Lauriston House

Quality Report

Lauriston House
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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

- Following our inspection in 2015, the provider had made improvements to the rehabilitation unit. During this inspection, we observed that in addition to the resuscitation trolley on the first floor, there was a "grab bag" on the ground floor of the building for use in an emergency situation. All call bells were working and the elevator was also working. Compliance with mandatory training had improved to 88% in line with the provider's target. An acuity and dependency tool was now in place and staffing on the unit was in line with national guidelines. There were flagging systems in place to identify and address the needs of patients living with dementia. Staff appraisals had risen from 60% during the last inspection to 99% in September 2016.
- The service monitored its safety thermometer information to improve patient safety. There were effective systems to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff.
- The environment and equipment was clean and supported safe care. Staff complied with infection prevention and control guidelines.
- Policies and procedures were developed in line with national guidance. Patients' needs were assessed and care was delivered in line with best practice guidelines. The service carried out audits to measure performance against set standards. Action plans were implemented to improve the service.
- Patients were cared for by appropriately qualified staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. There was effective internal and external multidisciplinary team working and practitioners worked with other staff across services.
- Staff provided kind and compassionate care and we received positive comments from patients. Patients and their relatives reported they were involved in their care and were given explanations about their treatment.
- Services were developed to meet the needs of patients. Discharge planning was managed from the first point of admission to the unit to ensure the correct equipment and care provision was available for people to return home safely.
- A community psychiatric nurse (CPN) was available to support vulnerable patients with mental health needs within the service and two care managers from the local authority dealt with matters relating to safeguarding.
- Carers were referred to relevant organisations that supported carers within the borough for carer assessments and support.
- There were very few complaints, where required learning from these was discussed with staff in the service.
- We saw good local leadership within the service and staff reflected this in their conversations with us. There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.
- There were effective governance systems in place and risks were proactively reviewed.

However:

- There was limited space in the rehabilitation unit. The gymnasium (gym) was split into two with a screen to enable staff to use one side as an office.
- We noted inconsistencies in the way National Early Warning Scores (NEWS) were calculated in some of the records reviewed.
- There were no therapy sessions at weekends.

Summary of findings

Contents

Good

Lauriston House

Services we looked at:
Community health inpatient services

Summary of this inspection

Background to Lauriston House

Lauriston House rehabilitation unit is a community adults inpatient unit managed by Bromley Healthcare Community Interest Company (Bromley Healthcare). Bromley Healthcare is a social enterprise company which provides community healthcare services to residents of Bromley, Bexley, Croydon and Lewisham.

Patients are admitted to Lauriston House rehabilitation unit for rehabilitation following discharge from hospital.

The rehabilitation unit has 36 inpatient beds provided in single or double rooms. Most of the rooms are located on the first floor of the building; however, there are a few rooms on the ground floor of the building shared with a separate care provider.

Our inspection team

Team Leader: Temi Oke, Care Quality Commission

The team included a CQC inspector and a physiotherapist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 7 November 2016. During the visit we talked with people who use services. We observed how people were being cared for and reviewed care records of people who use services. We reviewed the service's records such as policies, procedures and audits.

Information about Lauriston House

The unit provides rehabilitation services to adults aged 18 years and over.

The unit admitted 462 patients between July 2015 and June 2016. Forty of these patients were aged 18 to 74 years and above. All the patients were NHS funded.

On 7 November 2016, we carried out an announced inspection as part of our comprehensive community health services inspection programme.

At the time of the inspection, the rehabilitation unit was led by a Matron. A lead nurse, a lead physiotherapists and a lead occupational therapists supported the Matron.

Summary of this inspection

During the inspection, we reviewed the provider policies and procedures, staff training records, audits and performance data. We also looked at nine patient notes and observed care being provided. We spoke to seven patients, one relative and 16 members of staff including nurses, therapists, a consultant, a pharmacist and administrators.

What people who use the service say

Patients and relatives we spoke with were positive about the care and treatment they received. They told us they were involved in discussions about their treatment and staff treated them with dignity and respect.

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?

Good

We rated safe as good because:

- The service monitored its safety thermometer information to improve patient safety. There were effective systems to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff. There were effective arrangements for safeguarding vulnerable adults.
- Staff had access to a wide range of equipment and most equipment was adequately maintained.The environment and equipment was clean and supported safe care. Staff complied with infection prevention and control guidelines.
- Staffing levels on the unit were in line with national guidelines, although bank staff were often used to achieve this. Staff had achieved the provider's target for most of the mandatory training modules.

However:

- We noted inconsistencies in the way national early warning scores (NEWS) were calculated in some of the records reviewed.

Are services effective?

Good

We rated effective as good because:

- Policies and procedures were developed in line with national guidance. Patients' needs were assessed and care was delivered in line with best practice guidelines. The service carried out audits to measure performance against set standards. Action plans were implemented to improve the service.
- There was effective internal and external multidisciplinary team working and practitioners worked with other staff across services.
- Patients were cared for by appropriately qualified staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Ninety-nine per cent of staff had an appraisal in the last year.
- Staff knew their responsibilities in relation to consent and the Mental Capacity Act (2005).

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Staff provided kind and compassionate care and we received positive comments from patients. Patient's privacy and dignity was maintained.
- Patients and their relatives reported they were involved in their care and were given explanations about their treatment. Patients' feedback was sought and the latest Friend and Family Test results showed that most patients indicated they would recommend the service.
- Staff were aware of patient's individual needs and considered these when providing care.
- Patients were emotionally supported by staff and referrals were made to appropriate community teams.

Are services responsive?

Good

We rated responsive as good because:

- Services were developed to meet the needs of patients. Staff had access to translators when needed, giving patients the opportunity to make decisions about their care, and day to day tasks. There were systems in place for identifying patients with complex needs such as dementia and responding to their needs.
- A community psychiatric nurse (CPN) was available to support patients within the service. Carers were referred to relevant organisations that supported carers within the borough for carer assessments and support.
- Senior staff dealt with complaints appropriately and shared learning with all staff.
- About 98% of patients were transferred to the rehabilitation unit within two days of acceptance, although this was slightly below the target of 100%.

However:

- There was limited space in the rehabilitation unit. The gymnasium (gym) was split into two with a screen to enable staff to use one side as an office. It had an impact on the number of patients the gym could accommodate and the ability to run exercise classes.
- There were no therapy sessions at weekends.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Bi-monthly governance meetings were held with all service leads in attendance. We could identify actions put in place to address issues discussed at the meetings. The management team had oversight of the risks within the services and mitigating plans were in place.
- We saw good local leadership within the service and staff reflected this in their conversations with us. Staff were supported in their role and had opportunities for training and development. There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.
- There was evidence of staff engagement and changes being made as a result. Patients were engaged through surveys, feedback forms and online forums.

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	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Community health inpatient services

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

Are community health inpatient services safe?

Good

Summary

We rated safe as good because:

- The service monitored its safety thermometer information to improve patient safety. There were effective systems to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff.
- There were effective arrangements for safeguarding vulnerable adults.
- Staff had access to a wide range of equipment and most equipment was adequately maintained.
- Medicines were generally stored safely and securely.
- The environment and equipment was clean and supported safe care. Staff complied with infection prevention and control guidelines.
- Staffing levels on the unit were in line with national guidelines, although bank staff were often used to achieve this. Staff had achieved the provider's target for most of the mandatory training modules.

However:

- We noted inconsistencies in the way national early warning scores (NEWS) were calculated in some of the records reviewed.

Detailed findings

Safety performance

- The NHS Safety Thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care on one day each month. The service audited and monitored avoidable harms caused to patients. The service's safety thermometer data showed that between May 2016 and October 2016 the service provided an average of 92.7% harm free care. Pressure ulcer incidents during the period averaged 7.3%; however, this involved patients who had pressure ulcers before they were admitted. There were no incidents of falls with harm, venous thromboembolism (VTE) and urinary tract infections (UTIs).
- The two main categories of incidents reported between October 2015 and September 2016 were falls (71 incidents) and pressure ulcers (29 incidents). Sixty-six of the falls resulted in low or no harm, 12 resulted in moderate harm and one resulted in severe harm. All the pressure ulcers were classified as grade 2 pressure ulcers.
- The provider had committed to the sign up to safety national campaign for NHS services in England. The campaign aimed to reduce avoidable harm by half and save lives. In line with this campaign, the provider implemented the falls prevention plan across its services. This included standardisation of templates for a falls risk assessment, training of staff, development of falls champions and education for carers/families on fundamentals of care.
- The service had made improvements over the year by improving the falls risk assessment with the aim to complete this within two hours of admission and then

daily. They had also purchased bed sensors and motion alarms. The service's falls data indicated that the incidences of falls had declined from approximately 24 between January and March 2016, to 15 between July and September 2016.

- The provider had a pressure ulcer advisor who investigated pressure ulcer incidents across the services. A pressure ulcer panel was sent up to investigate any grade 3 or 4 pressure ulcer that occurred across the services. The panel was chaired by the director of nursing and attended by a multidisciplinary team including the tissue viability nurse, safeguarding advisor, case holder and the pressure ulcer advisor amongst others.
- There were daily board rounds with every patient discussed on a daily basis. There were twice daily safety briefings and safety hand overs.

Incident reporting, learning and improvement

- Staff reported incidents using the electronic reporting system. All the staff we spoke to knew how to report incidents. They told us they received feedback on individual incidents they reported and on trends within the service. Senior staff shared information regarding incidents and learning at handovers, during staff meetings and through staff bulletins.
- Staff reported 185 incidents between October 2015 and September 2016. Of these, 75 resulted in no harm, 96 resulted in low harm and 13 resulted in moderate harm. One incident resulted in death and was investigated under the serious incident framework.
- We reviewed the root cause analysis (RCA) report of a serious incident leading to death in March 2016. This was as a result of an unobserved fall resulting in head injury and admission to hospital. The patient subsequently died seven days after admission. The RCA report was sufficiently detailed, covering contributory factors, chronology, root cause and recommendations. The service contacted the family in line with the duty of candour regulations. The RCA identified that a falls risk assessment for the patient did not have an action plan or risk score. In addition there were no daily falls care plan in place.
- A detailed action plan accompanied the RCA and lessons learnt were subsequently communicated to staff. We observed a new falls risk assessment was in place during our inspection in line with the recommendations made. The risk assessment was completed on admission and subsequently updated daily or when there was a change in condition.The risk assessment had a score highlighting patients to be low, medium or high risk. A daily falls care plan was also in place to implement actions to minimise falls.
- There were no "never events" in the 12 months prior to the inspection. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- 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. Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. They provided examples where they adhered to this duty and we saw evidence of this being demonstrated in a written letter to the relatives of a patient who died following an unobserved fall.

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. Staff reported two safeguarding concerns in the 12 months preceding the inspection. No further action was required following investigation to those concerns.
- The provider had a dedicated safeguarding lead who could provide support to staff on demand. Staff we spoke to knew who the safeguarding lead was.
- The provider had a safeguarding adults policy and safeguarding children policy and staff were aware of how to access these.

- Ninety-three per cent of staff had completed the adult protection training against the provider's target of 85%. All staff had completed the children safeguarding training.

Medicines

- There were policies in place to manage the storage and administration of medication.
- Patients were discharged from local trusts with their 'to take out' (TTO) medication which were stored in their bedside lockers and locked.
- The patients' own controlled drugs (CDs) were stored inside a controlled drugs cupboard and locked. Staff audited controlled drugs on a daily basis and documented this in the CD register. The pharmacy team carried out quarterly medicine audits.
- A CD policy audit carried out in June 2016 showed staff adhered to the provider's policy to ensure the safe storage, administration and disposal of controlled drugs within the service. The audit identified that differences in the number of drugs recorded in the CD register and content of the CD cupboard were investigated in line with the provider's policy. The investigation revealed that nurses had administered a double dose of medication in line with new prescription but had not deducted the additional quantity administered from the CD book. Following the investigation, the CD book was amended to reflect the correct quantity and learning was shared with staff. The provider informed us they had completed monthly spot checks since September 2016 and a full written audit would be completed in January 2017.
- We saw that the allergy statuses of patients were routinely recorded on medicines charts.
- Staff monitored fridge temperatures on a daily basis and recorded minimum and maximum temperatures. Records showed the temperatures were within normal range.
- We found two tablets on the floor in the corridor. This was escalated to a senior staff who disposed of the medication.
- Bromley Healthcare had a community pharmacist who supported inpatient services and local arrangements had been made with an external pharmacy for the provision of medicines.

Environment and equipment

- Patients were cared for in a mix of single and double ensuite rooms. Patients were located mainly on the first floor of the building with a few patients on the ground floor of the building. There was a resuscitation trolley on the first floor of the building and we noted that there was a grab bag for emergency situations on the ground floor.
- Equipment checks in the unit were up to date. Equipment had maintenance stickers showing they had been serviced in the last year. Staff maintained resuscitation equipment with daily documented checks. All emergency drugs and consumables on the resuscitation trolley were in date.
- We observed that patients' beds were bigger than the door way as they had been built in the rooms. It was therefore impossible to move the beds out of the rooms in the event of an emergency. However, each mattress was fitted with a ski evacuation sheet to ensure rapid evacuation of patients in emergencies. The service carried out weekly fire alarm tests and there had been three fire drills in the last year.
- A register of equipment was maintained by the provider and we saw evidence that regular maintenance checks had been completed.

Quality of records

- Patient record folders were kept within an office, only accessible to staff. Prescribing, medical and general therapeutic notes, and risk assessments were inputted into the electronic record system. The rest of the notes, including nursing notes were in paper format.
- We looked at a random sample of nine patients' paper records. They were up to date and complete. Admission assessments, daily nursing and therapy notes were filed in a standardised order within an initial content guide so that staff could quickly locate the desired information. Nutrition and fluid intake was well monitored as was pressure area management, with body maps in place to identify areas of concern.

- However, one of the records we reviewed contained a risk assessment form relating to another patient. We flagged this up with senior staff and the record was removed and placed in the right folder.
- An audit of 21 patient records was carried out in January 2016 from a random selection of clinical records of patients who stayed at Lauriston House in July 2015. The audit showed an overall compliance of 78%. Every record reviewed had relevant, dated and signed care plans, however, only two set of records showed that care plans were reviewed and updated. Six of the records did not note the patients' ethnicity. There was occasional evidence of consent being obtained but this was not documented consistently for every contact with a patient. Only 19% of the records had a completed admission checklist.
- An action plan was put in place to address the areas of concern including consent, care plans and admission checklists. The findings were communicated to team members through emails and the communication book. A repeat audit was recommended within a year to ensure staff complied with the action plan.
- Our review of patients' notes indicated care plans were consistently reviewed, consent was documented and admission checklists were completed within two hours of admission. We also noted that the service carried out monthly ethnicity recording audits. The service's balanced scorecard showed that between April and September 2016, ethnicity recording ranged between 95% and 100%.
- Ninety per cent of staff had completed the information governance training against a target of 95%.

Cleanliness, infection control and hygiene

- All areas of the rehabilitation unit were visibly clean and all the patients we spoke with were satisfied with the cleanliness.
- Personal protective equipment (PPE), such as gloves and aprons were available in all clinical areas. All staff observed the 'bare below the elbow' policy and we observed them using PPE when required. Antibacterial hand gel was available in all clinical areas.
- Equipment used in the unit, including commodes and bedpans were clean. Staff used 'I am clean labels' to indicate an item of equipment was cleaned and decontaminated. Sharps bins were properly assembled, labelled and they were not filled above the line indicated on the bin
- Potentially infectious patients were isolated in single rooms set apart for that purpose. The doors were clearly marked to alert staff entering the room. However, we noted that the door to an isolation room was left open during our inspection which meant the sign was not always obvious to staff.
- The service undertook monthly hand hygiene audits based on the standards of the World Health Organisation's 'five moments to hand hygiene'. Between April 2016 and October 2016, hand hygiene compliance was 100%.
- Ninety-seven per cent of staff had completed the infection control training against the provider's target of 90%.
- There was one incident of Clostridium difficile in the last one year.
- The provider had an infection prevention and control specialist nurse who provided mandatory training, advice and support to staff.

Mandatory training

- Most staff were up to date with their mandatory training with overall compliance at 88%. This was against the provider's target of 85%. There had been an increase in the overall compliance with mandatory training from 74% in April 2016.
- Mandatory training included adult protection, safeguarding children, conflict resolution, equality and diversity, fire safety, level two food handling, health and safety, infection control, moving and handling, resuscitation and information governance.
- The rehabilitation unit fell below the target of 85% for level 2 food handling (53%). It also fell below the target of 90% for moving and handling for clinical staff (87%) and resuscitation (74%).
- Senior staff explained they had newly recruited staff who were not yet up to date with their training. We noted that all staff who were yet to complete their mandatory training were booked to attend their training within the next two to three months.

Good

Community health inpatient services

Assessing and responding to patient risk

- Risk assessments, including risks of falls were completed for patients and details were kept in the patients' notes and updated regularly. Our review of patients' notes showed that admission checklists were completed within two hours of admission. Senior staff informed us they had recruited additional staff to ensure the service was able to complete assessments on admission promptly.
- Staff used the National Early Warning Score (NEWS) to identify deteriorating patients and vital sign observations were recorded in patients' notes. Staff had been trained to carry out basic observations and staff could escalate concerns when necessary.
- Nursing staff were able to contact GPs attached to the service or contact could be made with the medical response team, a team of advance nurse practitioners and GPs who worked within the community out of hours. Where patients required urgent medical intervention, staff called for an ambulance. There was an emergency call bell system in place for any emergency.
- However, we noted inconsistencies in the way the NEWS was calculated in three of the nine records reviewed. In one record, NEWS was not calculated and the section was left blank. In the second record, the total scores on the observation chart were less than the NEWS calculated. In the third record, the patient had an elevated score, however, there was no corresponding record of how this was escalated in the paper or electronic records. We escalated this to senior staff who identified that the three observations were recorded by an agency staff who no longer worked at the unit. Senior staff told us they routinely audited patient records to monitor observation charts. Following the inspection, we were provided with an audit of 12 patient records carried out in the week prior to the inspection which showed 100% compliance with accurate calculation of NEWS.
- Senior staff informed us they routinely reviewed patients transferred to the hospital to determine if deterioration in the patients' condition could have been escalated earlier. The aim of the review was to use the learning to assist staff in identifying deteriorating patients and to prevent unnecessary transfers to the hospital. We were provided with a copy of the review for August and September 2016. This showed that four patients were transferred to the hospital in each month. The review indicated that all patients had been appropriately escalated for readmission to hospital and there were no concerns identified in relation to their care on the unit.

Staffing levels and caseload

- The inpatient rehabilitation unit was led by a band 8a Matron.
- The nursing team included a band 7 lead nurse, four band 6 registered nurses and 13 band 5 nurses. The therapy team included a band 7 occupational therapist, a band 7 physiotherapist, a band 6 physiotherapist, a band 6 occupational therapist, a band 5 physiotherapist and a band 5 occupational therapist.
- They were supported by band 3 therapy assistants, 32 band 3 nursing rehabilitation assistants (NRAs), nine band 2 NRAs and two service assistants.
- The service had filled vacancies with two registered nurses starting in November 2016 and one starting in December 2016. They had also recruited a therapist who started on the day of the inspection.
- The service used the Shelford safer staffing tool to ensure the right number of staff with the right skills were on each shift. Four registered nurses and eight nursing rehabilitation assistants were required during the day. Three registered nurses and four nursing rehabilitation assistant were required at night. Between April 2016 and September 2016, the average fill rate for day nursing staff was 93% whilst the rate for NRAs was 98%. The average fill rate for night nursing staff was 100% whilst the rate for NRAs was 99%. During the same period, 79% of the shifts were filled by substantive staff, 10% by bank staff and 11% by agency staff.
- Most staff informed us that there were sufficient numbers of staff to cover the shifts. However, one staff member indicated they were short staffed. We reviewed copies of the staff rota in the two months prior to the inspection and confirmed that it was in line with the staffing tool used by the rehabilitation unit.

Good

Community health inpatient services

- Medical staffing consisted of a consultant geriatrician who attended the unit one day a week. There was also GP cover from Monday to Friday. Out of hours' the service had access to GPs from the provider's Medical Response Team.

Managing anticipated risks and major incident awareness and training

- The provider had a major incident plan in place and an electronic copy was available on the provider's intranet. It included action cards, which explained roles in the event of a wide variety of incidents and scenarios.

Are community health inpatient services effective?

(for example, treatment is effective)

Good

Summary

We rated effective as good because:

- Policies and procedures were developed in line with national guidance. Patients' needs were assessed and care was delivered in line with best practice guidelines.
- The service carried out audits to measure performance against set standards. Action plans were implemented to improve the service.
- There was effective internal and external multidisciplinary team working and practitioners worked with other staff across services.
- Patients were cared for by appropriately qualified staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Ninety-nine per cent of staff had an appraisal in the last year.
- Staff knew their responsibilities in relation to consent and the Mental Capacity Act (2005).

Detailed findings

Evidence based care and treatment

- Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies such as the Royal College of Nursing and the National Institute for Health and Care Excellence (NICE). Guidelines were easily accessible on the provider's intranet page and were up to date. There were also hard copies available in folders in one of the offices on the unit.
- Patients' needs were assessed and care was delivered in line with best practice guidelines. Adherence to guidelines was encouraged through the development of care specific proformas. There were various templates in use including falls risk assessments and assessments for nutrition amongst others.
- A tissue viability nurse was available to the inpatient service and provided advice and support on the management and prevention of pressure wounds.
- The therapy team held a breakfast group to encourage patients to regain their independence. There was an assessment kitchen and patients were encouraged to make their own breakfast. Patients were also allowed to self-medicate as part of their rehabilitation in preparation for returning home.
- Staff used the Modified Barthel Index (MBI) tool to measure activities of daily living, which showed the degree of independence of a patient from any assistance. Staff also used the EuroQol five dimensions (EQ-5D), a standardised instrument for use as a measure of health outcome. The geriatrician completed an assessment for each patient and this was reviewed by the multidisciplinary team (MDT) to ensure holistic patient care.
- Compliance against the requirement to complete falls risk assessment within 72 hours of admission and VTE assessment on admission was initially low in April 2016 due to a move to using an electronic record template. However, in August and September 2016, there was 100% compliance for both assessments against a target of 95%.
- The service carried out audits to measure performance against set standards. A sepsis audit was carried out in September 2016 to review four patients readmitted to the acute sector or who died in September 2016. Result of the audit showed that staff were screening patients against five out of six of the

criteria to identify potential sepsis. Staff identified sepsis in one of the patients and this was clearly documented in the notes. There was a deficit in assessing patients' skin for mottled skin, ashen appearance, any cyanosis or non-blanching rash. However, the audit recognised that these might be very late signs of sepsis and the intention was to identify a deteriorating patient before these signs became apparent. An action plan was put in place to share learning with staff at a team meeting and for staff to record skin assessments.

Pain relief

- Staff used a standardised tool to assess patients' pain and recorded pain assessments in patients' notes. Pain relief was prescribed as appropriate by the inpatient consultant or by GPs who attended the service daily.
- An analgesia audit of 25 patient records carried out in August 2016 showed that staff recorded a pain score in all records reviewed. It also showed that analgesia was offered when patients were in pain. In addition, there were no missed administrations and where there was an omission, the reason was clearly documented. All controlled drugs administered were given and documented in line with the provider's policy.

Nutrition and hydration

- Staff carried out a malnutrition screening tool (MUST) assessment and also referred patients to the dietetic service were necessary.
- Patients' daily fluid and nutritional intake was monitored and recorded in their notes. They were accurately completed and indicated whether patients were at risk of malnutrition or dehydration.

Patient outcomes

- The service participated in the 2013 intermediate care audit, but had not been involved since 2014. The service had a programme of audits to monitor performance against specific patient outcomes.
- The provider's balance scorecard showed that in September 2016, 100% of patients demonstrated improved function on discharge using the Modified Bartel Index. This was an improvement from 50% in April 2016. Sixty-eight per cent of patients had improved scores on discharge using the EQ5D. The average length of stay between April 2016 and September 2016 was 25.4 days against a target of 27 days.
- The proportion of patients who developed a grade 2 pressure ulcer was above the target of 5% or less in April 2016 (8.6%) and July 2016 (6.1%). However, the service achieved the target of 5% or less in May, June and August 2016 (0%), and in September 2016 (3%).
- The number of patient falls with harm were below the target of 5% or less in April, May, June and August (0%), and in July 2016 (3%). However, they were above the target in September 2016 (6%).

Competent staff

- All new staff were allocated a mentor and went through a period of induction. They undertook competency based assessments and mandatory training.
- There had also been an improvement in the rate of staff appraisals. By September 2016, 99% of staff had had an appraisal when compared with 66% in April 2016.
- All nurses were up to date with their revalidation. There were systems in place to alert staff when their registration and revalidation was due for renewal or completion.
- All allied health professionals (AHPs) were registered with the Health and Care Professions Council (HCPC). Information provided by the unit indicates that all AHPs had current HCPC registration.
- The provider liaised with GP practices and acute trusts to monitor medical staff revalidation, appraisals and training.

Multi-disciplinary working and coordinated care pathways

- Staff reported good working relationships with the multidisciplinary team (MDT) of nurses, therapists, pharmacist, GPs, care managers and community teams. The service held daily MDT meetings attended by all staff. Weekly MDT meetings were held with the geriatrician also present.

- Staff also attended meetings and quality summits with wider Bromley Healthcare staff and could easily refer patients to the tissue viability nurse, speech and language therapist, community teams and dietitians within the service.
- Two local authority care managers (social workers) were based within the building and attended MDT meetings with clinical staff to support discharge planning. The care managers were also the lead professionals in safeguarding matters, and liaised with the local authority. Staff felt that the care managers were an integral part of the team and would provide feedback in relation to safeguarding concerns.

Referral, transfer, discharge and transition

- Patients were referred to the rehabilitation unit following discharge from local trusts.
- There was a discharge activity coordinator in post whose role was to coordinate discharges from the unit. Discharge planning commenced upon admission to the unit and patients had an estimated discharge date. We confirmed this in our discussions with patients and from reviewing the patients' notes.
- The discharge activity coordinator liaised with the rest of the therapy team and social services. Staff spoke with patients and their relatives and found out whether they had the correct level of support at home. Staff often visited patients' homes to access the environment's suitability for discharge.
- If patients required further therapy, they were discharged to the provider's rehabilitation home pathway service. Staff also referred patients to other services for support if necessary.
- Weekly multidisciplinary team meetings were held with the geriatrician who reviewed patients' suitability for discharge.
- Comprehensive patient discharge summary and functional reports were sent to patients' GPs following discharge from the unit.

Access to information

- Staff had access to relevant guidelines and policies on the intranet system. Staff also had access to patients' paper and electronic records.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had access to best practice guidance and local mental capacity policies. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment. Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards (DOLs) and how this would impact a patient on the unit.
- Thirty-three per cent of staff had completed the recently introduced Mental Capacity Act training whilst 62% had completed the DOLs training. We noted that compliance with MCA/DOLs training was highlighted on the risk register and staff were booked to attend this training by the time of our inspection.
- The service carried out 'do not attempt cardiopulmonary resuscitation' (DNACPR) audit in October 2016. Results of the audit showed that in 22 of the 23 patient records audited CPR was considered and documented. Eleven patients were considered to be appropriate for a DNAR decision and 10 of these patients had MDT discussion recorded in their notes.
- Of the 11 records with DNACPRs in place, eight patients had capacity to make the decision, one patient did not have capacity and two patients' capacity was unclear. Patients who had capacity were aware that a DNACPR was in place.
- The audit concluded there was generally good practice on the unit and patients with capacity were involved in CPR/DNACPR decision. However, it noted there were inconsistencies were a patient's capacity appeared contestable. In two cases, it was not clear whether capacity was evaluated but, the patients had a DNACPR in place. One was later revoked following a multidisciplinary team (MDT) decision. An action plan was put in place to check CPR/DNACPR decisions at MDT meetings and to improve communication and inclusion of relatives in decisions made. A re-audit was scheduled for January 2017.

Good

Community health inpatient services

Are community health inpatient services caring?

Good

Summary

We rated caring as good because:

- Staff provided kind and compassionate care and we received positive comments from patients.
- Patient's privacy and dignity was maintained.
- Patients and their relatives reported they were involved in their care and were given explanations about their treatment.
- Patients' feedback was sought and the latest Friend and Family Test results showed that most patients indicated they would recommend the service.
- Staff were aware of patient's individual needs and considered these when providing care.
- Patients were emotionally supported by staff and referrals were made to appropriate community teams.

Detailed findings

Compassionate care

- Patient, family and friends feedback was mostly positive. During all our observations, we saw staff treat patients with care. We observed staff interactions with patients. Staff were courteous, professional and demonstrated compassion to all patients.
- Patients told us staff were helpful and they would recommend the service. One patient said the service provided "really, really top class care, couldn't wish for a better place to be in". Patients said staff always responded to their calls and were all very pleasant.
- Personal care was provided in patients' rooms and we observed that staff maintained patients' privacy and dignity.
- The results of the Friends and Family Test (FFT) survey between April and September 2016 showed that an average of 92% of patients would recommend the service to their friends and family.

Understanding and involvement of patients and those close to them

- Patients and their relatives reported they were involved in their care and were given explanations about their treatment. We observed staff introducing themselves to patients before attending to them. Staff explained the procedure they were about to carry out and obtained consent.
- We saw that staff took time to understand patient preferences and provide care in line with them. Therapists drew up exercise plans in line with patient preferences. In addition, staff liaised effectively with patients to agree an estimated discharge date and involved relatives in the discharge process.

Emotional support

- Staff provided emotional support to patients and referred patients who present with low mood and anxieties to the team's community psychiatric nurse (CPN) for assessment. They also arranged for family members to come in if patients requested to see member of their family. The service also had links with religious organisations within the borough.
- The provider had a patient experience lead whose role was to help support both patients and their carers. The lead assists staff to identify carers and refer them to relevant organisations that provide support for carers within Bromley.

Are community health inpatient services responsive to people's needs? (for example, to feedback?)

Good

Summary

We rated responsive as good because:

- Services were developed to meet the needs of patients.

- Staff had access to translators when needed, giving patients the opportunity to make decisions about their care, and day to day tasks. There were systems in place for identifying patients with complex needs such as dementia and responding to their needs.
- A community psychiatric nurse (CPN) was available to support patients within the service. Carers were referred to relevant organisations that supported carers within the borough for carer assessments and support.
- Senior staff dealt with complaints appropriately and shared learning with all staff.
- About 98% of patients were transferred to the rehabilitation unit within two days of acceptance, although this was slightly below the target of 100%.

However:

- There was limited space in the rehabilitation unit. The gymnasium (gym) was split into two with a screen to enable staff to use one side as an office. It had an impact on the number of patients the gym could accommodate and the ability to run exercise classes.
- There were no therapy sessions at weekends.

Detailed findings

Planning and delivering services which meet people's needs

- Admission to the rehabilitation unit was available to patients who resided in Bromley or had registered with a GP in Bromley. Patients were admitted to the unit for rehabilitation following discharge from the hospital. The service was commissioned by the local clinical commissioning group (CCG) to provide rehabilitation to patients for a maximum of six weeks. The service supports patients to become independent before they are discharged home.
- There was a clear eligibility criteria for admitting patients. Patients were required to be over 18 years and should have been declared medically fit for discharge home or to Lauriston House by the hospital medical team. In addition, they should have consented to accept the service and participate in rehabilitation.
- Ninety one per cent of patients admitted on the unit were aged 75 years and above. Staff tailored services to address the needs of the elderly population. Senior staff told us majority of their patients would have been admitted following falls and had a falls care plan within their notes.
- Equipment was often required to be delivered to patients' homes prior to discharge. Staff ordered equipment in advance to avoid delays.
- There was limited space in the rehabilitation unit. The gymnasium (gym) was split into two with a screen to enable staff use one side as an office. Staff said the limited space in the gym had an impact on the ability to run exercise classes. It also had an impact on the number of patients the gym could accommodate during therapy sessions.
- The rehabilitation unit shared a building with a nursing home. The food was provided by the nursing home and the catering arrangements were clearly stipulated within the service level agreement with the home. Patients said the food was lovely and they had a choice of drinks with dinner. They said the food was nicely presented. Staff assisted patients with their meals and provided food in line with patient's preferences.

Equality and diversity

- Staff had access to interpreting services for patients and families who had difficulty understanding English. This included direct access to interpreters and telephone translation services.
- The services were planned to take account of the different needs of people, in particular the elderly.
- Staff had completed dementia training. Patients living with dementia were flagged with 'forget me not' magnets above their bed. There were also flagging systems in place within patients' notes.
- Senior staff told us they took cognisance of religious preferences and also accommodated preferences for male and female carers. Patients had different options for food including vegetarian and halal options. Staff said patients could bring in their own food if they preferred.

Meeting the needs of people in vulnerable circumstances

Good

Community health inpatient services

- The provider had set up a vulnerability panel chaired by the director of nursing to discuss patients with complex needs and action plans to address their needs.
- A community psychiatric nurse (CPN) was available on site and provided support for patients suffering from mental illness. The CPN was easily accessible by staff and staff that we spoke to felt able to contact the CPN when necessary and stated that they responded quickly to their queries.
- The service referred people to relevant organisations that provided support for carers within the borough for carer assessments and support. Patients and their carers were provided with information leaflets relevant to their care.

Access to the right care at the right time

- The service's balance scorecard showed that the service achieved its target of transferring 100% of patients to the rehabilitation unit within two days of acceptance in April 2016. However, it fell slightly below the target in the five months preceding the inspection in May (97.6%), June (97.6%), July (95%), August (97.5%) and September (99.1%).
- The maximum length of stay on the unit was 42 days. In the six months preceding the inspection, the percentage of patients discharged from the service within 42 days was between 89% and 93% against the target of 95%. However, the average length of stay during this period was 25.4 days against a target of 27 days.
- The average bed occupancy rate in the last six months was 95%.
- There were 19 delayed discharges in the three months preceding the inspection. Senior staff said this was sometimes due to delays in placements being matched by the care placement team at the local authority. Staff also said patients had to be medically fit for discharge and they would delay discharges if patients were unwell.
- Therapists were not rostered to work on weekends and therapy sessions were held during the week. Following the inspection, the provider informed us that all staff were trained to provide a range of therapy intervention programmes.
- Although not based within the unit, a speech and language therapist, podiatrist, dentist and dietician were available to patients following a referral from nursing staff.
- The service held a systems status call at 8.30am every day to facilitate smooth patient flow across the service. Staff reviewed daily activities, staffing, as well as discharges from the local acute hospital. The provider had an integrated discharge team (IDT) based within a local trust. The IDT team attended bed meetings at the local trust and provided feedback about the services' capacity to accept patients discharged from the trust.

Learning from complaints and concerns

- There had been three formal complaints in the last 12 months. One was in relation to care and treatment and two were in relation to staff attitude and behaviour. All the complaints were upheld and resolved locally. Minutes of staff meetings show that learning from complaints were disseminated to staff.
- Leaflets provided to patients included details about how to make a complaint. This included contact details for people to contact the service.
- We noted that the provider responded promptly to complaints logged on an online patient feedback website. This allowed service users to share their experience of using Bromley Healthcare service.
- The service had a dedicated patient experience lead. This was a relatively new role with the remit to get feedback on patient's care and experience.
- The service had implemented some changes based on with patient feedback. For example, the service produced patient information booklets about the unit in response to feedback indicating patients wanted more information about the unit.

Are community health inpatient services well-led?

Good

Summary

We rated well-led as good because:

- We saw good local leadership within the service and staff reflected this in their conversations with us. Staff were supported in their role and had opportunities for training and development.
- Bi-monthly governance meetings were held with all service leads in attendance. We could identify actions put in place to address issues discussed at the meetings. The management team had oversight of the risks within the services and mitigating plans were in place.
- There was a positive culture in the service and members of staff said they could raise concerns with the leadership team.
- There was evidence of staff engagement and changes being made as a result. Patients were engaged through surveys, feedback forms and online forums.

Detailed findings

Leadership of this service

- There were clear lines of responsibility in the service. The matron reported to the operations manager for hospital and unscheduled care, who reported to the provider's director of operations.
- All the staff we spoke with confirmed the leadership were visible and approachable. Staff spoke highly of the matron and the improvements made in the service this year. The local management confirmed that they were supported by the executive team and received prompt responses to their requests. For example, the matron had received additional therapy assistants following requests.
- There was evidence of good communication routes between senior managers and staff members. Meetings were well attended and information relating to service delivery was cascaded to all staff via email and on the intranet.

Service vision and strategy

- The service's vision was driven by the wider vision of Bromley Healthcare. This was summarised into three tenets: "to continually improve our services, to treat others as we would like to be treated ourselves and to hit our targets".
- On a local level, senior staff informed us they would like to be the best rehabilitation unit in the country. They also want to provide safe care, enable patients reach their goals and involve families in their journey. They want to have a team centred approach to what they do. Staff we spoke with could identify with the vision to rehabilitate patients and enable them reach their goals.

Governance, risk management and quality measurement

- Bi-monthly governance meetings were held with all service leads in attendance. Feedback from patients, the risk register, concerns and quality improvement issues were discussed and actions taken as a result. Evidence of this was seen in minutes of the meetings in July and September 2016.
- The service maintained a risk register including concerns and assessments of potential risks within the service. Mitigating plans were put in place and risk assessments were conducted where necessary. Senior staff routinely discussed risks at clinical governance meetings and service leads fed back discussions to the team during staff meetings.
- The risk register indicated that a number or staff needed to complete formal training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). To mitigate this risk, the safeguarding lead provided bite size sessions on MCA/DoLS, there were multidisciplinary team discussions of all new patients and any patient with functional or cognitive deterioration, and staff could refer any concerns to care managers and community psychiatric nurse that worked within the team. The risk register also indicated that training for staff was in progress.
- The provider's quality governance structure included a range of committees including workforce development group, clinical effectiveness, patient experience, safer care, safeguarding and medicines management. Every service was represented at committee meetings by the service leads.
- Staff attended monthly team meetings where they discussed incidents, mental capacity and deprivation of liberty safeguarding, recruitment, sickness and infection control.

- Our review of the rehabilitation service group meeting held on 28 July 2016 showed that service leads had met with a local trust to discuss discharge issues. These included problems around to take home (TTO) medication, inaccurate medication charts and patients being discharged with old and new medication making it difficult for staff to understand what medication the patient should be taking. The necessary arrangements and items for discharge were agreed at the meeting.

Culture within this service

- Staff told us there was a culture of openness and honesty within the service. Most staff indicated they were happy to work for the organisation and proud of the improvements made in the patients' journey. Staff said the rehabilitation unit was a nice place to work, and staff were friendly and professional.
- Staff told us they were happy with the care they provided and we saw that they received regular thank you cards from patients.
- One member of staff expressed concern about the limited space in the unit and said there was no staff room or changing room. The staff said they sometimes had their break interrupted by patients because they had to use the open dining area and still found themselves attending to patients during their break.
- The service encouraged personal development and training. Senior staff told us two staff members were taking foundation degrees in health and social care.

Public and staff engagement

- The provider monitored patient satisfaction from patient surveys and an online feedback website that allows service users to share their experience of using Bromley Healthcare services. We observed that the leadership team responded to online postings on an individual basis.
- The provider had three staff governors who acted as the link between the executive team and staff. The staff governors gave a presentation at every corporate induction session and informed new intakes about how to contact them.
- Staff received weekly updates from the Chief Executive Officer (CEO). There was also a CEO Blog where staff could comment anonymously about issues they wanted the leadership to address. We noted that the leadership team responded to each comment.
- There was an annual quality conference for clinical staff to showcase aspects of care. This involved training and development, discussions about incidents, patient experience, therapy outcome measures, and involving service users.
- Staff at Lauriston House arranged a cake competition and raised money for charity. The service also arranged a Halloween afternoon and patients said staff went out of their way to make it fun.
- There was a Bromley healthcare "Together with staff" magazine which provided monthly updates about the service. The September 2016 issue included sections on learning and development, stars of the month, staff changes and special mentions and charitable activities.
- The provider organised listening events in the previous year called "Fix it Fifty" to identify and address staff concerns across the services. Following the listening event, the provider published 50 issues raised by staff and what they had done to address the issues. For example staff raised concerns about the electronic recording system and IT support. The provider rolled out additional training to support staff.
- The provider organised an annual staff ball at which a number of staff awards were presented in recognition of staff contributions.

Innovation, improvement and sustainability

- The provider was developing a live dashboard for the unit and senior staff informed us it would be implemented within a week of the inspection. This would enable daily monitoring of the service and capture information about the number of patients on the caseload, the bed occupancy rate, average length of stay and quality and safety.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Continue to monitor patient clinical observations to ensure they are accurately recorded, and action is taken, where appropriate, in line with national guidelines.
- Review staff resources to improve access to therapy for patients on weekends.
- Review suitability of the environment to ensure it can meet patient's rehabilitation needs.