Locala Community Partnerships C.I.C.

1-256729774

Community health inpatient services

Quality Report

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Date of inspection visit: 11-14 October 2016, 27 and 28 October 2016 and 4 November 2016
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-285685937	Holme Valley Memorial Hospital	Community inpatient services	HD9 3TS

This report describes our judgement of the quality of care provided within this core service by Locala Community Partnerships C.I.C. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Locala Community Partnerships C.I.C. and these are brought together to inform our overall judgement of Locala Community Partnerships C.I.C.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall, we rated this service as inadequate because:

- The timing and pace of change within the organisation and intermediate care unit had a negative impact on the quality of care provided.
- Patient's risks were not consistently assessed and monitored to ensure that they were safe and received appropriate intervention and support. This included the risk of falls, venous thromboembolism (VTE), diabetes and epileptic seizures. We could not be assured that these patients were consistently receiving safe care.
- A computerised patient care record system had been introduced before staff had completed training on the system, which had resulted in staff not having access to the information that they needed to assess and monitor patient care. There were gaps in records and inconsistencies in the care documentation. The ward staff were experiencing difficulties in sustaining a safe and effective service that met people's needs.
- Staff did not follow the correct procedure when carrying out an investigation into a fall. They graded the fall as unavoidable. A further investigation was undertaken several months after the incident and the correct process was followed. The fall was graded as avoidable. This meant that the service had missed opportunities to address patient safety concerns in the period between the first and second investigation.
- Systems were in place to report safeguarding incidents. However, staff had not identified or taken action about a patient who may have been at risk of self-neglect.
- There had been several staff and local management changes, which had meant that staff had not had formal supervision or appraisal.

However:

- There were infection prevention and control systems in place to help reduce the spread of infection.
- Staffing levels had recently been reviewed and had been determined using National Institute for Health and Care Excellence (NICE) guidance.
- Multidisciplinary assessments were also carried out prior to the patient going home. This ensured patients' needs were met and they were not delayed.
- The service had started to use a monitoring tool for pain and four patients we asked told us they received pain free care.
- The service scored higher than the national average in the ward PLACE audit for maintaining the privacy and dignity of patients.
- They positively made changes following feedback from people who used services.

Summary of findings

Background to the service

Maple Ward was based within Holme Valley Memorial Hospital, Holmfirth and was a 24-hour, 7-day week, Intermediate Care Unit for the elderly. This included rehabilitation following a medical or physical acute event (such as a fall with injury), recovery from planned surgery, or admission from a GP referral from the community.

Maple Ward was a nurse led unit. Occupational therapists and physiotherapists worked alongside nursing and support staff in a multidisciplinary way caring for patients who used the service.

A Consultant for Elderly Medicine at Calderdale and Huddersfield Foundation Trust visited the ward every two weeks. A GP provided medical cover and worked three hours a day, Monday to Friday inclusive. Outside of these hours the 111 service and out of hours GP service was contacted.

In July 2016 as part of the provider's review of the intermediate bed base, the service reviewed the staffing levels and skill mix of staff. In doing so, they identified they needed a higher nurse to patient ratio and aimed to work to one nurse to eight patients. To achieve this the provider reduced their medical rehabilitation bed from 20 to16.

The provider contracted intermediate care beds in three adult social care settings. Other providers were responsible for the care in these facilities therefore they were not included as part of this inspection.

During the inspection, we spoke with 16 staff and eight patients. We looked at 14 care records and documentation. We reviewed information about the provider and data provided by the service.

Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Director of Nursing (retired)

Team Leader: Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a safeguarding specialist, a governance specialist, professional lead nurse for children's integrated therapy and nursing service, district nurses, a community matron and an occupational therapist. Additionally, there was an expert by experience who had experience of community health services.

Why we carried out this inspection

We inspected the following community health services as part of our comprehensive community health services inspection programme:

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

How we carried out this inspection

Locala Community Partnerships CIC provides a range of primary care and community services. These are GP services, community health services (as listed below), sexual health services and primary dental care. We didn't inspect all of these services in October and November 2016. In October and November 2016 we inspected the following community health services provided by Locala Community Partnerships CIC:

Summary of findings

- Community adults services (including end of life care)
- Community inpatient services
- Community dental services
- Community services for children, young people and families

We have not rated Locala Community Partnerships CIC as a provider for each of the five key questions or given an overall rating because we did not inspect how well-led the organisation was in relation to all the services that it provides.

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 four community health core services that we inspected and asked other organisations to share what they knew. We carried out an announced visit from 11 to 14 October 2016. We carried out unannounced visits on 27 and 28 October 2016 and 4 November 2016. During the announced inspection we held focus groups with a range of staff who worked within services we inspected including nurses, therapists, doctors and support staff. We also interviewed senior staff in each of the core services we inspected and executives. We talked with people who use the services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who used the services.

What people who use the provider say

We spoke with eight patients who used the service and with the exception of one, all of them commented positively about experiences of their stay.

Comments included:

- "I am very glad I came in here for re-hab. It's nice and very comfortable."
- One person said they had good communication with doctors and nurses. The GP visits daily and they could see the diabetic nurse, who will visit if requested.
- Another person said their food was served by a volunteer, "A really pleasant man."
- "Staff are very nice and responds quite quickly when I ring my bell."
- One of the patients told us the evening meal was served too early.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that there are robust procedures in place to ensure that incidents, including serious incidents and never events are correctly identified and reported and are comprehensively investigated and reviewed at an appropriate level within the organisation.
- Ensure that learning from incidents and complaints is shared and embedded across the organisation.
- Ensure that the duty of candour process is effective and embedded in practice across the organisation.
- Ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff, taking into account patients' dependency levels.
- Ensure that all staff have completed mandatory training and role specific training.
- Ensure that infection prevention and control policies and procedures are reviewed and in date.
- Ensure that the infection prevention and control audit programme is followed and actions are identified and implemented in a timely manner when issues are identified through the audit programme.
- Ensure that staff are up-to-date with appraisals and staff attend clinical supervision as required.

Summary of findings

- Ensure that there are in operation effective governance, reporting and assurance mechanisms.
- Ensure that there are in operation effective risk management systems so that risks can be identified, assessed, escalated and managed.
- The provider must have systems in place, such as regular audits of the services provided, to monitor and improve the quality of the service.
- Ensure that staff have undertaken safeguarding training at the appropriate levels for their role.
- Ensure that timely clinical risk assessments are undertaken and recorded and care plans are developed and recorded that are reflective of the patients' needs for patients on Maple Ward.
- Ensure that clinical risks are promptly identified and appropriately monitored on Maple Ward, including the calculation of National Early Warning Scores, as clinically appropriate.
- Ensure that patients who self-medicate on Maple Ward have been appropriately risk assessed.
- Ensure that patients having venous thromboembolism prophylaxis on Maple Ward are appropriately assessed as per current best practice guidance.

Action the provider SHOULD take to improve

- The provider should ensure the patient information leaflets can be reached by visitors and patients on Maple Ward.

Locala Community Partnerships C.I.C.

Community health inpatient services

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as inadequate because:

- Patient's risks were not consistently assessed and monitored to ensure that they were safe and received appropriate intervention and support. This included the risk of falls, venous thromboembolism (VTE), diabetes and epileptic seizures. We could not be assured that these patients were consistently receiving safe care.
- Clinical risks were not promptly identified and appropriately monitored, including the calculation of National Early Warning Scores.
- The monitoring of patients who had diabetes and epileptic seizures was not always taking place. This meant that it was difficult for staff to be able to identify when a patient's condition was deteriorating and then take action where appropriate to keep them safe.
- Patients who self-medicated had not been appropriately assessed to ensure that they were safe to administer their own medication.
- The procedure relating to the investigation of incidents had not been correctly followed. This meant that an investigation concluded an incident relating to a fall was avoidable when it was not. This also meant that the service had missed opportunities to address patient safety concerns in the period between the first and second investigation. We were not assured that key lessons had been learned following the incident and the required changes implemented.
- Systems were in place to report safeguarding concerns and potential abuse. However, staff had not documented or reported a patient who may have been at risk of self-neglect. We were not assured that all safeguarding concerns were identified and acted upon.
- Record keeping was of a poor standard. Not all staff had received training prior to the implementation of the electronic care records. Because of this, there were inconsistencies in the documentation and gaps in record keeping.

However:

- The service had recently reviewed staffing levels and staffing levels complied with best practice guidance at the time of inspection.

- There were infection prevention and control systems in place to help reduce the spread of infection. The service scored 99% in the PLACE audit for infection control. The national average was 98%.

Safety performance

- Monthly safety performance information was collected by the organisation which they told us was monitored and benchmarked within the Safety Thermometer. They also used this for monitoring, measuring and analysing patient harm and the percentage of harm free care. It looked at the incidence of falls, pressure ulcers and catheter related urinary tract infections.
- The ward manager told us that in the next few months they planned to have the safety performance data visible in the ward for patients and people visiting to see.
- During the period April 2016 - August 2016 data provided by the organisation showed patients received between 88 – 96% harm free care. The average for this period was 92%. This was the same as the national average of harm free care for community services.
- New pressure ulcers accounted for an average of 2% of patient harm over the five-month period. Catheters and new urinary tract infections was less than 1%. This was better than the national average of 6% and 1% respectively.
- Falls accounted for 5% of the harms and this was higher than the national average of 1%.

Incident reporting, learning and improvement

- There had been no never events reported during the period March 2016 - August 2016. 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. During the same period March 2016 – August 2016, there were 55 incidents reported in the service. Of these, 37 caused no harm and 18 caused harm. Out of the 18, six were classified as moderate harm and 12 as low harm.
- Six incidents where moderate short-term harm was caused related to four unsupervised falls and two category two pressure sores.
- Prior to the inspection, we received a root cause analysis (RCA) relating to an unsupervised fall. An RCA is a method of problem solving that tries to identify the root cause of incident. When incidents do happen, it is important lessons be learnt, to prevent the same incident occurring again.
- The incident was investigated however, the initial investigation incorrectly concluded that the fall was unavoidable and therefore was not a serious incident. A second RCA was carried out several months later when the incident had been identified as a serious incident and the outcome was recorded as avoidable.
- We saw at the inspection that some lessons had been learned from the incident in relation to incident investigations, signing off investigations at the serious incident panel and reporting incidents. However, because the incident had not been identified as a serious incident at the time it occurred and had been recorded as unavoidable, there was a delay in identifying and addressing patient safety concerns in the period between the first and second investigation. In particular, we saw that falls assessments were still not being consistently carried out on the ward, despite this being a contributory factor in the serious incident.
- Staff were encouraged to report incidents using an electronic reporting system. The staff members we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents, including near misses.
- Staff told us that where appropriate, they had received feedback from incidents reported and this included the feedback from recent falls.
- Staff told us and we saw that the provider had an intranet system for keeping staff up to date and this included learning from incidents. When staff logged onto the system information of importance was seen on the home page. The ward manager told us that when information was cascaded to their staff they received a receipt once it had been read. This gave assurance that the information had been seen.
- We saw that incident information and learning was a standing item on the ward meeting agenda. This helped to ensure that information was communicated to staff.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency. It 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 and managers had knowledge of the duty of candour and spoke about the need to be open and honest with patients and their carers. However, they told us that the process was carried out by the customer engagement manager and not by staff on the ward.
- We saw that the duty of candour process had been updated in August 2016 and this was to increase clinical oversight of all potential incidents. It stated that the Quality Manager reviewed all potential duty of candour incidents to determine whether the duty applied. Those incidents identified would be passed to the customer engagement managers for action. Following the implementation of the new process, the provider told us that only one incident had been identified as requiring a duty of candour response.

Safeguarding

- There was a safeguarding lead for the service and staff knew how to contact them for advice.
- Staff we spoke with told us they had completed safeguarding training. Training records showed between 91 to 100% of staff had completed role specific safeguarding adults training. The service aimed for a compliance target of 100% and we saw correspondence about the organisation's zero tolerance on meeting training targets.
- At the announced inspection staff we spoke with were aware of how to identify potential abuse and report safeguarding concerns, including whistleblowing. However, at the unannounced inspection we found a vulnerable adult who may have been neglecting themselves prior to their admission. Staff had not identified this as a potential safeguarding concern and there was no information in the patient's records to show that they had discussed any concerns with the safeguarding lead. Therefore, we could not be assured that all safeguarding concerns were identified and reported.
- Although staff were able to provide examples of feedback from safeguarding concerns and learning, they related to different areas of the organisation. This was because several staff had recently transferred from working in other areas. For example, the community.
- Several policies, including those relating to safeguarding had recently being updated and were to be ratified at the September Scrutiny Management Group.

Medicines

- We inspected 16 medicines administration records and spoke with one patient. We found there were appropriate arrangements in place for storing, recording and managing controlled drugs.
- Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely with access restricted to authorised staff.
- We found accurate records were maintained and balance checks were performed regularly.
- Medicines were stored in a treatment room and access was restricted. There was a system in place to check expiry dates and this was appropriately managed.
- Room and fridge temperatures were monitored daily and were within recommended ranges.
- We checked medicines and equipment for emergency use and found that they were fit for use and a system of checks was in place to ensure this. Emergency oxygen was in date and stored securely.
- At the time of our visit the pharmacy service was provided by a local NHS trust. We were provided with a clinical services specification template, which detailed the service provision. However, this covered the period 1 April 2011 to 31 March 2012 and therefore was not in-date to show the current service provision.
- We saw the internal 'Briefing on Pharmaceutical provision to Maple Ward' written by the Head of Medicines Management and dated January 2016. It informed staff of the plan and the implications should Locala take over the pharmacy service provision later in the year.
- We saw daily medicines were ordered from the local hospital trust. Medicines supplies were also available outside of the normal daily delivery and this involved the use of a taxi. We heard from staff that previous practice was to obtain medicines at the daily delivery. Through incident reporting on the occasions when patients waited up to 24 hours without newly prescribed medicines, the system was changed.
- The medicines management team had performed a two yearly audit of medicines management on 30

Inadequate

Are services safe?

September 2016. Compliance with policies used by the ward was reviewed. Identified non-compliance had been discussed with the ward managers and action plans developed.

- We found patients were given their medicines in a timely way and as prescribed and this included pain relief.
- The intermediate care matron showed us the self-medication storage, which had been purchased in readiness for patients to self-medicate. Medicines and maximising independence within intermediate care had been discussed with the matron at the specialist clinical nurse meeting in July 2016. They told us of their plan to introduce self-medication in the near future.
- There was a policy for self-medication and the provider sent this to CQC prior to inspection. At our inspection, staff told us that patients did not self-medicate. However, we found three medicines charts containing four items, where codes had been used to show the patients had self-medicated. No formal assessments of people's ability to look after their own medicines had taken place. Therefore, there was no evidence to show patients were safe to administer their own medication.
- A monthly medicines newsletter was introduced in March from the medicines management team. We saw issue three informed staff about the medicines management electronic learning module. For example, the 'Administration of Medicines' and 'Safe Handling of Medicines.' The newsletter also gave safety updates and learning from incidents for staff.

Environment and equipment

- Access to the ward was via an intercom system. There was a surveillance camera, which enabled staff to monitor people visiting and leaving these areas. It helped keep the patients and staff protected from intruders.
- The Patient Led Assessment of the Care Environment (PLACE) showed the service scored 99% for the condition, appearance and maintenance of the environment. This was higher than the national average of 93%.
- Staff told us that equipment was readily available and when further equipment was needed, it was made available in a timely manner. For example, a bariatric commode was delivered in 4 hours.
- To meet patients' needs the hospital loaned, replaced items or purchased new equipment when it was required and this was done in a timely manner.
- Safety testing of electrical equipment was taking place and there were dated stickers on the equipment to show that it has been tested.
- The service had a planned maintenance system for their equipment. The medical physics department at a local hospital trust annually maintained medical equipment.
- Appropriate resuscitation and emergency equipment checks were taking place.

Quality of records

- Records were stored securely in line with data protection procedures; preventing the risk of unauthorised access to patient information.
- We inspected 14 patient records and found that record keeping was of a poor standard. Care plans and risk assessments were not always in place.
- At the announced inspection, staff were using both paper and electronic systems for record keeping. This was confusing as information was held in both areas and there was not consistency in where information was documented in either the electronic or paper records. Staff relied on memory when discussing patient care and were not clear about where on the electronic system risk assessments and care plans should be recorded. We raised this with senior managers at the time of inspection. Staff told us that a decision had been made to transfer all records into the electronic system. Training had been arranged for all staff to attend prior to the implementation of the electronic system. However, we heard from the staff and manager how the computerised system had not been working properly for a couple of weeks. The majority of staff spoken with told us they had not had the training.
- Following the inspection, we were provided with updates of the provider's monitoring and their auditing of the patient care documentation. The audits were carried out to ensure that each patient had the correct and complete documentation in place to meet their needs. Where this was not so, the information showed the documentation had been added.

Inadequate

Are services safe?

Cleanliness, infection control and hygiene

- Patients admitted to the ward through the service Single Point of Contact (SPOC) had an infection control risk assessment completed prior to admission. This helped to ensure that where needed, patients were isolated to reduce the risk of the spread of infection.
- The areas we visited were visibly clean and equipment had stickers on them, which showed they had been cleaned.
- There had been no cases of hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia infections, Methicillin-Sensitive Staphylococcus Aureus (MSSA) bacteraemia or Clostridium Difficile (C.Diff) infections at the hospital for the period April 2015 to March 2016.
- Disposable bed/cubicle space curtains were changed six monthly and we saw evidence of dates when this had taken place.
- The service had an infection control nurse and an identified ward infection control link nurse. An example of an infection, prevention and control audit was seen for the ward; dated August 2016. The information included a completed action plan with dates and a person responsible to make sure that the actions identified took place.
- The service scored 99% in the 2016 PLACE assessment for infection control in the care environment. This was slightly higher than the national average of 98%.
- We saw that staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons.
- Hand washing facilities and antibacterial gel dispensers were available at the entrance of the ward and in the ward corridors. We saw that hand hygiene audits had been identified on the wards Rapid Improvement Plan (RIP) to be completed by the 5 October 2016. At the time of the inspection the RIP showed the status of the audit was 'open' which showed that the audit had not been completed.

Mandatory training

- Mandatory training was delivered either face-to-face or by e-learning. It included topics such as, safeguarding for adults, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS), basic life support and defibrillator training, infection prevention and control, manual handling, fire safety, information governance, risk awareness, PREVENT (The Government's counter-terrorism strategy), equality and diversity and dementia awareness.
- The ward-training matrix showed that their compliance for mandatory training on the 31 August 2016 was 73.2%.
- Staff told they were allocated time for e-learning. However, the manager and staff told us that the computerised system had not been working for several weeks and therefore staff had difficulty in completing training.
- The manager and individual staff were aware of the training completed and those they needed to complete. All staff had access to mandatory training.

Assessing and responding to patient risk

- From 1 June 2010, the Department of Health required that venous thromboembolism (VTE) risk assessments were carried out on every patient and that results were closely monitored in order to reduce preventable deaths. The National Institute for Clinical Excellence (NICE, 2010) recommended that all patients should be assessed for risk of developing thrombosis on a regular basis. This included, on admission to hospital, 24 hours after admission, if their medical condition changed and before discharge.
- The VTE risk assessment screening was not routinely carried out on Maple Ward. The assessment was recorded on the medication sheet and was only seen in four of the 16 medication records that we inspected. The information reviewed also showed that 11 patients had VTE prophylaxis prescribed but no indication as to why or for how long it had been in use as it was not recorded on the chart.
- The National Early Warning System (NEWS) is a clinical assessment tool used to identify deteriorating patients. In using the tool a patients observations such as blood pressure, respirations and conscious level would be assessed and recorded.
- We found that the NEWS tool was not routinely used and when used not calculated when patients had observations recorded. For example, on the 28 October 2016, we inspected the care records of a patient who had a history of epileptic seizures and diabetes. We saw that the NEWS chart was last completed on 13 October 2016. It had not been used to monitor the patient's condition and, where appropriate, action taken.

- We found the care records also identified this person needed a seizure chart to monitor their epileptic seizures for patterns, duration and frequency. There was no evidence in the records we reviewed that this had been put in place. There was also no evidence that a care plan had been developed to support staff when caring for this patient.
- One patient was an insulin dependent diabetic. We reviewed the patient's records on 4 November 2016 and found their blood glucose levels were not consistently recorded and a diabetic care plan had not been instigated until the 29 October 2016.
- On the 28 October 2016, we inspected the care records of a patient with a temperature of 38.1°C and tachycardia (high heart rate) on admission. We found there was no documentation of what actions staff had taken as a result of the observations. We also found there had been no documented further check of the patient's observations that day and the next set of observations recorded for the patient was the next day.
- On the 27 October 2016, we identified nine patients on the ward who had a history of falls prior to their admission. We reviewed the care records of these patients and found that six of the nine patients had not had a falls risk assessment completed.
- At the unannounced inspections on 28 October and 4 November 2016, we requested that the provider review the patient care and documentation for all patients on the ward as a matter of urgency. They were requested to provide evidence that appropriate risk assessments and care plans were in place. This was subsequently provided.
- There had been 90 falls during the period of April 2015 to March 2016. Falls, assessments, care pathways and observations were discussed at the September 2016 ward staff meeting and we saw records of this in the minutes of the meeting. They were also identified on the Locala risk register and part of the ward Rapid Improvement Plan (RIP). Staff were asked for volunteers to lead a community project to help raise awareness in the risk of falls, their prevention and subsequently reduce falls related admissions.
- On the ward notice boards, we saw information for patients about the use of correct footwear to help reduce the risk of falls. A falls detector was ordered for a bed and chair and staff were heard reminding patients about using the nurse call bell when they needed.

Staffing levels and caseload

- In response to a serious incident that had occurred on the ward, the provider reviewed the intermediate care bed base. This included a review of the staffing levels and skill mix of staff between the 9 August and 6 September 2016.
- The service used the 'Safer Nursing Care Tool' in line with the National Institute for NICE guidance (SG1). Through the guidance, the unit identified they needed a staffing ratio of one registered nurse to eight patients.
- To achieve this they reduced their medical rehabilitation beds from 20 to 16 beds. We saw information to suggest this had been in place since July 2016.
- In the interim period of recruiting more staff to cover the increase in establishment, agency registered nurses worked on regular contracted hours.
- We spoke with one of the agency staff on the day of inspection. The staff confirmed they worked regular shifts on the ward. This would have helped to provide continuity of care from staff who knew the patients and the ward routine.
- We inspected the day and night staffing levels for the week commencing 19 September to 11 October 2016. There were two registered nurses and three health care assistants during the daytime shift and two nurses and one health care assistant on the night shift. This equated to one nurse to every eight patients day and night and therefore complied with the current staffing guidance. The registered nurse, night staffing levels had increased from one to two nurses and one health care assistant. This had been in place from the 11 July 2016.
- We saw there was one shift on the night duty when a nurse phoned in sick and a district nurse from the service had covered.
- Staff told us there had been previous occasions when the weekend duty cover was a concern and there were insufficient registered nurses to provide the required two night staff. As a result, a system was established and checks carried out prior to the weekend to make sure staff were available for their shift and if not alternative cover arranged. Staff told us that this had helped reduce the anxiety of not knowing if staff would attend for duty.
- The day and night planned and actual staffing levels during the inspection were the same. The information was on display on the ward for the staff, patients and visitors to see.

Inadequate

Are services safe?

- Staff were able to tell us the action they would take if staff phoned in sick and shifts were not covered. Following the inspection, we were sent a copy of the ward escalation-staffing plan. The information provided a contact telephone number for the on-call manager.
- The manager told us there was one 30 hours, nurse vacancy and they were short listing for the post. There was also one health care assistant on long-term sick leave.
- Therapists worked across the units, which in doing so, encouraged a seamless service. The therapists included: 6 WTE qualified occupational therapists and 7.5 WTE qualified physiotherapist (various grades).
- At the time of the visit, we heard how a locum occupational therapist had been in post since April 2016 covering long-term sickness. One member of care staff also told us that when a physiotherapist was on leave it could have an impact on patient care and a potential delay in their discharge. We heard from the physiotherapy staff and the manager how the physiotherapist worked flexibly across the units and would visit as needed on an ad hoc basis.

Medical Staffing

- There was a policy for General Practitioner and Medical Cover Visits.
- A Consultant for Elderly Medicine for Calderdale and Huddersfield Foundation Trust visited the ward every two weeks. Together with a resident GP, they reviewed patients that required a Consultant assessment.
- The GP worked three hours a day, Monday to Friday, inclusive. Outside of these hours the 111 service GP would be contacted for medical assistance.
- The resident GP told us their role was to 'book in' patients and this included the completion of medicines charts. Where patients needed medicines at short notice a taxi was used to collect the drugs from the local NHS hospital. The GP was able to access the systematic relief policy on the computerized system (Systmone).

Managing anticipated risks

- Potential risks were taken into account when planning services, for example seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing.

Major incident awareness and training

- Staff we spoke with were aware of business continuity plans and could give examples of when this might be instigated. There had been an incident earlier in the year when there was a disruption in the telephone power. Action was taken and the situation was addressed.
- A resilience plan was in place for all services and the Trust Board agreed the corporate framework in October 2015.

Requires improvement

Are services effective?

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

Summary

We rated effective as requires improvement because:

- The National Institute for Health and Care Excellence (NICE) and clinical guidelines were accessible to all staff on the provider's intranet. However, we saw for one patient the Malnutrition Universal Screening Tool (MUST) indicated there was a concern. Consistent monitoring of the patient's nutritional state had not taken place and a care plan had not been developed to support staff in caring for the patient. This showed that best practice guidance had not been followed and the patient could have been at risk.
- National patient outcome audits had not been completed for the service and there was limited monitoring of patient outcomes on Maple Ward.
- Intentional rounding was not consistently taking place to ensure patient's needs were met.
- The staff appraisals had not taken place. Therefore, there was no evidence that their performance had been reviewed.

However:

- Good multi-disciplinary working was taking place.
- We saw where appropriate a do not attempt cardiopulmonary resuscitation had been completed and the information was known to the ward staff.
- Patients said they received appropriate pain relief when needed.
- The service received a higher score than the national average for the quality of food in the patient led assessment of the care environment.
- The physiotherapist team leader set goals with patients and were starting to use the therapy outcome measures assessment tool.

Evidence based care and treatment

- We saw that policies were developed in consultation with multidisciplinary teams and key stakeholders. These included, GPs, Operation Managers (Integrated Adults, Adults Planned and Health and Wellbeing) and the Head of Operations.
- NICE and clinical guidelines were accessible to all staff on the provider's intranet. With the exception of one policy, policies and procedures inspected were in date.
- Although there were policies and procedures in place, staff were not always following them. For example, in the management of the deteriorating patient the use of the assessment guidance was not been consistently followed in meeting patient need.

Pain relief

- Through the review of 16 medication administration charts, we saw that pain relief had been given to patients at regular intervals.
- On the first day of our inspection, we saw staff carried out regular two hourly checks (intentional rounding) on patients. This included, making sure they were safe and pain free. However, at the unannounced inspection we found intentional rounding was not always taking place.
- Four patients we spoke with told us they were comfortable and pain free. Another patient told us that they could request painkillers when necessary.
- Following the inspection, the provider sent information to say they had reviewed their pain score sheet and replaced it with the Abbey Pain Score. They had also linked the care plan to the pain score sheet.

Nutrition and hydration

- The patient led assessment of the care environment (PLACE) showed that the service scored 92% for the choice of food. This was higher than the national average of 88%.
- We asked six patients about the quality and variety of food they received during their stay. Without exception, patients told us the food was good and there was plenty of choice. The only negative comment from two patients was the timing of the evening meal was too early.
- Staff and volunteers offered regular beverages to patients and their visitors. Jugs and glasses of water were also available and accessible to patients in the communal areas and patient's rooms.
- Patients had fluid balance charts in place as required to monitor their fluid intake and output.

Requires improvement

Are services effective?

- At the announced inspection, the nationally recognised universal Malnutrition Universal Screening Tool (MUST) was seen to have been competed where appropriate in four of the care records we inspected.
- At the unannounced inspection, we found for one patient had a MUST score of 2 and their BMI was 17, which indicated there was a concern about potential malnutrition. There was no information in the patient's care records to indicate that staff had highlighted nutrition as a particular concern for the patient. There was no consistent monitoring of the patient's diet nor had a care plan been developed to support staff in caring for this patient.
- At one of the multidisciplinary ward meetings, we heard staff speak about patient's nutrition and a referral to the Speech and Language Therapy (SALT) team. This was for patient having swallowing difficulty.

Patient outcomes

- The Locala Single Point of Access (SPOC) triaged patients prior to admission. The ward staff carried out their own assessment to ensure the patient met their admission criteria. We were told by staff and saw information on the ward corridor for patients to see, that complex medical patient admissions may transfer to one of the rehabilitation units when medically stable. This helped to ensure patients received the right care in the right setting and helped to ensure there were sufficient rehabilitation beds on Maple Ward to meet patient's needs. At the time of the inspection, none of the patient records we inspected had information to suggest they had been re-assessed with a view to them transferring to another unit.
- The therapists worked on the ward and rehabilitation units. This encouraged a seamless service and continuity of treatment for patients who received care at both units.
- The physiotherapist team leader set goals with patients and were starting to use the therapy outcome measures assessment tool.
- Prior to inspection, we requested that the provider send CQC completed audits of patient outcomes**.** The information we received from this service showed that national outcome audits had not been completed during the CQC monitoring period. We were provided with data relating to Key Performance Indicators. However, although the information stated it related to the 'Bedded Areas' it showed areas such as the Rapid Response Supported transfer.
- In April 2015, a delayed discharge audit was carried out on 30 patients who used the service. The outcome of the audit showed 11 of the patients admitted from hospital achieved their estimated date of discharge (EDD) whilst 13 patients did not. Out of six patients admitted to the service from home, all six achieved their discharge date. The information showed the delays were due to patients having on -going therapy.
- From the 1 December 2015 – 31 May 2016 there had been 40 delayed discharges. The data stated these were due to social care delays and this included patients waiting for care home placements. There were 13 re-admissions to the ward for the same reporting period. Information was not provided relating to any trends and the manager was not aware of why the re-admissions had taken place.
- The ward rapid improvement plan showed a record keeping audit was developed on the 20 September 2016 and monthly audits were to take place. These were to be discussed at the governance meeting and an improvement plan developed on the audit results. The outcome of the records audits have been referred to in the record keeping and governance section of this report.

Competent staff

- The intermediate care matron attended monthly Specialist Nursing Operational Meetings. Information showed that staff training, nurse revalidation, staff competencies and future appraisal were discussed together with support for staff in meeting compliance.
- Staff told us they were supported in keeping up to date with professional development and there were opportunities in the organisation for staff to access a range of courses and events.
- Appraisal data showed that the ward manager had received an annual appraisal but that the remaining 34 staff had not had an appraisal. The manager who had recently come into post to cover maternity leave had arranged dates for staff to have an appraisal.
- Following our inspection, we were sent a copy of the improvement plan for Maple Ward that was developed in response to the concerns that we raised during the inspection. The plan identified that the ward team was

to have training and their competency in care records reviewed. The plan included a timescale and the lead person responsible for its completion. The information also stated that a training package had been developed and staff would have training from the beginning of November 2016. The information stated the training would include areas such as the deteriorating patient and falls. This would help ensure that staff had the competencies to meet patient needs.

- The organisation told us they were introducing the Calderdale Framework for shared competencies. This is a recognised and established process for exploring, understanding and delivering care through competence based roles.

Multi-disciplinary working and coordinated care pathways

- We saw staff worked well together and there was respect across disciplines. For example, between the care staff and therapists.
- We attended a ward multidisciplinary team (MDT) handover. Staff were given a computerised print out of information about the patients. The meeting included the manager, doctor, therapists and ward staff. Areas discussed included patients who were booked for admissions, current in- patients and their dependencies.
- The physiotherapist led the MDT meetings. We were informed that the social worker would usually have led the meeting however, they were on leave. The meeting was patient focused and concerned with all elements of a patient's well-being. For example, risk management, equipment, diet, speech therapy and safety strategies were discussed for when the patient returned home.
- The one record we reviewed relating to the discharge planning had detailed information, which included therapy assessments, care/discharge planning, and MDT review.

Referral, transfer, discharge and transition

- Most referrals to the ward were via the single point of contact. These usually came from the hospital or community GPs. The call handlers triaged the patient information using an algorithm and the information was sent via systmOne (electronic record system). The ward staff ensured they could meet the person's needs and the intermediate admission criteria. The patient would then be admitted to the ward. If this was out of hours, the on call GP 111 service would be called to admit the patient and prescribe any medicines.
- The hospitals had an effective process for medicines to promote a timely discharge for patients. A taxi would be used to obtain medicines from the local trust where necessary.
- SystmOne was used for the timely reporting of discharge information to GPs and district nurses.

Arrangements were in place for patient transfers to the local hospital trust where ward staff were unable to manage the patient's acute medical condition.

Access to information

- The provider had a policy relating to the access of information and this included consent from patients prior to sharing information with external organisations. Staff were aware of the policies and how to access them on the provider intranet.
- The care records were a mixture of paper records and electronic records. Staff were in the process of transferring the records on to the electronic system. However, due to computer issues the training of staff was delayed. This meant staff did not know how to use the computerised care documentation. Risk assessments were not completed and staff were not aware of patient's needs. This meant patients were at risk of not having their needs identified and action taken to address those needs.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The updated consent policy was seen and had been passed to the quality management team for their comments prior to update and implementation.
- We saw on the ward rapid improvement plan that a consent tab had been added to the computerised daily observations and notes template used by all staff. On the second day of our inspection, we inspected one of the records and the consent part of the record had been completed. Staff told us they always asked patients for their consent. This included consent to go into people's homes and carry out pre-discharge assessments.
- Most staff we spoke with had worked in the organisation for some time and were able to articulate the requirements of the deprivation of liberty safeguards

Requires improvement

Are services effective?

(DoLS). The service had a flow chart for staff about the DoLS process and this was on the notice board in the ward. All staff we spoke with had attended safeguarding training and told us the DoLS training was part of this.

- Information provided showed an audit of Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) forms had not taken place since June 2015. The information was from across the service and not specific to Maple Ward. The audited showed 80% of forms were completed to a high standard. The areas which had not been completed included the patient's hospital number, telephone numbers (where patients did not have access to a phone), and their next of kin/relationship.
- We saw the GP compiled a DNACPR form when appropriate on admission and the information was available to ward staff.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Feedback from patients and those close to them was positive about the way staff treated people.
- We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection.
- The service scored higher than the national average in the ward PLACE audit for maintaining the privacy and dignity of patients.
- The ward had a volunteers befriending service. Patients told us they were well looked after and enjoyed the company of the volunteers.
- Patient support group information was available. For example, for Parkinson's disease.

Compassionate care

- Patients told us that they felt the staff respected them and their privacy and dignity was protected.
- We saw staff were considerate when discussing private issues by closing doors or through quiet, discreet conversation.
- Staff were seen to be sensitive and discreet when offering personal support.
- The service scored 93% in the 2016 ward patient led assessment of the care environment for maintaining the privancy and dignity of patients. This was higher than the national average of 84%.
- Patients told us when they experienced pain, or discomfort the staff had responded in a compassionate and timely way.

Understanding and involvement of patients and those close to them

- During the inspection, we witnessed positive patient and staff interactions. Patients reported feeling safe.
- Patients told us that they had plenty of opportunities to ask the nurses, doctor or therapists for updates and information relating to their care.

Emotional support

- Staff understood the importance of emotional support needed when delivering care. We saw staff interact in a supportive way with patients who were anxious and upset.
- Multi-disciplinary team staff discussed the impact that a person's anxiety had on their wellbeing and on those close to them and access to future emotional support was considered.
- Volunteers offered a befriending service for patient when in hospital and patients told us they were well looked after and enjoyed the company of the volunteers.
- Patient support group information was available. For example, for Parkinson's disease.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Patients were assessed prior to admission to ensure therapy and nursing staff in the community setting could meet their needs.
- A multidisciplinary staff team carried out a patient assessment prior to patient's going home. This ensured patient's needs would be met and they were not delayed.
- There was a telephone translation service for patients and families whose first language was not English.
- Disabled access to the buildings was good with accessible toilet facilities available and clear signage.
- Patients knew how to complain and complaints leaflets were displayed on the ward for patients and visitors to help themselves. Locala also had a website where patients and visitors could post their concerns and receive feedback.

Planning and delivering services which meet people's needs

- The needs of the local population were considered in how the community services were planned and delivered. Commissioners and relevant stakeholders were involved in planning services to provide continuity of care.
- All patients were assessed prior to admission to ensure therapy and nursing staff in the community setting could meet their needs and a multi-disciplinary team (MDT) commenced at the point of patient referral.
- An estimated discharge date was part of the admission assessment process and all the MDT worked towards achieving this date from admission.
- The estimated date of discharge was reviewed within 24 – 48 hours of admission and where required it was changed.
- A discharge checklist was utilised to ensure that all tasks were completed prior to the patient being discharged.
- A self-discharge checklist was used should a patient wish to leave against the advice of clinical staff.
- Procedures were in place to cover therapy staff duties when they were on leave. This ensured patient's discharge was not delayed.

Equality and diversity

- Equality and diversity issues were managed appropriately. The service had access to a telephone translation service for patients and families whose first language was not English.
- Disabled access to the buildings was good, with accessible toilet facilities available and clear signage.

Meeting the needs of people in vulnerable circumstances

- Dementia awareness training was mandatory and 27 out of 33 staff had received this training. The service was working towards creating a dementia friendly environment and this included the use of recognised mobility aids and coloured toilet seats.
- Multidisciplinary assessments were carried out to ensure that people's needs were met. These included a physiotherapist and an occupational therapist who arranged home adaptations prior to patient discharge.
- White boards were used to assist in communicating with patients who had a hearing impairment.
- During the inspection, we heard and saw nurse call bells being answered promptly.
- Patient information leaflets were available and these included support groups, such as for Parkinson's disease.

Access to the right care at the right time

- The average length of stay was 25 days. Further information was not available relating to referral, assessment and admission times.
- There were no mixed sex accommodation breaches. The layout of the premises and the reduction in beds provided flexibility of patient accommodation.

Learning from complaints and concerns

- Information on how to make a complaint was seen on the patient information boards located in the ward. Patients we spoke with knew how to complain; they told us they had no concerns. However, two people in wheelchairs told us that although they knew how to complain, the information and complaints leaflets were located too high for them to reach.

Good

Are services responsive to people's needs?

- We saw there was a complaints policy and procedure, with a review date of December 2018.
- Staff we spoke with were clear about the complaints process and action they should take if someone wished to complain.
- In a 12 months period, from 1 July 2015 to 12 July 2016 the provider received seven complaints relating to intermediate care. There were no trends identified.
- We saw an example where a complainant had received an explanation and apology when things had gone not according to plan.
- All complaints were reviewed at a complaints closure panel to provide assurance they had been fully investigated and lessons learned identified.
- Following the closure of a complaint a feedback form was sent to the complainant who invited them to feedback on the complaints process. However the provider reported no one had fedback on their experience.
- Leaning from complaints were shared with staff and this included via the weekly information email entitled 'Locala Live'.
- Locala also had a website where patients and visitors could post their concerns and receive feedback.

Inadequate

Are services well-led?

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

Summary

We rated well led as inadequate because:

- The governance, risk management and quality measurement mechanisms were not sufficiently robust to ensure that patients were not at risk of harm.
- Locala had identified some areas of concern on Maple Ward and an improvement plan was in place at the time of inspection. However, the scale of the issues we found at inspection had not been identified by the service and we found patient safety continued to be at risk. Patients' care was not consistently assessed and monitored to ensure they were safe and received appropriate intervention and support.
- Although managers were carrying out care plan audits and monitoring these had not been effective in identifying the scale and extent of the patient safety issues on the ward.
- Systems and processes for investigating incidents was not followed in relation to a serious incident and there was evidence of missed opportunities to address patient safety concerns as a result of this.
- The timing and pace of change on the ward had a negative impact on the quality of care provided. For example, staff had not had training prior to the implementation of a computerised care plan system.
- There were mixed views about the culture of the service. Some staff told us the culture was open and transparent. There were opportunities for professional development and managers supported them, whilst others told us they had no incentive for career development and the new management appointments would take time to embed.

However:

- The service made changes following feedback from people who used services. For example, arranging entertainment on the ward in response to patient feedback.
- An integrated approach to care across the rehabilitation bed bases was supported by the cross cover working of therapists and health care assistants.

Leadership of this service

- Staff we spoke with individually and in focus groups told us the chief executive was visible and approachable.
- There had been management changes in the organisation and this included the retirement of several key staff. Following the retirement of the matron, a new appointment was made in August 2016. The ward manager was also appointed in August 2016 to cover maternity leave. Staff told us the new management appointments would take time to embed.
- However, staff also told us that with the current changes and pace of change within the organisation the new processes including the computerised systems had been challenging and had a negative impact on the quality and care provided.
- Staff told us that before the management changes they were not always aware of what was going on in the organisation. They said they had recently attended three meetings in which they were updated with information about the ward and organisation.
- New ward staff told us the managers were responsive. They gave an example of how a manager had supported them to change their work location due to their health needs. Staff told us how they had transferred from working in the community to the ward and managers had provided them with additional support.
- Staff told us the ward manager supported them, was very positive and valued the staff.

Service vision and strategy

- The organisation had a vision and strategy. The vision, values and philosophy were displayed on the corridor of the ward for patients and visitors to see.
- The values of the organisation were to 'Be caring, inspirational and be part of it' and this had been shared with staff.
- The organisation had a five-year strategy, which commenced in 2013.

Inadequate

Are services well-led?

- We saw staff had voted on the Locala quality clinical priorities. One of these was to enhance the quality of clinical record keeping across all services and improve the percentage completed at the time of the patient intervention.
- The ward was introducing digital processes in line with the organisational strategy. This included the use of electronic care records.

Governance, risk management and quality measurement

- Governance arrangements for the organisation were in place and had been revised in August 2016. A structured approach to meetings from team level to Board was established in August and had a focus on quality, operations and people. We saw from the meeting minutes that they were taking place with key operational and management staff. However, it was too early for us to assess the effectiveness of the changes that had been made.
- We found that governance, management and ward meetings included standing agenda items such as, clinical issues, audit, safeguarding and incident reporting for discussion and actions.
- Risk registers for the organisation were known as KORS – key opportunities, risks and success. A new template for recording KORS was introduced recently. Each service had a KORS document. The ward manager who came into her post in August 2016 told us they had not seen the KORS for Maple Ward prior to our visit.
- On the 5 October 2016 Locala provided CQC with a copy of their service improvement plan for the ward. This was a working document and included information such as the improvements needed, actions and updates. They were dated and each one had an allocated manager responsible for the updates and reviews. The areas included care plans, risk management, clinical documentation, the computerised system and records audits.
- We saw from the information provided by Locala that the improvement plan was reviewed twice a week and in addition twice weekly management calls were taking place. A number of areas we found at inspection had been recorded on the improvement plan for action. For example, on the 10 and 14 October 2016 we saw that the plan included staff training for care plans and records. This had been added on the 20 September 2016 and the care plan computerised training was to take place on the 27 and 30 September 2016. At the time of inspection we heard how there was a delay in the training due to computer issues. This meant care plans and risk assessments were not consistently recorded.
- Despite these improvement actions, the service had not identified the scale of the issues we found at inspection. We found patient safety continued to be at risk. The processes in place were not robust and patient's safety was not consistently assessed and monitored to ensure they were safe and received appropriate intervention and support.
- We were not assured that all safeguarding concerns were identified and actioned, as during the inspection we found a patient might have been at risk of potential self-neglect. This had not been identified and reported by the service. This information had not been identified within the provider's monitoring systems. We requested they reviewed and carried out a care plan audit.
- The procedure relating to the incident investigation of a fall had not been correctly followed. This meant the investigation concluded the fall was avoidable when it was not. The provider re-investigated the incident following the correct procedure and found it to be avoidable. However, we were not assured that key lessons had been learned following the incident and the required changes implemented.

Culture within this service

- Staff reported the culture to be open and transparent. The June 2016 pulse staff survey results showed 77% of staff (out of 161 responses) felt secure in raising concerns about unsafe clinical or non-clinical practice.
- Some staff told us there were opportunities for professional development and managers supported these. For example, one member of staff told us how they were supported and sponsored to do their nurse training. They told us they felt valued by the service.
- Two staff told us they had no incentive for career development. They had completed additional training, however they told us there was no further career prospects in their current role. They were not as positive about the effect of changes, progression opportunities and how they were valued.
- Staff told us that qualified staff had previously felt anxious on night duty. If someone called in sick, at short

notice, there may have been difficulty arranging cover. However, they also said that the review of the staffing and subsequent reduction in bed numbers had taken some of the pressure off.

Public engagement

- We saw that there was an internet site for patients and visitors to provide and receive feedback about the service. The information included, 'You said, we did.' For example, patients had said there was not enough entertainment on the ward. The service responded by the appointment of an activities manager and they were in the process of developing the ward entertainment.
- Friends and family forms were used to encourage people to comment on their experience of using the service. Feedback included. "Your services at Holme Valley Memorial Hospital aren't widely publicised enough within the Hospital and I would like to learn more about them." Additional notice boards had been installed with information regarding the services and updated patient information leaflets.
- The ward had volunteer helpers and fundraising from the League of Friends. The fundraising donations this year had been used to buy equipment such as patient hoists, blinds for the conservatory, seating, fans, newspapers and benches.
- The provider had a Summer/Autumn 2016 volunteer's newsletter. The newsletter contained results from a survey where volunteers were asked what they thought about Locala. Ninety six percent of people said they felt valued and were treated with kindness, courtesy and respect by their team. Ninety four percent of people said they had sufficient training and ongoing support to carry out their role successfully.

Staff engagement

- Staff were informed about changes to the service and learning, through meetings, away days, emails and newsletters. For example, a weekly Locala Live email was sent to staff with updates. A monthly Team Talk newsletter updated staff **o**n the quality of care, finance, performance and the service workforce. However, some staff told us due to their work commitments they did not have time to read their emails.
- The June 2016 staff survey results showed 42% of the staff agreed that communication was effective across the organisation. The most positive themes showed staff liked the communication systems and technology was said to have helped. The lack of time and too much information were reported negatively in the survey.
- Locala celebrated success and colleagues personal achievements during 2016 with an annual awards night. This included long service awards and awards to staff who throughout the year had demonstrated they were living the Locala values. One of the managers at the inpatient service had achieved a living the Locala values award.

Innovation, improvement and sustainability

- The cross cover working of therapists and health care assistants supported an integrated approach to seamless care across the rehabilitation bed bases.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (a) Assessing the risks to the health and safety of service users of receiving the care or treatment** • Clinical risks on Maple Ward were not robustly assessed, monitored and recorded. **Regulation 12 (2) (b) Doing all that is reasonably practicable to mitigate any such risks** **How the regulation was not being met** • An incident was not identified as a serious for five months. • A serious incident had been incorrectly determined as unavoidable. • Learning from the serious incident on Maple Ward was not embedded in the service. • Care plans had not been developed for some patients on Maple Ward. Care plans were not person centred.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.** **How the regulation was not being met** • The processes for identifying and reviewing serious incident investigations were not robust. • Action plans were not always comprehensive and their implementation was not always robustly monitored.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) Persons employed by the provider in the provision of a regulated activity must - Regulation 18 (2) (a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform How the regulation was not being met • Mandatory training compliance rates were significantly below target in some of the services that we inspected. • Appraisal rates were low in the community adults and community inpatients services.
	Regulation 17 (2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity How the regulation was not being met • Risks were not appropriately escalated and managed within the organisation. • Audit programmes were not always followed and outcomes were not consistently reported through the governance structure.