standard operating procedures. We observed care and treatment, reviewed performance and assessed information about the hospital. We inspected the environment to determine if it was an appropriate setting for delivering care and treatment and for use by patients and staff. Following the inspection we requested additional information which was provided in a timely manner.

What people who use the service say

We spoke with three patients who were very positive about the service provided at Tarporley War Memorial Hospital, and they told us the staff were kind and helpful and the facilities met their needs. Patients were also happy with the choice and quality of food and drink on offer.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated community health inpatient services as 'Requires Improvement' for safe. This was because:

- There was no documented evidence that those patients deemed at risk of pressure ulcers were provided with the correct control measures to mitigate the risk of pressure damage such as monitoring and implementing a repositioning regime.
- Although there was an incident reporting system in place, we found that there was limited assurance that all incidents were reported and that learning took place following incidents that were reported.
- The hospital was not a purpose built healthcare facility and was an older building. This posed some challenges from an environmental point of view.
- The acuity tool used to determine staffing levels did not provide a measurable level that would indicate when extra staff were required.
- Archived patient records were not stored appropriately.
- Staff treating children and young people for minor injuries were not trained to level 3 safeguarding.
- The hospital policy for the use of bed rails by gaining consent from a relative rather than assessing if the patient had capacity is contrary to the Mental Capacity Act 2015.

However we also found;

- Tarporley War Memorial hospital recorded safety thermometer information to enable them to determine their levels of harm free care.
- The hospital reported no serious incidents and greater than moderate harm to their patients during the reporting period February 2016 to January 2017.
- The hospital understood their responsibilities regarding safeguarding vulnerable adults, 85% of staff had completed training on safeguarding to level two and the hospital had not made any referrals during the reporting period.
- Medicines were stored securely and there were processes in place to ensure they remained suitable for use.
- Resuscitation equipment was in place and records indicated this was consistently checked.
- Other equipment was serviced and maintained regularly and appropriate records kept.

Summary of this inspection

- Satisfactory minimum levels of staff were on duty to maintain patient safety.
- Staff were up to date with their mandatory training at 92%.

Are services effective?

Requires improvement

We rated community health inpatient services as 'Requires Improvement' for effective. This was because:

- The hospital did not always follow evidence based care and treatment guidance and the National Institute for Health and Care Excellence (NICE) guidance.
- We found ten out of 13 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms were incorrectly completed.
- The hospital did not have a system to ascertain which NICE guidance applied to their scope of practice.
- The hospital failed to follow best practice in relation to the NICE guidance on the prevention of pressure ulcers.
- There was limited assurance of an adequate and effective auditing programme.
- We identified a lack of understanding and incorrect application of the Mental Capacity Act legislation. Some patients did not have satisfactory evidence of the two stage mental capacity assessment documented. The hospital's own policy was not aligned with mental capacity act legislation.
- We saw limited assurance that the competency of health care assistants was assessed and recorded when acting as second checker for medicines administered in the absence of a second registered nurse.

However we also found;

- The hospital followed evidence based guidance in connection with wound care and risk assessments.
- Rehabilitation patients received assessments and input around their activities of daily living from occupational therapists and physiotherapists.
- Patients stated they were asked about pain and were satisfied with their pain relief.
- Nutrition and hydration needs were assessed and recorded; food provision was both appetising and nutritious.
- There was evidence of multidisciplinary input and involvement in patient care.
- Staff were generally competent and received the appropriate training to undertake their roles.
- A formal induction policy was in place for new staff.

Summary of this inspection

Are services caring?

Good

We rated community health inpatient services as 'Good' for caring. This was because:

- Patients were extremely positive about the care provided by staff.
- We saw that patients were treated with care and compassion and that their privacy and dignity was maintained.
- The hospital had very good patient feedback and positive feedback on their patient satisfaction surveys.
- We found many positive examples that demonstrated the kindness and thoughtfulness of staff towards their patients.
- Patients and those close to them were involved and consulted in their care and treatment.
- Provision was made for the emotional and psychological support of patients during their stay at the hospital.

Are services responsive?

Requires improvement

We rated Community health inpatient services as 'Requires improvement' for responsive. This was because:

- The hospital did not gather information to identify the types of people who used the service. For example, the number of children who used the mini minor injuries service or the number of people living with dementia who used the hospital was not monitored. Trends in the reasons why people were admitted for respite care were not identified. This meant plans to develop the hospital were not informed by information about the types of people who became patients.
- More consideration was needed in relation to responding to people living with dementia or in vulnerable circumstances such as better signage throughout the hospital; large print leaflets readily available or a colour scheme in the public areas which separated private from public areas.
- Equality and diversity needs of patients and their families were not addressed by the service.
- The criteria for admission and the admission processes were not robust which meant people could be admitted to the service whose needs could not be met.
- Patients' needs were not reassessed before each admission for respite care.
- The complaints policy did not provide correct information and was not accessible to patients.
- Complaints received were fully investigated and independent specialists were involved when appropriate. Findings were discussed with the complainant and the outcomes shared with staff involved at the team brief.

Summary of this inspection

However we found:

- Patients were able to get involved with planning and providing a service through involvement in the fundraising initiatives and volunteer schemes.
- Patients were able to access the service in a timely manner and care and treatment was co-ordinated with other providers.
- Bed occupancy rates for 2015/16 was 62% which meant people had ready access to the service.
- The service worked with a clinical commissioning group (CCG) to plan and deliver step down bed for patients who did not need to be in acute hospitals.
- Systems were in place to inform the local hospitals, GPs and others about beds available at the hospital.
- For those staff who could not attend the team brief a written team brief was circulated, however staff we spoke to on inspection did not know about the team brief.

Are services well-led?

Requires improvement

We rated Community health inpatient services as 'Requires improvement' for Well-led. This was because:

We found:

- There was no central vision shared by managers and staff concerning the care and treatment of patients.
- Governance arrangements were not embedded and were not robust enough to fully monitor quality, performance and patient safety.
- The hospital did not participate in national audits, but they undertook some local audits, however, there was no actual analysis of audit findings, improvement actions or monitoring.
- The risk register was not robust and did not identify clear processes for mitigating risks and ongoing monitoring with given time scales.
- The process for staff to escalate local level ideas and risks was unclear.

However we found:

- There was clear evidence that information from meetings was shared so all staff were aware. The Hospital Director was visible and staff told us they felt supported and valued by their peers and direct line managers.
- There was an open culture and staff felt they would be able to raise any concerns however they did not always receive feedback.

Summary of this inspection

- There was a turnaround plan which identified areas that needed to be developed and improved in all aspects of managing the hospital.
- Patient feedback was positive and the local population were involved in planning and providing the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Requires improvement

Community health inpatient services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are community health inpatient services safe?

Requires improvement

Safety performance

- Safety Thermometer reporting is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free care'. Monthly data was collected on pressure ulcers, urinary tract infections (for people with catheters) and falls. This provides the hospital with a 'temperature check' on harm which can be used to measure progress on providing a harm free care for patients.
- Tarporley War Memorial Hospital reported that from April 2016 to December 2016, there were 11 cases of hospital acquired pressure ulcers, no cases of clostridium difficile (c.difficile) and no cases of methicillin resistant staphylococcus aureus (MRSA).
- They reported 25 falls which resulted in no harm and one fall which resulted in harm for the same period.
- The hospital had only recently starting recording blood clot (venous thromboembolism or VTE) data as per national processes and reported zero since December 2016.

Incident reporting, learning and improvement

- The hospital used a written book system for reporting incidents. Staff followed the local incident reporting policy which was understood and available to staff through their computer system and a copy was available in a resource file at the nurse's station.
- We saw limited evidence that there was an effective process that facilitated learning from incidents. Investigations that we checked were very brief and the hospital did not use a recognised root cause analysis tool. It was confirmed that no staff or Trustees had been provided with root cause analysis training. We saw limited evidence of learning from incidents due to the limitations in the investigation process and the absence of action plans and follow up reviews.
- Incidents were reported to and reviewed at a local quality assurance group meeting and details being shared in a 'team brief' newsletter with an 'incident review report' being circulated to staff. We reviewed the minutes of the meetings contents of these documents and found that the document merely described that the main areas in which incidents occurred rather than demonstrating actions or ways of reducing reoccurrence.
- The main incidents reported were medicine errors and patient falls, we saw some evidence that these had been analysed for trends and patterns. However, in response to medication incidents we saw that the hospital advised 'we will remind staff to take extra care when administering medicines', as opposed to reviewing practices and competencies of staff.
- During our inspection we learnt of two events which might constitute an incident that were not reported as such. These were where a patient was transferred from the hospital in order to receive more acute care at the local NHS hospital and where there were delays in the mini minor injuries service due to the unavailability of a nurse. The opportunity to learn and share information regarding such situations was therefore missed.
- We reviewed the hospital incident reporting policy entitled 'Recognising and reporting adverse incidents'

dated December 2016. This stipulated that incidents which "resulted, or had the potential to result, in injury, damage or other loss" should be reported. This narrowed the scope of incidents that might be learned from as it appeared to focus on patient injury rather than a broader understanding of incidents.

- The hospital had a policy in place outlining the reporting of 'serious untoward incidents'. This described the process for notifying relevant organisations including the Care Quality Commission. The hospital had not had any serious incidents during the period February 2016 to January 2017 and so no reports were made.
- The hospital reported no never events for the period February 2016 to January 2017.Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- A mortality review was undertaken examining a sample of five of the 12 deaths which occurred at the hospital between January 2016 and December 2016. This review was presented to the hospital director and board of trustees and as a result a new system is to be put in place to capture and audits deaths in the future.
- Staff told us if they witnessed poor practice they would have no reservation to raise their concerns to a manager. They agreed that there was a supportive and no blame culture in which openness was encouraged. They felt confident that concerns would be acted upon.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The hospital did not have a duty of candour policy in place. However, they reported they have not had an incident which might fit into the scope of the duty of candour principles.
- We asked managers of their understanding of the principles and they understood the principles of their duty. We also asked staff about the principles of openness and transparency and they stated this was part of the culture of the hospital.
- The hospital supplied records of various examples of the hospital demonstrating openness and transparency with patients and their relatives where things had gone wrong, although these were not 'notifiable safety incidents' in terms of the regulations.

Safeguarding

- Staff undertook training in the safeguarding of vulnerable adults and child protection as part of their mandatory training package. Records showed that 85% of all clinical staff had received level 2 training, only two new staff members and two on long term absence had not received the training.
- The Intercollegiate Document 'Safeguarding Children and Young People: Roles and Competences for Health Care Staff', states that healthcare staff "who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person" require safeguarding training and competencies to level 3 standards. Staff in the mini minor injuries department were assessing and treating children and young persons but none had received the required level 3 training.
- The staff we spoke with were aware of their responsibilities regarding safeguarding of patients and could describe the procedures they would follow and who to speak to for advice. There was a policy in place which staff understood which they had access to in a resource file and via the hospital computer system.
- The hospital had made no safeguarding referral during the reporting period February 2016 to January 2017.

Medicines

- The hospital had a medicine's management policy and standard operating practice in place; this was accessible to hospital staff and they were familiar with the contents
- We undertook a sample check of medications and found them to be in date and stored appropriately and in line with recommendations.
- Our sample checks on controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) showed these

were in date, stored securely within a double locked cabinet with access restricted to authorised staff and that books used to record their administration were completed appropriately.

- The hospital undertook an audit of medication charts in December 2016, this highlighted areas of non-compliance, the action plan consisted of reminders to staff and a further audit in March 2017, rather than a recognised plan for implementing improvement.
- We examined 11 sets of medicine administration records sheets (MARS) and saw that on the majority were completed satisfactorily. They were legible, amendments were made appropriately and there were no omissions. With the exception of one record which indicated that two items of medication had not been given with no explanation provided. Another record had a miss-aligned printed identification label which had some sections of the identification details missing from the label.
- We saw records that fridge and room temperatures were regularly checked, recorded and adjusted as appropriate. For the period of the records we checked these had not gone out of range however, when asked staff were able to describe what they would do if they found they had gone out of range to ensure that any medicines would remain suitable for use.
- We saw that the hospital had a process for assessing self-administration of medicines for those patients who wanted to and were assessed as competent to do so.
- The medicines required by patients to take home with them were prescribed by a GP and dispensed by a local community pharmacy. Arrangements were in place to obtain medications in a timely way and we were told that this did not lead to delays in discharge.

Environment and equipment

- The hospital was not a purpose built healthcare facility and was an older building. This posed some challenges from an environmental point of view. There was some uneven flooring which might increase the risk of trips and falls for those with mobility and sight difficulties. However we were advised by the hospital that these risks were managed based on individual patients' needs. They also point out that there had been no reported incidents such as trips or falls attributed to this flooring.
- The reception area and the outpatients area was bright and welcoming, this had undergone a refurbishment recently. It provided a pleasant seating area for waiting patients and several treatment and consulting rooms, which were furnished and maintained to a high standard.
- Within the ward area, there was a main 'L' shaped corridor with individual patient rooms and patient bays, leading off it. The corridor was mostly clear and uncluttered although at times we saw that a used mop bucket had been left when not in use. This posed as a risk for patients who may be at risk of falling. We raised this with staff and this was moved straightaway to be stored elsewhere.
- Equipment was serviced and maintained regularly. We saw evidence that this information was recorded and monitored effectively in order that equipment remained fit for use.
- We checked a sample of electrical equipment and medical devices and found these had been checked and were up to date with servicing.
- The hospital had a dirty utility room was used appropriately and equipment appeared clean and fit for purpose. Hospital waste and clinical specimens were handled and disposed of appropriately, this included safe sorting, storage, labelling and handling.
- The hospital had a small stock of equipment and aids for use by patients, such as zimmer frames and seat raisers. If specific equipment was required this could usually be obtained within a week through a contract with an external organisation.
- Hoists and mobility aids were regularly serviced and maintained according to manufacturer's instructions to remain fit for purpose.
- Mattresses were inspected and checked monthly to ensure they remained fit for purpose.
- Resuscitation and emergency equipment was checked regularly and documented. However, the trolley was an older style one which could not be sealed to make it tamper evident. This meant that emergency drugs were accessible and items on the trolley could be tampered with. We raised this issue during our inspection and managers told us they were aware of this issue and had placed an order for a new tamper evident trolley. In the meantime a risk assessment and action plan was completed to ensure that this remained both safe and accessible until the new trolley arrived.

- The storage of cleaning chemicals and substances that were hazardous to health were securely stored and were not accessible to patients and visitors. This was compliant with the Control of Substances Hazardous to Health Guidelines (COSHH).
- At the time of the inspection, three inspectors observed that a room, labelled 'mortuary room' was occasionally used as a mortuary, but was also being utilised for storing equipment and was not fit for the use as a mortuary.
- There was a room on site. Staff stated this room used to have a mortuary fridge which had been removed because the body of deceased people were usually collected by the funeral director very quickly.
- This room was small room with a single window and we found that it was being used to store equipment on open shelves. The equipment stored included a bariatric chair; a bag of paper shrouds; a bedside cabinet; a broken foot-pedal bin and pressure relieving mattresses. Using the mortuary as a storage room was not appropriate because the National Institute for health and care excellence (NICE) guidance states that the body of deceased persons should be cared for in a culturally sensitive and dignified manner.
- We were told that relatives did not use this as a viewing room and that it wasn't used very often or for long periods. However staff said the room was used when people died at the hospital, especially if someone died at night.

Quality of records

- We checked 22 sets of patients' records, some from current and some for patients discharged within the last 6 months.
- We saw ward staff and allied health professionals wrote in the patients' records which included information about test results, care plans and risk assessments in a timely way and we found that these notes were in sufficient detail as to inform other staff on the circumstances of those patients.
- We found nursing care entries to be legible, signed, dated and timed with the authors name and designation provided. However, we found that medical entries were often not timed and on occasions not dated.
- A record keeping audit was undertaken in June 2016, they identified that documentation was of a good standard but found issues with storage and the recording of the involvement of patients and carers in care planning. There was an action plan drawn up but no timescales were detailed and there was no indication how progress would be measured or reviewed. Eight records which recorded care for patients at the end of their life were completed effectively with entries relating to communication, psycho-social needs, nutrition and hydration and care being completed to a good standard.
- We did not see documentation of regimes or any repositioning charts for patients who were at risk of developing pressure ulcers (see section on assessing and responding to risk).
- Patient notes were locked away securely in the nurse's office which was accessible by key coded lock; this reduced the risk of unauthorised access and helped to protect patient confidentiality.
- We saw evidence that patients' medicine charts were audited in December 2016 and that an action plan was completed to drive improvement, however we did not see any timeframes or review of the action plan to assess of actions had been met and improvements seen.
- Archived noted were removed from files and stored in wallets, they were not bound together which meant loose leafs could become detached.
- We reviewed 13 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms for current and past patients. Of those we checked; 10 of the forms had not been completed properly in some way. These were due to the wrong, none or all boxes being ticked in relation to the reasons why cardiopulmonary resuscitation (CPR) should not be attempted; some were not signed or dated and recorded non-medical reasons for not attempting CPR such as frailty. These issues were raised with managers at the time of inspection and were rectified immediately.
- When we returned for the unannounced inspection we found further evidence of incorrectly completed forms. We again raised this with managers and immediate action was taken. However, we did not see evidence or assurance that there was a robust quality control process in place undertaken by the health care professionals who might rely on legitimacy of these forms for their withholding CPR to their patients. It was the case that these forms had not been checked for

accuracy and completeness either when they were completed by GPs acting on behalf of the hospital, nor those that transferred with the patient when they were admitted and been issued by other institutions.

Cleanliness, infection control and hygiene

- The environment appeared visibly clean and hygienic.
- The hospital used the services of an external cleaning service. Regular cleaning schedules and monthly audits were in undertaken by the external provider. The audits showed cleanliness 'scores' of 85% to 95%, highlighting dust being found in some areas. The hospital matron, as the designated infection control lead joined the audit every third month. However, there was no matron in post at the time of our visit, the previous matron had left and the new matron was not yet in post. We were advised that in the meantime senior staff nurses deputised in the matron's absence.
- Waste management and infection control policies and procedures were available and accessible to staff and the staff we spoke with were familiar with those policies and where to seek advice if they needed to.
- We observed staff following hand hygiene procedures and 'bare below the elbow' guidance. We saw staff using appropriate protective personal equipment, such as gloves and aprons, when delivering care.
- Hand hygiene audits were undertaken by the hospital matron, the last audit was completed in September 2016 and we were told these would resume when the new matron comes into post in March 2017.
- Information provided by the hospital showed that there had been zero cases of MRSA and clostridium difficile (c.difficile) for the period April 2016 to December 2016.
- The last infection control audit was undertaken in November 2015. This was undertaken by an external specialist infection control provider. This audit showed good compliance with standards. An internal infection control audit was planned for February 2017, reporting to the quality assurance group.
- Staff stated that expert advice could be sought if required from a specialist infection control nurse from a local NHS community healthcare organisation.

Mandatory training

- Mandatory training was updated annually by attendance on training courses, provided internally and some by external organisations. The subjects classed as mandatory were those which are considered the most important such as cardiopulmonary resuscitation (CPR), safeguarding patients, infection control and moving and handling. They also offered other training in person or electronic when the need arose, such as wound care and administering local anaesthetics.
- The hospital records showed that 92% of staff were up to date with their mandatory training out of a target of 100%. The manager explained that this was due to the training sessions only running three times a year. They said that if a member of staff was unable to attend the session, they might not get the chance to undertake it for several months. They had risk assessed the situation and stated that if any member of staff had missed their mandatory training they were instructed to review the relevant guidance to ensure they remained up to date. The manager is to reassess training provision in the near future and was looking at ways of linking in with NHS training provision.

Assessing and responding to patient risk

- Patients were assessed prior to admission through history taking, description of current needs and expectations of the service. They were assessed against the hospital admission criteria and policy to determine if the patients' needs could be met at this facility. However, we were told that this process was not always effective as on occasions patients arrived with needs greater than could be met, which necessitated transfer to another more suitable facility. The hospital did not compile data on these cases nor did they report such occurrences as incidents.
- Upon admission, the patients' co-morbidity conditions, past medical history and lifestyle issues were captured appropriately and documented in their patient records. They were examined within 24 hours by a general practitioner (GP) and a baseline set of clinical observations were recorded. Care plans were established to deal with any highlighted needs such as diabetes and wound care.
- Physiotherapists and occupational therapists undertook full functional assessments of patients within 48 hours of admission to establish if patients needed any aids or assistance with their activities of daily living.
- Handovers took place at the start of each shift in order to update incoming staff of the events of the previous

shift and for key information to be shared. During handovers, staff were made aware of any patients who were at risk, for example, those at risk of falls or those who were confused.

- Risk assessments were completed in areas such as malnutrition, manual handling, falls, skin integrity and wound care. In the patient records we reviewed, there was evidence of risk assessments being completed, updated and reviewed at suitable intervals.
- The hospital undertook a recognised risk assessment scoring tool to assess skin integrity and risk of developing pressure ulcers. We also saw that body maps were completed documenting and highlighting the status of the patients' skin such as any wounds or areas of damage. Whilst this appeared to be satisfactory, we found that those at high risk of developing pressure ulcers and those who had already been highlighted as showing signs of pressure damage were not placed on repositioning regimes. The National Institute for Health and Care Excellence (NICE) clinical guideline 'CG179: Pressure ulcers: prevention and management' states that healthcare provides should 'document the frequency of repositioning required'. Repositioning charts enable healthcare staff to monitor the position of patients to ensure and enable the adequate relief of pressure areas on a regular basis. It also enables staff to record what they have done and if a patient opts not to follow advice on pressure area relief.
- We spoke with some staff about repositioning regimes; they were of the opinion that these were not necessary, as the patients were capable of relieving their own pressure areas. They did not document steps taken to encourage position changes, or if a patient refused. They did not record or time the patient's position in order to know when and if that position had changed. Furthermore, we also found that patients who were bed bound, those who lacked capacity, those with existing pressure damage and those who were at the end of their live also did not have repositioning charts in place.
- The hospital did not routinely take the 'observations' of patients in their care, except to record their baseline observations upon admission. They would only take observations if the GP requested this or if there was a clinical reason to do so. For example, if the patient became unwell, or had suffered a fall and required a period of assessment.
- The hospital had a flow chart to determine their response to care of the deteriorating patient. This dictated what to do if there was a concern about the condition of the patient. This advised that a registered nurse should assess the patient and recording their observations. They then used their clinical judgement as to whether to call for an urgent GP assessment, to dial 999 or to have the patient assessed routinely on the next GP ward round. It was left to the clinical judgement of the healthcare professional as to the frequency of observations for their patient.
- The hospital risk assessed patients' for their risk of falling; this was done using a recognised assessment tool. The service had 25 patient falls between April 2016 and December 2016. These were reported to have resulted in 24 falls with no harm and one which resulted in harm to the patient.
- The hospital used non-restrictive movement sensor alarms for patients who were high risk of falls and who were unable to alert staff or request help with mobilising. We saw evidence that falls risk assessments were undertaken and a further risk assessment and care plan for the deployment of the alarm.
- There was a policy in place for the use of bed rails and this was accessible to staff. The policy had an appendix which was used to seek written consent for bed rails and we saw evidence of these in use in patients' records. However, this referenced gaining consent from patients' next of kin if they lack capacity to consent. This policy contradicted the hospital's own consent policy and was contrary to the Mental Capacity Act 2005. The act states a capacity assessment must first be completed and documented, followed by a 'best interests' care planning decision that the use of bed rails is in the patients' best interests. There is no legal basis that a relative or carer can consent to any intervention on a patient's behalf where they lack capacity.

Staffing levels and caseload

- The hospital followed their 'staffing level' policy which dictated the establishment of staff; registered nurses and health care assistants for the inpatient ward and mini minor injuries service. This changed for day and night shifts and for weekday and weekends shifts. It stated that additional staff should be deployed based on patient dependency and acuity.
- Patient dependency and acuity was determined by a traffic light scoring system. Depending on patients' category and based on a cumulative patient dependency judgement, it was then decided if the case

load was manageable or not. This system did not provide a specific measurable threshold which dictated that extra support was required. It appeared to be based on personal judgement as to whether staff could manage or not.

- We looked at past records and saw that at times there were significant numbers of patients with increased dependency but it was deemed that no extra staff were necessary. However, we also saw evidence that on several occasions extra staff were requested and obtained. We were therefore unsure about the consistency and reliability of the tool that was being used.
- The hospital had an informal procedure for getting additional staff during the night shift if patient dependency increased and if they needed extra support. This involved telephoning a senior member of staff at home who would arrange extra staff. Staff told us there were plans to implement a more formalised 'on call' rota in the near future, but there was no specific date this was to be implemented.
- The hospital filled 202 shifts using bank and agency staff for the three month period 1 August 2016 to 31 October 2016. This was mainly to cover for staff vacancies and sickness.
- Risk assessments had been completed for the level of staff required at night and it was decided by management, that one registered nurse and one health care assistant were sufficient for night duties. We were told that there was a trial period where three staff were on night duty and it was found that most nights there was no clinical need to have an extra member of staff. Evacuation exercises were also carried and staff were able to evacuate in emergency situations.
- We observed how staff managed during this period. We saw that staff were very busy at the time patients were going to bed and a lot of activity happened during that period. However, no patients were left waiting, buzzers were answered in a timely way and the medication round was completed with no interruptions. We also found there was no evidence that falls, complaints or accidents increased during the night shift. It appeared that patient safety was not compromised. However, the ward might benefit from additional staffing during this busy time.
- The hospital also has a "mini minor injuries service". This was a facility which allowed members of the public to attend the hospital with very minor injuries, for example a cut, or graze or bang to the head.
- This service used to have extended opening times however following a risk assessment, it was identified that this placed a staffing burden on ward staff which risked compromising care on the ward. Therefore the opening hours had been reduced to Monday to Friday 8am to 4pm and Saturday and Sunday 9am - 3pm. This change was made approximately two months before our inspection. The numbers who attended this service were small and equated to 16 attendances per month.
- Staff said that this did not impact upon patient care as patients on the ward would always be prioritised.
- The hospital also provided a dressings clinic service for the local community daily between 2pm-3pm and 6.30-7pm. Throughout 2016 the hospital saw an average of 135 patients a month, this service was provided by staff from the ward.
- There was a designated member of staff who worked within outpatients as a chaperone and assistant for the doctors and stenographer who offered services there. These services were provided by external providers through a service level agreement using a member of staff and rooms at the hospital.

Managing anticipated risks

- The hospital held a risk register to identify areas of possible risk to the hospital, staff and patients. This was maintained by the hospital manager.
- Risk assessments in relation to individual patients, such as pressure ulcer, falls and nutrition were completed and updated regularly.
- Other risks where dealt with on an ad-hoc basis by the management team.
- The hospital undertook a 'comprehensive risk assessment' in December 2016, considering various aspects of care delivery, environment and procedures. This recognised several areas for improvement within the hospital and these changes were implemented in a timely way.

Major incident awareness and training

- Business continuity plans were in place for unanticipated events such as flood, loss of power and major incidents. Staff were aware of the plans and knew how to access the documents if required to do so.

Requires improvement

Community health inpatient services

- Fire and bomb procedures were in place and drills were practised regularly.

Are community health inpatient services effective?

(for example, treatment is effective)

Requires improvement

Evidence based care and treatment

- The hospital did not always follow evidence based care and treatment guidance and the National Institute for Health and Care Excellence (NICE) guidance for example they did not follow NICE guidance CG179 'pressure ulcers: prevention and management.
- We did not see evidence of how the hospital determined which NICE guidance applied to their scope of practice. Furthermore, we did not see any clinical audits against evidence based practice.
- The hospital did not participate in national audits, but they undertook some local audits. We saw a hospital audit programme, however there was limited actual analysis of audit findings and limited improvement or learning outcomes. Any actions identified did not identify person responsible or the timeframe. This meant there was a risk that actions were not followed up or monitored.
- We found that the hospital did not comply with best practice in relation to the prevention and management of pressure ulcers.
- Patients who were suitable for rehabilitation were assessed by physiotherapists and occupational therapist within 48 hours of admission. Individualised rehabilitation care plan were implemented which set out clear outcome goals and these were reviewed and amended regularly in consultation with the patient and wider multidisciplinary team.
- They followed a wound care formulary for the care and treatment and dressings selection which was produced by the local community healthcare organisation, this contained advice which was based on evidence based practice.
- We saw evidence of care plans being put in place in connection with common conditions such as diabetes and limitations in mobility.
- The hospital utilised the expertise of the local community NHS trust where they needed specific expertise. They used such sources for consultation and advice on national policies and recommendations.
- They had recently started audits following all aspects of the safety thermometer to measure harm free care but did not currently submit their data.
- End of Life (EoL) care was in line with national standards because each of the five EoL patient records reviewed showed that a standardised end of life care pathway based on best practice and endorsed by the local NHS trust was used by the service. These records included the records of patients who had recently died.

Pain relief

- We did not see documented evidence that pain assessments were undertaken regularly for each and every patient, however pain was assessed on admission and analgesia reviewed accordingly. Furthermore, when we asked patients themselves, they stated that any pain issues were assessed and dealt with in a timely and effective way.
- For those patients with chronic pain conditions, we saw that care plans were in place and medications prescribed appropriately.
- If a patient developed acute pain, processes were in place to ensure patients were reviewed and pain control obtained in a timely way, including during the night and at weekends.
- The hospital had access to a community pain control nurse should advice and input be required.

Nutrition and hydration

- Risk assessments were carried out by nursing staff to identify those patient who might be at risk of malnutrition or dehydration. A recognised nutrition risk screening tool was completed on admission and at appropriate intervals to monitor patients' nutritional status.
- We saw that within the 22 patients' records we checked, all had completed nutrition risk screening tool assessments and for those patients placed on fluid and food charts, we saw these were completed regularly.
- Patients' weights were recorded upon admission and reviewed weekly or sooner if there was cause to do so.
- The nutritional requirements of individual patients were highlighted during handovers, ward rounds and

multidisciplinary meetings. Those who needed assistance or encouragement with eating and drinking was highlighted and assistance given during meal and drink times.
- Patients were offered the opportunity to attend the dining room for their meals if they wished to do so, or they could eat their meals by their bedside.
- The patients we spoke with stated that the food in the hospital was of a very high standard and that the meals were warm, tasty and nutritious and they were offered a choice of meal.
- Hospital staff told us that all meals were prepared on site and food was sourced from local suppliers. The hospital had been awarded a 5 star food hygiene rating from the local authority.
- Hot and cold drinks were offered at regular intervals and we were told that snacks were available in between meal times and during the evening.
- The hospital had access to a community dietician, nutritionist, specialist diabetes nurse and speech and language therapist should they be required to help with the patients nutritional needs.

Patient outcomes

- The hospital maintained a performance dashboard to record outcomes for patients such as harm recorded, length of stay, discharges and occupancy levels.
- The hospital reported occupancy levels of 63% for the period April 2016 to December 2016.
- The hospital reporting caring for eight patients during the end of the lives between April 2016 and December 2016.
- They provided 700 respite bed days to patients during April 2016 and December 2016.
- The hospital undertook patient satisfaction surveys to gain feedback on their stay. This was overwhelmingly positive and patients reported to be satisfied with their care.
- The hospital engaged the services of an independent pharmacist to act as a 'critical friend' in the performance of the hospital in relation to medicines management.

Competent staff

- We saw that some controlled drugs had been signed for by a registered nurse and checked by a health care assistant. This practice is allowed for when there is no other registered practitioner available to act as second checker, however both National Institute for Health and Care Excellence (NICE) and the Nursing and Midwifery Council guidance state that a second checker should be assessed as competent to do so. The hospital's policy stated that the healthcare assistant should be knowledgeable but we did not see satisfactory evidence that competency was being assessed and recorded. This issue had also been highlighted during an external pharmacy review which was undertaken in November 2016. We raised this with the management who introduced competency checks and documentary evidence pending a review of the practice and policy.
- Annual appraisals give an opportunity for staff and managers to meet, review performance and development opportunities which promotes competence, well-being and capability. Data provided by the hospital showed that 85% of staff had received an appraisal in the last twelve months.
- Staff said they had access to regular, high quality, face to face training some of which was provided by local community and acute healthcare organisations which they rated as a high standard, for example basic life support and cardiopulmonary resuscitation.
- The hospital kept training and competency files for each staff member, these included copies of their training certificates and their performance development review.
- We were told that several health care assistants had enrolled and participated in the care certificate qualification scheme and saw some evidence of national vocational certificates in staff competency files.
- A formal induction policy was in place for new staff, this was comprehensive and documented and signed off by a mentor. Staff told us that new agency staff attending the hospital for the first time underwent an induction process also, but that this was not documented.
- Staff felt their close relationships with other local healthcare organisations provided them with access to specialists with expertise which they could access readily such as tissue viability and infection control advice.
- Staff told us there was a supportive and inclusive team spirit within the hospital and managers were available for advice and guidance. However, the hospital had a new non-clinical manager in place and the matron had left the organisation early in January 2017. This left the hospital without a senior member of staff to provide clinical support and a point of reference for a period of several months, although the matron did attend at the hospital one day each week to provide leadership

support to the senior staff nurses. A newly appointed matron was due to start at the hospital who would provide support in ensuring staff were competent in providing care.

Multi-disciplinary working and coordinated care pathways

- A multidisciplinary meeting was undertaken every Monday to discuss the plan of care for each patient. This involved occupational therapists, physiotherapists and registered nurses. It previously included the matron, but there was not one in post at the time of inspection. It also included social services representatives and community specialists as appropriate. They also gave input into the assessing, planning and delivering people's care and treatment.
- The hospital had links with the local community health service providers and utilised the expertise and assistance of specialist community nurses such as tissue viability, dieticians, speech and language therapists and infection control nurses.
- The hospital could refer their patients to community psychological support services and obtain condition specific emotional support from specialist nurses and Macmillan nurses.
- We noted that the occupational therapist documented in patients notes when they had passed specific tests such as the stair test and this information was shared with staff during the nurse's handover.
- The hospital worked with local authority social care representatives with regards to funding, assessing and securing ongoing care and the patients' needs on discharge from the hospital such as equipment and adaptations to their home environment.

Referral, transfer, discharge and transition

- Referrals into the hospital came from local acute hospitals, GPs, community and palliative care teams and private patient seeking respite, rehabilitation or palliative care.
- The hospital report 20 delayed discharges during the period April 2016 to December 2016. These delays were reported as being mainly due to ongoing care packages in the community and waiting for residential care places. These issues were discussed at the quality assurance group meetings, but no action plans were implemented.
- A member of staff was designated as discharge co-ordinator for the day; they were responsible for ensuring discharges were planned effectively and in a timely way. We were told that planning for discharge was started upon admission and continued as assessments were undertaken.
- During the period April 2016 and December 2016, 19 patients were discharged from the hospital into NHS acute care. This was where the hospital could not meet the continuing needs of the patient due to deterioration in their condition which required more intensive care than could be provided at this hospital. The hospital did not have a policy which dictated the circumstances where the hospital could no longer meet the needs of a patient; this was based on a clinical decision by the medical and nursing staff.
- Data provided by the hospital showed that 127 patients were discharged to their intended place of care whether that was their own home or ongoing residential care.
- The hospital reported that seven patients were readmitted to the hospital within 90 days of being discharged. However, some of these were respite patients who returned for further periods of respite and some were patients who had 'stepped up' to the acute NHS hospital for treatment and then returned to the hospital for further rehabilitation. These cases were discussed at the quality assurance group meetings, but no action plans were implemented.

Access to information

- Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues.
- Staff had access to a computer with internal and external information such as policies and procedures. A hard copy of useful guidance and policies were kept in the nurses' station for staff to access easily.
- We were told by staff that the hospital didn't always obtain sufficient information from the referrer to enable a decision to be made as to whether the hospital could safely accommodate the patient's needs. We were told that on occasion following the patient's arrival at the hospital, it became apparent that admission had been inappropriate. We saw an instance of this during our inspection following the admission of a patient, it was realised that their needs could not be met safely and the

referral had been inappropriate. We did see however that the hospital did implement a contingency plan to ensure that care was suitable until alternative arrangements were found.
- We were advised that discharge letters were sent to patients' GPs upon admission, detailing information about the circumstances of their inpatient stay.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had undertaken Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DOLs) training as part of their mandatory training package. Records showed that 92% of staff had completed their training.
- A consent policy was in place and this was accessible to staff. We saw evidence of the application of this policy through the use of the appendix being completed in patients' records.
- The hospital had a policy and staff guidance on the Deprivation of Liberty Safeguards. We reviewed this document and found it not to be in keeping with the legislation. This was because it instructed staff to apply for a 'standard' authorisation, when an 'urgent' authority was required. It also stated that the patients' compliance with deprivation and their family's consent was relevant, which should not be a factor in determining if a patient is being deprived of their liberty or not. It also stated that if the patient was not expected to stay more than three days then an application was not necessary. We looked at the records of four patients that had DOLs applications made. We found that three of these had administrative errors on the application forms. The hospital submitted 'standard' applications for authority to deprive patients of their liberty, but also required an 'urgent' authority in addition. This was because the patients were deprived of their liberty with immediate effect.
- Furthermore, in two of the four cases, there was no 'two stage assessment of capacity' within the patients' records, which the legislation mandates. There was no documentation describing why and by whom it was determined that the treatment provided was in the 'best interests' of the patient, given they were deemed to be incapable of consenting to the treatment themselves.
- From discussions with staff, it appeared that there was a lack of understanding of the requirements of the legislation and a lack of oversight that the requirements of the legislation were being met by the management team.

Are community health inpatient services caring?

Good

Compassionate care

- We observed kind and thoughtful staff interaction with patients.
- During our inspection we saw that staff were very person-centred in caring for their patients. We saw that staff put patients at the centre of everything they did and strived to make patients as comfortable and happy as possible.
- We saw staff anticipated and responded to patients' needs promptly and effectively and did so in a patient and kind manner.
- Without exception, all of the patients we spoke with felt that they had been treated well, with kindness and compassion and their privacy and dignity had been maintained.
- During our inspection we gathered examples of instances of staff demonstrating compassion and kindness towards their patients which demonstrated their readiness and commitment to deliver the best care they could to their patients.
- The hospital participated in 'pet therapy' initiatives, this was where an animal attended the hospital to visit and engage with patients on the ward. This therapy was reported to be beneficial for both mental and physical wellbeing of patients.
- Staff had demonstrated their kindness for patients who were at the end of their lives. They made arrangements for patients' beloved pets to visit them in the hospital which brought great comfort to them. For other patients they put up pictures that have significance for them, for one patient they put up a giant picture of their garden as it was very important to them.
- Staff arranged periods of hospital leave for patients for family events including weddings, christenings and family members visiting from abroad. They facilitated

this whenever possible and worked out an agreed plan with the doctors and families. The staff helped the patients do their hair and make-up and helped get them dressed ready for their day out.

- On Christmas Day, there was a party, every patient received a present, the local GPs and their families came to the hospital and carved up the turkey with the patients gathered around. They also shared a glass of champagne for those able to, with their Christmas dinner. They did a similar thing at Easter.
- They routinely provided the 'Tarporley makeover' to many patients by doing their hair, manicures, baths and grooming during their stay, so they felt cared for. They painted patients' toes and pampered them in various ways if they felt down or self-conscious.
- Staff brought in magazines and read to patients. They brought in knitting items for a patient who said they like to knit. A staff member brought a cappuccino from a patient's local café as she said really missed her daily visit there.

Understanding and involvement of patients and those close to them

- Records showed that the opinion of relatives was taken into consideration when planning respite care and in the hospital and discharge planning.
- During our inspection we saw evidence that patients' families and friends were involved and updated on the care and treatment of their loved one. We saw that staff allowed questions to be asked and ensured information was understood.
- We saw from records that patients and those close to them were involved with care planning for end of life patients and that their wishes and preferences were listened to and acted upon.
- The patients we asked stated that they were involved in decisions about their care and that they understood their treatment plans. They said they had opportunities to speak with staff and have their questions answered.
- Patients also described the rehabilitation exercises they had completed with the occupational therapist such as going up and down stairs and dressing in preparation for discharge.
- Records confirmed that the opinion of relatives was taken into consideration when planning respite care and discharge planning.
- We saw how the rules about visiting times could impact on the involvement of those close to the patient. For example during the inspection a visitor was refused entry at lunchtime to see an elderly patient. We noted that this patient was sitting alone with their meal and needed encouragement to eat. Staff did return and give encouragement, however social interaction with a friend or family member may have also lifted the person's mood as well as encouraged them to eat and drink.
- The hospital did not participate in the Friends and Family test. This is an NHS survey which asks patients whether they would recommend the service they have used to friends and family.

Emotional support

- Reports were written from the patient's point of view and demonstrated that feelings were taken into account. For example, a nurse had recorded when they had taken the hand of a patient which provided comfort and reduced distress and anxiety.
- We saw documentation in patients' records that the psychological and social needs of patients were considered and appropriate support was provided.

Are community health inpatient services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Planning and delivering services which meet people's needs

- The service could not plan for the needs of all the patients because they were not aware of the categories of patients treated. For example, the minor injuries service provided care and treatment to children but the service did not gather data about the number of children treated or the outcome of that treatment. The system could not provide data about the different age groups or reason for admission for people admitted as in patients.
- Systems were in place to find out what service people wanted and provided opportunities to contribute to service delivery through volunteering and fundraising.
- Volunteers from the local community worked with patients under supervision from the fundraising and

volunteer's coordinator. Checks included taking up references and disclosure and barring checks were completed. Volunteers were issued with photo identity badges.

- The service worked with local clinical commissioning groups (CCGs); local hospitals, local social services and local GPs to plan and deliver services across the population of Tarporley and the local district.
- The senior managers said the hospital provided step down beds for patients who needed nursing care but did not need to be in an acute hospital. The local CCG also commissioned two short stay places for patients who were medically fit but needed rehabilitation. The hospital also provided respite care which was self-funded by the client, but rates were subsidised by the charity.
- Continuity of care was promoted because most patients who used the service lived within a three mile radius of the hospital, this meant their own GPs and community nurses could be fully involved in their discharge plan and an integrated care pathway put in place. In addition, ward rounds were carried out by GP's from four wider GP practices.
- The service had admission criteria for inpatients with the aim of ensuring that the patients' needs were met. However the process of admission needed to be more robust because patients were sometimes admitted and it was quickly discovered that their needs could not be met.
- Staff described that this happened on occasions however; such occurrences were not reported as an incident and audited. One such occurrence was witnessed by inspectors during the site visit.
- The admission process did not include information about the level of need or acuity of patients that could be cared for at the service.
- The sister, staff nurses and health care assistants told us they worked closely with the NHS physiotherapy and occupational health teams to ensure patients received the correct level of care or support in relation to discharge planning.
- The systems for collaborative working such as access to the occupational therapy, speech and language therapy or physiotherapy were not formalised and service level agreements were not in place. The response of the allied health care professionals to the need of patients were not monitored to check how well the multidisciplinary team met identified needs or identify where improvements could be made.
- We observed care and care records indicated that GPs worked closely with the nursing staff to respond to the needs of the patients by visiting the hospital Monday to Friday and being available through direct contact with the GP surgeries. The service also had direct access to the medical Out of Hours service Monday to Friday evening and each Saturday morning.
- The hospital provided a minor injuries service and although there was a flowchart for the management of minor injury patients and a standard operating procedure this service was not reviewed in relation to waiting times, numbers of patients treated, age of patients, types of injury or outcomes. This meant the provider could not confirm whether this service was operating as expected and meeting the required standard.
- At the time of the unannounced inspection we noted that many patients and visitors were elderly and at least two of the nine in-patients were identified as living with dementia. Some aspects of the environment met the needs of this population group in that there was level access and the reception area was bright. However, signage to different departments and the toilets were not dementia friendly or helpful to people with visual impairment. This was because doors to different areas and departments including the toilets, side bedrooms rooms, clinic room, sluice and other rooms were painted the same dark blue. Signage was not in easy read or pictorial format, neither were they prominently placed. The corridor leading to the toilet and the toilet cubical were dark and lights were not sensitive to movement.
- Families and friends were not well catered for in that there were no private sitting areas for times when privacy was needed and there was no access to tea or coffee making facilities.
- Cultural and spiritual needs were not fully met because although a local Church of England vicar provided regular spiritual support a room was not aside for private prayer or reflection.
- Privacy and dignity was preserved because there was a separate male and female ward.

- Inpatients did not have a dedicated day room but were encouraged to use the day activity centre run at the hospital. The centre was run by an activities coordinator employed by the service.

Equality and diversity

- An equality and diversity (E&D) policy was in place to address staff recruitment but there was no E&D policy looking at the rights or needs of patients.
- Staff had not received equality and diversity training. Staff did not show that they understood the far reaching effects of equality and diversity issues and told us that because of the hospitals location such issues were not common place. Staff did say however that they would treat people as individuals, according to their expressed needs or wishes.
- A leaflet was in place for a language translation service however, the information did not include an access code or account number for staff to use if they needed the service. There was no policy or guidance provided by the service about how to use the language line service. Staff said they had never had to use the service because everyone who used the hospital spoke English.
- The registered provider stated that leaflets could be photocopied in large print when required. The leaflets and patient information we read through during the visit was in ordinary print and did not include information about larger print.

Meeting the needs of people in vulnerable circumstances

- The service did not have specific policies for working with people in vulnerable circumstances such as people living with dementia or learning disabilities. Dementia training was listed on the training plan but a date for training delivery had not been confirmed.
- The admission, equality and diversity policies and procedures did not include guidance related to meeting the needs of people in vulnerable circumstances.
- Records indicated however that people with dementia and sensory loss were admitted to the service. For example, on the day of the announced inspection medical and nursing records indicated that doctors had confirmed a number of patients were experiencing the effects of living with dementia. We also noted that a number of patients had difficulty hearing. However, formal processes were not in place to ensure these needs were always considered and addressed. For example, there were no information leaflets or information available in large print, braille or easy read, the toilet for public use was not wheelchair friendly; the wards and side rooms were not decorated in a manner which would assist people living with dementia. There were no policies in place guiding staff about supporting people with additional needs.

Access to the right care at the right time

- Systems were in place to update nurses and clinicians about the beds available at the hospital. This included daily telephone calls and email messages, to contacts at the local hospitals and GPs. This meant clinicians and nurses knew when beds were available so that suitable patients could be referred.
- The admission process did not ensure the needs of the people who accessed the service could be met. This was because people could self-refer for respite care and the general public were not provided with a clear criterion for admission. In addition the preadmission assessment process was not robust.
- Staff stated the needs of patients were not always reassessed from one admission to another which meant they could be admitted even though they no longer met the criteria or their needs had changed. This was specifically with regards to respite patients.
- The preadmission questionnaire was completed by administration staff and did not include indicators that would identify those who were suitable for the service.
- The number of inappropriate admissions was not monitored however staff indicated this did happen on occasion and inspectors witnessed this on the day of the unannounced inspection.
- Information about the level of treatment available at the minor injuries service was published on the hospital website but the service did not monitor the type of care, treatment or advice delivered. This meant the service could not be sure of that appropriate people coming to the service and neither did they check whether in the main patients received the right care at the right time.
- The average occupancy rate for the hospital during 2016 was 62%. This was better than the acceptable average of 85% and meant the risks associated with overcrowding such as delayed or cancelled admissions and infection control problems were low. The provider stated no admissions had been delayed or cancelled due a lack of beds.

Requires improvement

Community health inpatient services

Learning from complaints and concerns

- There was a policy in place for managing complaints and informal concerns dated August 2016. The hospital standard was to resolve verbal complaints within two working days acknowledge all written complaints within 24 hours and investigate and respond to complaints within 21 days.
- The service had received six complaints between January 2016 and January 2017. These were not related to the standard of care however one concerned a lack of flexibility in relation to visiting hours. The complainant was contacted and a resolution reached. The records showed that all complaints were fully reviewed and investigated in line with the hospitals policy.
- Complaints received were fully investigated and independent specialists were involved when appropriate. Findings were discussed with the complainant and the outcomes shared with staff involved, but we found not all reported incidents were shared with the wider staff team. This meant that the learning from complaints investigated could not be applied in all departments. Management told us that all complaints were discussed with all staff at a team brief and for those that could not attend a paper version was available. However, staff commented to us that they would appreciate feedback from the outcome of all investigations.
- We noted that information in the 2016 complaints policy and guidance was inaccurate. This was because the policy incorrectly directed patients and staff to the Care Quality Commission if a complaint was unresolved following a local investigation. The Care Quality Commission does not have the power to handle unresolved individual complaints.
- The complaints policy was not readily available to patients and staff because copies were not available in public areas. The service had recently developed an admission pack which included information about raising concerns. We noted that not all patients had the packs to hand and the information was in very small print and difficult read.

Are community health inpatient services well-led?

Requires improvement

Leadership of this service

- A number of senior staff including the Hospital Director of 10 years and the matron of the service left their posts within six months of each other. During the same time frame, three trustees also resigned. This had impacted on staff morale and further added to staff concerns around sustainability of the hospital.
- At the time of the inspection the replacement Hospital Director had been in post for four months since September 2016 and the matron was due to take up post in March 2017. Although the previous matron did attend at the hospital one day each week to provide leadership support to the senior staff nurses, there was risk that governance and risk management was not being led effectively at a senior level, on the remaining days.
- During the same six month period a number of well-established registered nurses had also retired. These had been replaced by offering permanent contracts to registered nurses who had worked at the hospital for a number of years through an agency. Two of these RGN's had been promoted to senior staff nurses. Discussion indicated these nurses were settling into their roles and waiting for the matron to take up post before reviewing and introducing new processes. This meant that risk management was not being effectively led at ward level.
- The trustee board were not operational but held the Hospital Director to account for the running of the service. The Trustees were all unpaid roles and some also worked as volunteers and served coffee and tea to the patients.
- The GPs worked closely with the trustees and Hospital Director and valued the services they are able to offer their patients at the hospital.
- It was recognised that the trustee membership would benefit from having a nurse on the board and the Hospital Director was actively seeking a trustee with a nursing background. We noted an advert and role description for a nurse to join the board had been posted on the hospital website.

Requires improvement

Community health inpatient services

- The Hospital Director planned to develop leadership skills amongst senior staff however this had not been formalised at the time of the inspection.

Service vision and strategy

- The hospitals strategy was clear to the public and staff and was featured on the home page of their website; 'We aim to provide the people of Tarporley and its surrounding villages with a modern, accessible and caring health care service'.
- There had been a number of significant changes in the leadership team over the last twelve months. This has impacted on the development of the vision and strategy for the service. Particularly as developments that had been discussed, such as refurbishment of the hospital, had not been fully explored and developed prior to these changes.
- At the time of this inspection the new management team was not fully in place, however the Hospital Director and Trustees were reviewing the current governance systems. This meant identifying priorities in relation to strategy and the future was at an early stage.
- Staff were aware of some strategic changes and discussed the plans which included the commissioning of two short stay beds, plans to increase the number of beds to allow more respite placements and possible improvements to the environment.
- We spoke to trustees of the hospital who had strong ideas on the vision for the future of the hospital, dependant on fundraising, which included; increasing the evening night staffing levels, to increase private sales of respite care beds and long term, to extend the size of the building and increase the number of in-patient beds to 22.
- We reviewed the services 'quality framework tool for excellence in care' which featured an 'Action plan' for 'Care environment' dated June 2016,this mentioned a review of bed spaces, but no target dates, or further details.
- We spoke to trustees of the hospital who had strong ideas on the vision for the future of the hospital; however, the hospital staff could not describe the overarching vision or stated values. There was no quality strategy or clearly articulated quality priorities.
- We were told that an external review had been undertaken around twelve months ago around sustainability that provided the hospital's strategic direction. This resulted in a number of risk scenarios and an agreed business model for going forward. We were provided with a project risk register for this model and there is a Project Steering Group in place.
- The willingness and flexibility of the staff had ensured the safety of the patients and staff had attended shifts whenever there was a staff shortage, if called by the management. This was conducted in an informal manner and the hospitals are aware that improvements need to be made and had discussed a more robust and reliable on call system for the future.

Governance, risk management and quality measurement

- There was a lack of robust quality assurance framework to ensure that standards of care were being maintained.
- There were no clinical audits against evidence based practice. We saw a hospital audit programme but no actual analysis of audit findings, improvement actions or monitoring. The documentation audit was a proforma with over 50 questions. We saw one proforma, completed by the previous hospital manager, but no analysis or learning points. There appeared to have been a reliance and confidence that the previous matron would not allow any unsafe practice to take place. However, actual documented evidence to support this was available.
- Quality measurements to check the standard of the running of the ward and the minor injuries service had not been completed. Discussion at the trustee's board meeting around quality or outcomes was very limited. We were told that the 'Performance dashboard' was introduced to improve the way the board reviewed quality and there had been an agreement that the quality aim was for there to be no cases of avoidable patient harm within the hospital; this was not being met with regards to pressure ulcers.
- We requested information about who accessed the service and outcomes; how quickly call bells were answered; how well records were completed, or for any other quality monitoring processes the provider would like to give to show that checks on the quality of the service provided had been completed and these were not provided. Local quality indicators or audit results were not available.
- We reviewed the risk register dated 9 December 2016 and associated risk assessments and plans. Risk assessments checklists were in place but these were not

aligned to robust action plans and did not accurately reflect all the risks at the hospital. The risk descriptions were poor in that they did not describe the condition, cause and consequence of the risks. Controls were not always actions, and actions instead of the risk to be dealt with, was included in the risk register. Examples included; not having a Mental Capacity Act 2005 (MCA) policy and not recording clinical risk assessments appropriately.

- We discussed the risk register and monitoring local risks with the Hospital Director and we were told risk management training was going to be provided to senior registered nurses when the new matron came into post. It was acknowledged that the risk register was a new tool for the hospital.
- We found that policies were not in a standard format and although reviewed, had not been amended for five to ten years. This meant that they were largely out of date with current best practice For example, the policy on verbal and written complaints was last reviewed in August 2016, however it had not been amended since 2008 and one out-of-date bullet point informed complainants who remained dissatisfied with their response from the hospital to contact the Care Quality Commission.
- The hospital management team had highlighted policy management as a known issue.
- The hospital had a governance structure in place and a monthly trustee board meeting was held, with a Quality advisory Group as one of the subcommittees. We looked at minutes to the meetings which displayed actions and name leads. They also display an update at the next meeting. Patient experience was not discussed at every meeting, but was reviewed as part of incident review or ongoing patient satisfaction survey reviews.
- We saw external advisors were involved in investigations when appropriate. An example of this was when an information sharing error was made the investigation included the then hospital matron, the administration department and a trustees of the hospital. The learning identified included additional training for a newly employed member of staff.
- The hospital had also sought external advice and guidance for information governance, risk management, clinical outcomes and developing best practice policies regarding Deprivation of Liberty safeguards.
- The hospital recognised their limitations and sought support and knowledge from other health care organisations.

Culture within this service

- Staff reported a positive culture and said everyone worked as a team. Staff reported that everyone was willing to 'go the extra mile' to provide good care and support each other.
- During the inspection we observed the day, evening and night staff team working together efficiently. We also noted that each team member also worked efficiently and had a positive attitude towards each other and the management team.
- Staff morale appeared good although all staff were looking forward to the new matron taking up the post in March 2017.
- All staff were aware of who the director was and had had the opportunity to meet with them when they regularly came onto the wards.
- There was an overall 'family' feel to the dynamics of the staff and a number of agency staff had gone on to take up permanent rolls within the hospital.

Public engagement

- The hospital had a process in place for obtaining feedback from patients; however the analysis of this was limited, with no exact figures. We looked at the July 2016 report which commented on 'nearly everyone' considered the catering service to be excellent and 'the ward was always clean', but it did not record how many patients had provided these comments.
- The hospital is very much part of the local community. The GPs view their relationship with the hospital as symbiotic and very much value the services they are able to offer their patients via the hospital.
- The hospital carried out a Patient satisfaction survey, which went into further detail and did include figures, however there had only been 11 responses from September 2016 to December 2016. This showed that the service responded to most of the comments received. For example, an update was provided about issues that had been addressed such as improvements to the day room and investigations into providing a payphone. However, there was also a comment that visiting time was too late and this was not picked up in the report. During the inspection we saw an example of a visitor wishing to see a patient during lunchtime which

has restricted visiting rules and there was no flexibility to the rule and the visitor had to leave without seeing the patient. There did not appear to be flexible visiting on an individual patient basis.

- The fundraising team regularly engaged with individuals who used services, their family and local organisations such as the Women's Institute, local parish councils, schools and businesses to find out the contributions people were willing to make and raise awareness about what the hospital needed.

Staff engagement

- The Hospital Director stated there was an open door policy and staff were able to speak to them at any time. This was confirmed by staff who also stated that the Hospital Director spent time working on the wards and visited each area daily.
- A monthly team brief was published and this included information about expected conduct; events and training.
- Efforts were being made to engage with staff and a staff survey had been distributed in the December 2016 salary slips. At the time of inspection eight out of 30 had been returned. The Hospital Director stated there was an intention to redistribute and have a drive to encourage staff to complete the survey.
- Staff were positive about their managers and 76.9% of staff said they felt listen to by their manager.
- Staff told us that in the past suggestions had been made and some had been taken up such providing a table and chairs in the staff room to make this area more comfortable.
- Staff also told us that they did not always receive feedback about why some suggestions were responded to and others not. For a number of staff commented that in the past they had said that the doors in the ward areas should be different colours for public areas, toilets and exit however, they had not received feedback about this suggestion. Staff said there was not a standard forum for discussing and having suggestion recorded so that they could be raised and considered at a senior level.

Innovation, improvement and sustainability

- The hospital had a Campaign Action group which included local people and they met officially meet four times a year; however more meetings could be arranged around an event. The notes from the 1 February 2017 meeting confirmed that the service used social media to raise awareness about the hospital in the local community. The notes also indicated that people were aware of the hospitals priorities and 'wish list' for future purchases. For example, the group discussed the fundraising and marketing team plans to increase the take up of private respite beds. The group also discussed the financial situation of the hospital and their part in closing the gap. The group identified a need to widen interest in the hospital to people who lived outside of Tarporley. The undertakings of the campaign action group were communicated to the board through the fundraising report. We saw that the hospital director had agreed to attend future meetings.
- The Fundraising manager had introduced a fundraising database which collated information about fundraising streams and helped to set budget priorities. Monthly update emails were sent to all members of the action group.
- The service held monthly GP practice cluster meetings and Trust Board meetings every two months. We reviewed two sets of cluster meeting notes and the board meeting for September 2016. Meetings included the Hospital Director, Trustees and fundraising team. Minutes indicated that issues related to current changes, futures improvements and sustainability of the service were discussed and decisions made.
- The meeting members looked at how to secure the future of the hospital through improving long-term fundraising, increasing the number of private respite beds and reviewing the contracts with commissioners such as the clinical commissioning group and local NHS hospital trusts. Issues which might cause the service to cease such as lack of funding were also discussed and ideas for mitigating the issues identified. However corresponding action plans were not in place to ensure ideas were carried forward monitored and reviewed.
- In January 2017 the service developed a 'Turnaround plan' which was a list of potential activities and plans for improving the quality of the service and promoting sustainability. The plan was formed with trustee input to bring together work streams that may secure the future of the hospital. This project was in the early stages of development at the time of the inspection, but it was planned that updates on progress would be reported to the steering group and board of trustees.

Requires improvement

Community health inpatient services

- We spoke to trustees who informed us that the hospital finances were in deficit however, the care of the patents was never compromised and we did not see any evidence of the contrary.
- The systems for collaborative working such as access to the occupational therapy, speech and language therapy or physiotherapy, should be formalised and service level agreements put in place.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital is very much part of the local community and many of the neighbouring areas cherish the hospital. Members of the public regularly held charitable fundraising events and likewise the hospital fundraising team regularly engaged with individuals who used the services, their families and local organisations and made them feel part of the hospital. Whilst we were visiting the director went to receive a large donation from a member of the public and had their photographs taken for the local paper, many of the villages attended the giving ceremony. The charitable events organised by the hospital, also brought the community together. The hospital had its own brochure informing the public on where their donations were being used and of forth coming events.

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure effective correct control measures are in place to mitigate the risk of pressure damage for those patient's deemed at risk of pressure ulcers, such as monitoring and implementing a repositioning regime, these should be clearly documented in patients' records.
- 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms must be quality assessed to ensure they are correctly completed.
- The hospital must ensure they undertake a comprehensive and effective auditing programme.
- The hospital must ensure they implement a policy and procedure that meets duty of candour requirements.
- The hospital must ensure compliance with the Mental Capacity Act legislation and must ensure that the two stage mental capacity assessment is completed and clearly documented in patients' records.
- The hospital must ensure best interest decisions are completed and documented for those who are unable to consent to care and treatment in line with the Mental Capacity Act 2005.
- Health care assistants acting as second checker for medicines must receive appropriate training and be assessed as competent to carry out the role. This process should be clearly documented.
- The registered provider should take steps to ensure robust policies, procedures and guidelines are in place, including; equality and diversity issues are considered and addressed for patients, guidelines are in place and followed in relation to meeting the needs of people in vulnerable circumstances and the complaints policy is accessible and provides accurate information about the next step if patients are not satisfied with the outcome of an investigation.
- The risk register must be robust and identify clear processes for mitigating risks and ongoing monitoring with given time scales. The process for staff to escalate local level ideas and risks must be clear.

Action the provider SHOULD take to improve

- The incident reporting system should be improved to ensure that all incidents are reported and that effective learning takes place following incidents that are reported.
- A reliable acuity tool should be implemented to determine staffing levels and provide a measurable level to indicate when extra staff are required.
- Archived patient records should be stored securely and loose papers made secure.
- Staff treating children and young people for minor injuries should receive level 3 safeguarding training.
- The hospital should develop a system to ascertain which NICE guidance applies to their scope of practice and ensure the hospital follows that guidance.
- The hospital should review their policy on consent for bed rails to ensure it meets the requirements of the Mental Capacity Act 2005.
- The hospital should ensure that the 'two stage assessment of capacity' is always completed and included within the patients' records,
- The hospital should consider making the environment dementia and sensory disability friendly.

Outstanding practice and areas for improvement

- The room used as a mortuary should be made suitable if it is going to be used as such.
- The hospital should ensure that doctors comply with best practice around record keeping.
- The hospital should ensure that hand hygiene audits are reinstated when the matron takes up post.
- The hospital should consider a formal system for on call staff should additional support may be required out of hours.
- The hospital should consider the implementation of an additional shift staff member to ease the high demands of staff at certain times of the evening
- The hospital should look into how rules about visiting could impact on the involvement of those close to patients.
- The hospital should ensure that the admission process is reviewed to include a full assessment of the needs of the people. Members of the public and patients who can self-refer for respite care should be provided with a clear criteria for admission.
- The hospital should ensure that they always obtain sufficient information from the referrer to enable a decision to be made as to whether the hospital could safely accommodate the patient's needs.
- The hospital should formalise multidisciplinary team meetings so that a record is kept and the outcomes reviewed.
- The hospital should look at implementing actions plans with regards to delayed discharges.
- The hospital should plan for the needs of all the patients by implementing a system to gather data about the patients they are providing a service for.
- The hospital should consider auditing the mini-minor injuries department to look at patient outcomes.
- The hospital should consider equality and diversity training and that guidance and policies and reviewed.
- All hospital 'Action plans' should include target dates, who is responsible and be updated regularly.
- The hospital should provide feedback to staff regarding suggestions they make and should consider a forum for discussing suggestion.
- Minutes to meetings should include evidence of formal action tracking to support actions agreed at the meetings, with name leads and timescales.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: You had failed to provide safe care and treatment to patients who were at risk of developing pressure ulcers. We found that patients at high risk of developing pressure ulcers and those who had already been highlighted as showing signs of pressure damage, were not placed on repositioning regimes. **Regulation12 (1)(2)(a) Safe Care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance You failed to maintain relevant, up to date policies. There was no policy that referenced the duty of candour. The hospital did not have a policy for the application and management of the Mental Capacity Act (MCA). The Hospital risk register did not record accurately the condition, cause or consequence of the risk and did not appear to reflect all the risks within the hospital. You failed to have a robust audit system in place to assess, monitor and improve the quality of the service. For example, do not attempt cardio pulmonary resuscitation (DNACPR) forms issued by the GPs providing care and treatment to patients, were completed incorrectly.

This section is primarily information for the provider

Enforcement actions

There was a limited audit system in place and as a result applications to deprive patients of their liberty due to their lack of capacity were incorrectly applied for.

You have failed to analyse clinical audit findings and identify service improvements and as a result you were not monitoring or identifying issues that required remedial action, or improvement. For example there was no system in place to check the competence of staff to administer medicines safely.

Regulation 17 (1)(2)(a)(b)(c), Good governance, of The Health and Social Care Act 2008(Regulated Activities) Regulation 2014.

Due to concerns and issues found on inspection we have taken enforcement action regarding the above breaches.

The hospital was given a compliance date and we will follow this up to check compliance with the regulations.