WM QRS West Midlands Quality Review Service

NHS

Transfer from Acute Hospital Care and Intermediate Care

Dudley Health and Social Care Economy

Visit Date: 3rd & 4th March 2015 Report Date: July 2015

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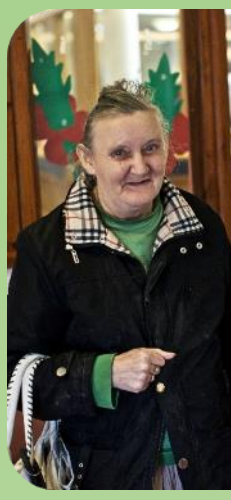

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INTRODUCTION

This report presents the findings of the review of services for the transfer of care from acute hospital care and intermediate care that took place on 3rd and 4th March 2015. The purpose of the visit was to review compliance with the following West Midlands Quality Review Service (WMQRS) Quality Standards:

- Transfer from Acute Hospital Care and Intermediate Care, V1 August 2014

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting team which reviewed the services in Dudley. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- The Dudley Group NHS Foundation Trust
- NHS Dudley Clinical Commissioning Group

Social care is fundamental to the pathway for transfer from acute hospital care and intermediate care and some aspects of this report cover providers and commissioners of social care in Dudley or jointly provided or commissioned services. Actions by commissioners and providers of social care maybe required in order to address the issues identified in this report.

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Dudley Clinical Commissioning Group.

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews – often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on www.wmqrs.nhs.uk

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and service users and carers of Dudley health and social care economy for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

Transfer from Acute Hospital Care and Intermediate Care

This review looked at the following aspects of the pathway of transfer from acute hospital care and intermediate care in the Dudley health and social care economy:

Pathway	Provider	Commissioner	Quality Standards	Notes
Primary care	-	-	Primary care	No GPs attended the meeting with reviewers to discuss the pathway. Compliance with Quality Standards is based on the information available from other sources.
Acute Trust: All wards	The Dudley Group NHS Foundation Trust	NHS Dudley CCG	Acute Trust: All wards	
Netherton Green – Saltwell House	BUPA, supported by The Dudley Group NHS Foundation Trust	NHS Dudley CCG	Intermediate care	Intermediate care providers did not appear to have been involved in the preparation of the self-assessment of compliance with Quality Standards, and documentary evidence of compliance with Quality Standards was not supplied to reviewers.
Tiled House	Dudley Metropolitan Borough Council	NHS Dudley CCG	Intermediate care	
Hollycroft Nursing Home	Leyton Healthcare	NHS Dudley CCG	Intermediate care	
Commissioning	NHS Dudley Clinical Commissioning Group	N/A	Commissioning	Evidence for some compliance with Quality Standards was not available at the time of the review but was provided following the review.

Other services available within Dudley included Emergency Department 'Diversion Beds' and other residential intermediate care provided by Dudley Metropolitan Borough Council (32 beds). These services were not identified as providing intermediate care when this review was planned, and so were not included in the scope of the review visit. Reviewers also did not meet the Dudley 'Living Independently Team' and so were not able to comment on this aspect of the pathway of care.

Some of the findings of this review were common across the health and social care economy and are summarised at the start of this report.

Health and Social Care Economy

General Comments and Achievements

Considerable work had taken place in Dudley to improve the pathway for transfer from acute hospital care and intermediate care. 'Discharge to assess' arrangements (Pathway 1) were in place seven days a week for people going home. Patients with non-complex needs were discharged within 24 hours, and those with more complex needs within 72 hours, of the 'Activities of Daily Living' report being completed.

A multi-disciplinary Discharge Team was available in Russells Hall Hospital seven days a week; this comprised a Registrar, a nurse, a social worker, a pharmacist and therapists. This team identified patients who were ready for discharge. Nurses from the Clinical Commissioning Group then came in each day to undertake assessments.

Good Practice

1 A survey of patients' experience of discharge had been undertaken by *HealthWatch.* This included filming people so that their description was captured effectively. A report had been produced and there were plans to use the material for staff training.

Concerns

1 **Strategy for the transfer from acute hospital care and intermediate care**

Dudley health and social care economy did not appear to have a clear strategy for transfer from acute hospital care and intermediate care. A draft strategy was in place at the time of the review but was not made available to the reviewers and, despite this being in place, staff who met the visiting team could not articulate the local 'vision' and how their service fitted into this. The Dudley Group NHS Foundation Trust had a strategy but this covered only services provided by the Trust.

The services supporting transfer from acute hospital care appeared disparate and disjointed. 'Integrated health and social care' was provided at community level in five locality hubs, with good links to general practice. Therapists provided input to these hubs but were not part of the core 'hub' team. Links between the 'hubs' and consultants in the care of older people were not yet in place. A Rapid Response Team and a 'Virtual Ward' were available. These services were provided by nurses, but there was no therapy input to the care of patients and no specific medical input to the work of the teams. The 'Virtual Ward' provided long-term care, and mechanisms for linking with intermediate care services were not clear.

Intermediate care provision was heavily 'bed-based' with, at the time of the review, at least 198 beds available for intermediate care. Due to the number of beds and the number and type of facilities, it was difficult to provide a consistent approach to clinical management that covered all intermediate care beds. The CCG was aware that there was no common standard for clinical review across all intermediate care beds. The response to capacity problems in Russells Hall Hospital appeared to be to put pressure on commissioners to increase the number of beds, to improve the acute flow. A strong culture of and commitment to providing intermediate care in people's homes was not apparent to reviewers. For example, a multi-agency patient information leaflet about 'Dudley Intermediate Care Services' described only bed-based services, and staff who talked to reviewers mostly assumed that 'intermediate care' meant bed-based rather than home-based care. Delays caused by the allocation of social workers also had an impact on the number of patients transferred to beds rather than home.

The criteria for admission to the different intermediate care facilities were not clearly defined or understood by staff in intermediate care services or staff in Russells Hall Hospital. Reviewers were told that this resulted in difficult discussions between hospital and intermediate care staff, especially when the hospital was under pressure. Reviewers also saw some examples of patients whose admission to an intermediate care facility appeared inappropriate: some patients could have gone to their own homes with some support, and other patients who had been referred with rehabilitation potential did not have this potential. Also, the needs of some patients whose transfer from acute hospital care was delayed had changed by the time they were admitted to intermediate care. Patients appeared to be admitted to intermediate care based on the decision of the CCG nurses who were managing the admissions process. Some audits were made available after the review but, at the time of the visit, reviewers did not see evidence of audits of the appropriateness of these decisions or mechanisms for feedback and learning about problems experienced by either Russells Hall Hospital or intermediate care providers. Criteria for admission to palliative care beds were in place and were being used.

Staff in intermediate care services who met reviewers were not clear about the service they were expected to provide. An Operational Policy for Intermediate Care and transfer policies for accessing all the 'step-down' intermediate care facilities were made available after the review visit. These documents contained clear specifications for both bed-based and home-based intermediate care. A referral pathway with criteria for GPs to access the intermediate care team was also made available. This pathway included assessment

criteria for admission to a bedded unit and for remaining at home with intermediate care support. Staff providing intermediate care who met the visiting team were not aware of the content of any of these documents. The lead at Netherton Green was trying to write a specification for the service provided.

A community intravenous antibiotic service was available, and this provided twice-daily home visits (if required) or a clinic-based service. This service had good information available for patients. This service did not support patients in intermediate care beds, and a systematic approach to the provision of community-based sub-acute care (including intravenous drugs, fluid administration and active management of exacerbations) was not evident.

2 **Social care assessments**

Long delays in allocation to a social worker were reported. These delays had been up to six weeks, although, at the time of the review, reviewers were told that they had reduced to two weeks. Reviewers saw some patients who had been waiting for two months for the allocation of a social worker. Reviewers were concerned that a patient's condition may have changed during this time and so assessments and plans discussed previously may no longer be appropriate. Care packages from an appropriate range of care agencies were available once clients had been seen by a social worker.

One full-time and three part-time social workers covered all of the nearly 200 intermediate care beds. This appeared insufficient and may be contributing to the lack of flow through these beds and delays in discharge from Russells Hall Hospital.

An 'Activities of Daily Living' (ADL) assessment was required before a social services assessment could be undertaken, even if a Section 2 form had been completed. This appeared to reviewers to be an unnecessary step in the process of transfer of care. A significant amount of therapists' time was taken up in completing ADL assessments. The information was readily accessible in the therapists' clinical notes, and social workers would have been aware of it if they had attended the ward multi-disciplinary discussions.

Reviewers were also told by some intermediate care services that a social worker assessment could not be undertaken until another ADL form had been completed (even if an ADL form had been submitted shortly before).

3 **Health and social care economy coordinating group**

At the time of the review, no health and social care economy-wide group focusing on transfer from acute hospital care and intermediate care was in place, and services appeared to be working in isolation from each other with no effective communication between them or shared learning from difficulties and problems. Three groups relating to urgent care were running, and the Urgent Care Operational Group discussed discharge planning and elements of the intermediate care pathway. The mechanism for the patient and carer 'voice' to be heard in decisions about the pathway for transfer from acute hospital care and intermediate care was not clear, and reviewers saw no evidence that patients and their carers had been involved in developing the intermediate care pathway or any of the patient flow strategies that were in development. Patients on the *HealthWatch* video said that they thought they had been discharged from hospital too soon, but it was not clear what action was being taken in response to this. Clinical staff reported to reviewers that they were not involved in the development of the local strategy or in decision-making about the pathway of transfer from acute hospital care and intermediate care.

4 **Guidelines**

Guidelines covering transfer of care between services in the health and social care economy were not yet in place. Expected guidelines on therapeutic interventions provided by intermediate care services were also not yet in place in any of the services reviewed.

Further Consideration

1 Reviewers were told by ward staff that transport to intermediate care services had a 'cut off' time, and that this was brought forward when it was dark. This resulted in patients who were going to a bedded facility being given priority for transport over those who were going home, which appeared inappropriate. Reviewers were also unclear why a light-related cut-off for transfers to bedded facilities was needed, and suggested that a time of night after which a transfer would not take place may be more appropriate.

2 With the exception of patients going to Netherton Green, patients did not appear to be receiving appropriate preparation for transfer to intermediate care; for example, they did not seem to be given information about the service to which they were being transferred. This particularly affected patients who were transferred to intermediate care beds in a nursing home without adequate explanation of the accommodation. Reviewers were told that some patients were distressed, as they thought they had been moved to a nursing home without their consent. Patients were assessed in hospital by CCG nurses, but these nurses did not prepare the patients for transfer. Several patients at Hollycroft reported that they had not known they were going to a nursing home and staff in intermediate care facilities said that they "liked to receive patients early so that they could calm them down before bedtime". Patients transferring to Netherton Green received good preparation, including good information about the home and plans for their care.

3 Arrangements for the transfer of information (transfer of care plan) to intermediate care services were variable. Netherton Green and Hollycroft received the patients' discharge letters and a photocopy of patients' notes for the acute episode of care, and found this information very useful. This information was not usually sent with patients transferring to Tiled House, and a new assessment was therefore started on admission. A standard format for a 'transfer of care plan' was provided as evidence to reviewers, but this was not available on the Trust intranet and did not appear to be in use at the time of the review.

4 Some staff who met the reviewing team were under the impression that the Dudley Falls Team was not commissioned to provide a service to residents in intermediate care beds. Reviewers considered that further work on educating staff about the work of this team may be helpful, as people receiving intermediate care are probably at a higher risk of falling because of the emphasis on encouraging independent mobilisation.

The review team suggested that development of a communication and educational strategy based on the Dudley 'Strategy for Intermediate Care and Transfer from Acute Care', including communication to 'front-line' staff, may be helpful with the aim of gaining commitment to the Strategy's principles for discharge planning and transfer of care. Reviewers also suggested that further work on the role of the 'Trusted Assessor' would be useful in order to streamline assessment processes and reduce the need for multiple assessments.

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PRIMARY CARE

No specific issues were identified.

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ACUTE TRUST – ALL WARDS

General Comments and Achievements

The Trust 'Capacity Hub' appeared to be working well, with a relaxed but focused approach to capacity, and actions and responsibilities clearly identified. Working relationships between the Discharge Coordinator and the hospital social work team appeared to be working well, with evidence of good collaboration. 'Care Home Select' was being used for patients being discharged to long-term nursing home care.

Good Practice

1 Two elderly care wards (C3 & A3) were particularly impressive, with good leadership and clearly visible team-working. The wards were clean, and patients were attended to quickly and carefully by staff with a cheerful approach. Board 'huddles' took place twice a day, covering quality issues and discharge planning. 'Friends and Family Test' cards were given to all patients on discharge.

2 The Trust was actively developing new Trust-wide roles, including an Acute Confusion Team and a Well-being Team. At the time of the review, the Well-Being Team consisted of six health care assistants who were providing 1:1 care for patients with particular needs, including those who were confused, liable to fall or lacking mental capacity. Several other innovations were being trialled – for example, the use of a taxi capable of carrying a wheelchair in order to speed up the discharge of patients.

3 The Trust had a large number of pharmacist prescribers who were actively reducing the time to availability of drugs 'to take home'.

Immediate Risks: No immediate risks were identified.

Concerns: See health and social care economy section of this report.

Further Consideration

1 The short-stay Frailty Unit appeared to be functioning as a short-stay ward for older people rather than as a unit caring for people who were particularly frail. In particular, comprehensive geriatric assessments were not undertaken on the unit. Two advanced nurse practitioners had been trained to lead the unit but both had left. Reviewers suggested that the function and staffing of this unit may benefit from review to ensure it is appropriately staffed for the role it is expected to perform.

2 Therapists were not effectively linked into the community 'hubs' (see the health and social care economy section of this report), and some issues relating to therapists (for example, the completion of ADL assessments) did not appear to be being effectively addressed. Reviewers suggested that the mechanism for addressing issues relating to therapy services within The Dudley Group NHS Foundation Trust may benefit from review.

3 Newly introduced arrangements for the off-site supply of Medi-boxes had resulted in significant savings, but Medi-boxes were available the same day only if the need was identified before 11am.

4 Several capacity meetings took place between 8.45am and 6pm, and a significant amount of clinical and managerial time was taken up in these meetings. Ways of streamlining information-gathering, the use of telephone conferences and other approaches may help to reduce the time taken by these meetings.

See also health and social care economy section of this report.

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INTERMEDIATE CARE SERVICES

NETHERTON GREEN – SALTWELL HOUSE

General Comments and Achievements

Saltwell House provided 30 'step-down' intermediate care beds. The service was well-organised and had very good links with the acute care of older people consultant. This consultant talked to all families of patients being admitted to Netherton Green, and gave them a brochure explaining the service and the plan of care. Derby House was not an intermediate care facility. It provided five 'step-down' beds for patients not suitable for rehabilitation.

Good Practice

1 Medical support for the care of residents at Netherton Green was good. A Staff Grade Doctor attended daily from Monday to Friday, undertook a 'board round', and saw any residents about whom staff had medical concerns. Prescribing arrangements were clearly defined. The doctor prescribed using FP10 forms, and a local pharmacy delivered medications quickly.

2 A dentist and an optician visited the home weekly and saw any residents needing their care.

3 Residents were actively supported to return home. Activity plans were embedded into care plans. The home had an 'activities lead' and a positive approach to rehabilitation. Length of stay was four to six weeks, with about 90% of residents returning home.

Immediate Risks: No immediate risks were identified.

Concerns

1 **Speech and language therapy staffing**

Speech and language therapy staffing had been reduced, and at the time of the review there was no speech and language therapy support for patients in intermediate care facilities. This caused particular problems because up to 10 of the 30 residents were receiving rehabilitation following a stroke. Because of staffing difficulties, the speech and language therapy service had, since January 2015, been operating a triage system, with priority being given to patients with urgent needs.

See also health and social care economy section of this report.

Further Consideration

1 The home received discharge summaries and a photocopy of the recent admission notes. Staff suggested that access to residents' hospital notes would help them to provide better and more integrated care.

2 The environment at the home was dated and the interior was in need of re-decoration and refurbishment. Reviewers suggested that an improved environment, including some rooms with en-suite bathroom facilities, could help staff to provide more personalised care.

3 A customer survey in the autumn of 2014 had highlighted some problems with call bell answering. This issue did not appear to have been addressed and was still reported as a problem by some residents.

4 Residents in Derby House were waiting up to four months for assessment by a social worker. Reviewers suggested that arrangements for ensuring these residents were not being deprived of their liberty while waiting for an assessment may benefit from review, as the facility was locked and residents were unable to become mobile without assistance. This issue did not apply to any of the residents of Derby House at the time of the review visit but could potentially happen in the future.

See also health and social care economy section of this report.

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TILED HOUSE

General Comments and Achievements

Tiled House was a large unit providing residential care. A total of 47 intermediate care beds were provided in six units spread over two floors. Therapist input to the care of residents at Tiled House was good, with good collaborative working between therapists and carers in support of residents' rehabilitation and re-ablement.

Immediate Risks

1 The environment at Tiled House was cluttered, with equipment stored in corridors; in particular, mattresses were stacked in the corridor, making it difficult for people in wheelchairs to use that route to the main exit. A significant amount of equipment was stored in an old day room that, at the time of the review, was being used for exercise classes. Ladders were stored behind the television. Reviewers considered that these issues comprised a risk to residents, especially those with dementia.

2 Several issues relating to infection control were identified by reviewers. No hand gel was available. Personal protective equipment was not easily available around the building; in particular, there was no personal protective equipment in the toilets and bathrooms seen by reviewers. Some aprons were stored in the old day room but not in the areas where they were likely to be needed. Sofas and chairs in the entrance to Tiled House were dirty. Dead flowers in stagnant water had been left in the kitchen / dining area of one of the units. Dried food goods were stored with equipment in the day room. Posters were not laminated.

Concerns

1 **Care Plans**

Residents' care plans seen by reviewers were not up to date, and some were incomplete or barely legible (photocopies of photocopies). Care plans were reviewed only on a monthly basis. Residents had five separate sets of notes (medical, nursing, therapy and carers' notes, plus a multi-disciplinary team file). The notes seen by reviewers did not have evidence of goal setting or discharge planning. Some entries were not signed and dated.

2 **Assessments**

Assessments, including ADL assessments, were repeated on admission to Tiled House. Staff read the assessments undertaken in hospital and used these as background information, but then re-started assessment processes.

3 **Staffing Levels and Competences**

a. Staffing at night comprised three carers for up to 47 residents, including six with dementia, spread over two floors of the building. No evidence of competences, including mandatory training of staff, was available to reviewers. Staff were not clear about the arrangements for training and assessment of competences.

b. Social worker input to the service was insufficient. No social worker attended the weekly multi-disciplinary team meeting.

c. There was no medical input to the weekly multi-disciplinary team meeting.

See also health and social care economy section of this report.

Further Consideration

1 Several aspects of the facilities and equipment at Tiled House were in need of attention. The unit was in the middle of a refurbishment programme, half of which had been completed. Therapy staff did not have access to the Dudley Group IT systems, and so drove to other centres to access residents' records. (Reviewers were told that therapists could use the CCG nurses' computers, but the therapists were not

aware of this.) There was no courier service to Tiled House and so nursing staff were transporting specimens and equipment to Russells Hall Hospital.

2 Visiting hours were only two hours in the afternoon (2pm to 4pm) and two hours in the evening (6pm to 8pm). Reviewers suggested that these could be extended.

3 Tiled House appeared to look to the CCG nurses as the leaders of the service, partly because of their role in deciding who was admitted and in chairing the weekly MDT meetings. Reviewers considered that there may be a conflict of interest in commissioners being so heavily involved in managing the care of residents. The manager of the service may need support in order to fully undertake the leadership role expected. Assurance was subsequently given that the CCG nurses managed the patient flow through the intermediate care beds and had a role in challenging the clinical decision-making within the MDT meeting, but did not provide any 'hands on' clinical care.

4 Reviewers were told of some difficulties with the supply of medications but were unsure of the extent of the problem. Further work to clarify this may be helpful.

See also health and social care economy section of this report.

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HOLLYCROFT NURSING HOME

General Comments and Achievements

Hollycroft Nursing Home was a nursing home with 32 beds, of which 20 were intermediate care beds for rehabilitation or 'step down'. Leadership of the home was strong, and a GP lead provided good support. Staffing was stable. The environment was pleasant, with plenty of natural light in residents' rooms and good bathroom facilities. The home could access pressure-relieving mattresses within a few hours and was able to manage residents requiring PEG feeds or heparin treatment. The home was interested in providing care to people needing intravenous therapy, and was prepared for staff to undertake training and develop competences so that this service could be provided.

Good Practice

1 An acuity tool was in use, which enabled the home to flex staffing levels so that care appropriate to residents' needs could be provided.

2 Daily handover took place using the white board, with a strong emphasis on residents achieving goals and working towards their rehabilitation potential. Activity plans were embedded into care plans. This approach was also taken for permanent residents in the home.

Immediate Risks: No immediate risks were identified.

Concerns: See health and social care economy section of this report.

Further Consideration

1 The home did not have allied health professional (therapist) support at weekends.

2 Weekly multi-disciplinary team meetings were held, but it was not clear how the outcome of these meetings was communicated to families.

See also health and social care economy section of this report.

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COMMISSIONING

All issues in the health and social care economy section of this report relate to the commissioning of the pathway for transfer from acute hospital care and intermediate care. Some issues in the provider sections of this report will also require commissioner monitoring and support to ensure they are addressed:

1 Immediate risks: See Intermediate Care Services, Tiled House

2 Strategy for the transfer from acute hospital care and intermediate care: See health and Social Care Economy, Concern 1

3 Social care assessments: See health and Social Care Economy, Concern 2

4 Health and social care economy coordinating group: See health and Social Care Economy, Concern 3

5 Guidelines: See health and Social Care Economy, Concern 4

6 Speech and language therapy staffing: See Intermediate Care Services (Netherton Green – Saltwell House), Concern 1

7 Care Plans: See Intermediate Care Services (Tiled House), Concern 1

8 Assessments: See Intermediate Care Services (Tiled House), Concern 2

9 Staffing Levels and Competences: See Intermediate Care Services (Tiled House), Concern 3

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APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team

Elaine Day	Patient Representative	
Adele Dean	Clinical Quality Manager	West Midlands Ambulance Service NHS Foundation Trust
Dr Stuart Hutchinson	Consultant, Geriatrics	The Royal Wolverhampton NHS Trust
Marsha Jones	Matron for Patient Flow	Worcestershire Acute Hospitals NHS Trust
Sue Lear	Acute Associate, Service Redesign and Innovation	NHS Arden Commissioning Support Unit
Samantha McIntosh	Integrated Health & Social Care Team Manager	The Royal Wolverhampton NHS Trust
Cath Molineux	Nurse Consultant Primary Care	Shropshire Community Health NHS Trust
Jennifer Robinson	Lead Nurse Older Adults	Walsall Healthcare NHS Trust
Julie Thompson	Head Nurse, Frail Older Person & Dementia	Burton Hospitals NHS Foundation Trust
Liza Walsh	Associate Director of Nursing/Interim Clinical Director Adults & Communities	Birmingham Community Healthcare NHS Trust

WMQRS Team

Jane Eminson	Acting Director	West Midlands Quality Review Service
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service
Sue McIldowie	Quality Manager	West Midlands Quality Review Service
Jane Smith	Clinical Lead	West Midlands Quality Review Service

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APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but', where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 – Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Transfer from Acute Hospital Care and Intermediate Care			
Primary Care	2	0	0
Acute Trust – All Wards	23	7	30
Intermediate Care Services	99	25	25
Netherton Green	(33)	(12)	(36)
Tiled House	(33)	(1)	(3)
Hollycroft Nursing Home	(33)	(12)	(36)
Commissioning	4	1	25
Health Economy	**128**	**33**	**26**

Pathway and Service Letters: Standards for Transfer from Acute Hospital Care use the pathway letter S. The Standards are in the following sections:

	Pathway	Service
SA -	Transfer from Acute Hospital Care	Primary Care
SM-	Transfer from Acute Hospital Care	Acute Trust: All wards
SN -	Transfer from Acute Hospital Care	Intermediate Care Service
SZ -	Transfer from Acute Hospital Care	Commissioning

Topic Sections: Each section covers the following topics:

-100	Information and Support for Patients and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

PRIMARY CARE

Ref	Standard	Met?	Comment
SA-101	**Patients at High Risk of Admission** Patients at high risk of admission to an acute hospital should have a 'Patient Passport' or equivalent patient-held record that covers: a. Diagnoses b. Allergies c. Medication d. Care package (or equivalent) e. Name and contact details of GP f. Name and contact details of main carer/s g. Advice for the patient and their carers on likely problems and what to do in an emergency h. Advice to emergency services on likely problems and recommendations for their management i. Advice for acute hospital services on the most appropriate ward (if admission is required)	N	Patient Passports were not in place for all patients with complex needs. Passports did not travel with the patient when they were admitted for acute or intermediate care. Reviewers were told that many GPs were not using the patient passports even when they were available.
SA-601	**Summary Medical Record** A summary of the patient's medical record including diagnoses, allergies, medication and agencies involved in their care should be sent with each patient referred to intermediate care or to an acute hospital for assessment or admission.	N	Summaries of patients' medical records were not sent with the patient when they were admitted from home. Electronic discharge letters and photocopies of recent acute admission information were sent with the patient when they were transferred from acute care.

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ACUTE TRUST – ALL WARDS

Ref	Standard	Met?	Comment
SM-101	**Planned Admissions** All patients awaiting a planned admission to hospital should be offered written information about arrangements for leaving the hospital and returning to their usual place of residence.	N	Information was not given to patients prior to planned admissions. Information on services was given.
SM-102	**Information about Leaving Hospital** Each ward should clearly display information for patients, carers and staff about arrangements for transfer of care on leaving the hospital, covering at least: a. The process of transfer of care b. Additional support available in the patient's usual place of residence c. Intermediate care options, criteria for accessing these and time limits on their provision (if applicable) d. How to access a discussion with medical and/or nursing staff about the patient's condition and plans for care on leaving hospital	N	Some staff were not aware of the information available and some of the information leaflets seen were not in regular use. The reviewers also found that some wards did not have information available for patients and their families and carers. This Quality Standard was met for patients going to Netherton Green as the clinical lead met with all patients prior to transfer and gave them an information leaflet.
SM-103	**Discussion with Families** Members of the multi-disciplinary team should be easily available to families for discussions about the patient's condition and plans for care on leaving hospital. Information on how to arrange a discussion should be clearly displayed in all ward areas.	N	Although the welcome letter advised patients and their families and carers to contact the lead nurse if there were concerns regarding the patient's care, there was not a consistent approach to how to arrange a discussion with members of the team.
SM-104	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their admission.	N	The use of the Patient Passport was not routine.

Ref	Standard	Met?	Comment
SM-196	**Transfer of Care Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the hospital and should be given a written summary of their Transfer of Care Plan, which should include: a. Expected date of discharge b. Essential pre-discharge assessments c. Care after leaving the acute hospital, including self-care d. Medication required on leaving the acute hospital e. Who is taking medical responsibility for care after leaving the acute hospital f. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange g. Possible complications and what to do if these occur, including in an emergency h. Transport i. Equipment supply or loan j. Dressings and continence aids k. Who to contact with queries or for advice l. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This Transfer of Care Plan should be copied to the patient's GP and to all services involved in providing after-hospital care.	N	The Trust had a transfer of care plan but it was out of date and was not available on the intranet. The transfer of care document did not cover all aspects of transfer to nursing homes or intermediate care settings. Paper copies of the plan were being used.
SM-198	**Carers' Needs** Carers should be offered advice and written information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access benefits advice c. Services available to provide support	Y	A good carers leaflet was available and support mechanisms were in place.
SM-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about transfer of care from the acute hospital b. Examples of changes made as a result of feedback and involvement of patients and carers	Y	The CCG, Dudley Group NHS Foundation Trust and HealthWatch had commissioned an independent survey on patients' experience of discharge, including filming people's experience. Results of the survey had been released and Dudley Group NHS Foundation Trust was in the process of developing an action plan.

Ref	Standard	Met?	Comment
SM-201	**Multi-Disciplinary Teams** A multi-disciplinary team to coordinate discharge planning should be available on each ward including: a. Staff with occupational therapy and physiotherapy competences with time allocated daily (7/7) for discharge planning, essential pre-discharge assessments and active pre-discharge rehabilitation b. Senior decision-maker review of patients' fitness for discharge at least daily (7/7) c. Nurse with competences in 'event-led' discharge from 9am to 8pm daily (7/7) d. Someone identified to coordinate discharge planning and preparation for discharge from 9am to 8pm daily (7/7) e. Access to social services staff available to undertake social care assessment within 24 hours of request f. Access to pharmacy services and medication 'To Take Out' available within four hours of request	N	Multi-disciplinary working seven days a week had been implemented but members of the multi-disciplinary team did not attend meetings consistently. Competences in event led discharge were not yet in place. Reviewers did not see evidence of discharge planning competences for staff. Social services were unable to undertake discharge assessments within 24 hours.
SM-202	**'Trusted Assessors'** A member of staff 'trusted' and with competences to assess for local intermediate care services, including intermediate care in community hospitals, in care homes or at home, should be available to each ward daily (7/7) and able to respond on the same day to requests received by 12 noon.	Y	Trusted Assessors were employed by the CCG and assessed all patients requiring intermediate care. Trusted Assessors were not part of the ward multi-disciplinary teams. See also main report.
SM-203	**Training in Transfer of Care from the Acute Hospital** All staff, including junior medical staff, should have training in the hospital transfer of care pathway (QS SM-597), local intermediate care services (QS SM-602) and local enabling agreements (QS SZ-602).	Y	Discharge coordinators provided training. Discharge planning workshops had been held and the Lead Clinician delivered training about intermediate care to each junior doctor intake. Training about discharge arrangements had also been provided by an external provider.

Ref	Standard	Met?	Comment
SM-301	**Support Services** Access to the following support services should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Patient transport able to respond within four hours of request c. 'Simple' equipment available within four hours of request d. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request e. All equipment, including beds and hoists, available within 24 hours of request f. 'Simple' adaptations available within 24 hours of request g. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days h. 'Simple' assistive technology available within 24 hours of request i. Medicines reconciliation (7/7)	N	The services listed were available, but the expected timescales were not met. Reviewers were told that transport services had to prioritise transfers to intermediate care beds over patients being transferred home because care homes stipulated that they would not receive patients after dark.
SM-302	**Short-Term Care at Home** Additional health and social care support should be available within four hours of request, comprising up to four visits per day for at least 72 hours after return home.	N	Reviewers did not see evidence of short-term care provision at home. Patients who were known to the Virtual Ward could be referred back to the service following their acute admission. The IMPACT team had access to some emergency care beds and care packages. CRRT did provide some short-term care. Domiciliary care was provided if required but not up to four times a day.
SM-499	**IT System** 'Trusted assessors' and ward-based staff responsible for coordinating discharge planning (QS SM-201) should have electronic access to: a. Health and social care records of patients from the main areas served by the hospital b. 'Patient Passports' (if electronic)	N	There was no evidence of the usage of Patient Passports. Community services were unable to access electronic records of acute care.
SM-595	**Ward and Consultant Handover** The latest version of their Transfer of Care Plan should be handed over to the new ward or consultant whenever patients are transferred to another ward within the acute hospital or to the care of another consultant and the Transfer of Care Checklist (QS SM-601) updated.	Y	An Electronic Discharge Summary was completed for every patient transferred to a bedded intermediate care facility. A photocopy of the patient's acute episode of care was transferred with the patient.

Ref	Standard	Met?	Comment
SM-596	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge, ideally within 12 hours of admission b. 'Event-led' discharge c. Discussion with patients and carers about the Transfer of Care Plan d. Multi-disciplinary review for complex discharges or where discharge destination is unclear, ideally within 24 hours of admission e. Single assessment process f. Transport options including patient transport service, relatives, taxis or care home transport g. Development, agreement and giving the patient, GP and, where appropriate, carers a copy of the of the Transfer of Care Plan: i. Expected date of discharge ii. Essential pre-discharge assessments iii. Care after leaving the acute hospital, including self-care iv. Medication required on leaving the acute hospital v. Who is taking medical responsibility for care after leaving the acute hospital vi. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving hospital, and who will arrange these, including separately identifying any of these which the GP is expected to arrange vii. Possible complications and what to do if these occur, including in an emergency viii. Transport ix. Equipment supply or loan x. Dressings and continence aids xi. Who to contact with queries or for advice xii. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required h. How to access funding decisions on specialist care not normally available in the local area i. Latest time when patients can normally be discharged home or to care homes j. Handover of the Transfer of Care Plan to services providing after-hospital care, including intermediate care services k. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left hospital, ideally within four hours of transfer of care l. Contingency plan when capacity in intermediate care services is not available	N	Some guidance on transfer of care was in place but this did not cover all the requirements of the Quality Standard. The guidance in place at the time of the review could be found within the discharge policy, goal plans, single assessment process and Multi-disciplinary Assessment Framework documentation.

Ref	Standard	Met?	Comment
SM-597	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree a Transfer of Care Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not yet in place.
SM-601	**Ward-Level Arrangements** The following arrangements should be implemented on each ward: a. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission b. Availability for discussion with families (QS SM-103) c. A 'Patient at a Glance' or equivalent system so that all staff can see the patient's stage on the transfer of care pathway and actions required d. A Transfer of Care checklist (or equivalent) in each patient's notes showing their stage on the transfer of care pathway and actions required e. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available f. Rapid access to investigations and consultant clinics for patients following discharge (7/7) g. Local enabling agreements (QS SZ-602)	N	Some processes were in place. At the time of the visit arrangements were not in place for a)i and ii, e, f and g.

Ref	Standard	Met?	Comment
SM-602	**Intermediate Care** A protocol on access to local intermediate care services should be in use on each ward covering at least: a. Criteria for acceptance by each local intermediate care service and time limit for provision of the service (if applicable) b. Type of care, rehabilitation and re-ablement provided and, in particular, whether the service is able to support: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care c. 'Trusted Assessor' (QS SM-202) or other arrangements for agreement of patient suitability d. Arrangements for handover of the patient's Transfer of Care Plan	N	A protocol on access to local intermediate care services was not in place on each ward. In practice staff were able to demonstrate to reviewers that this was discussed at the ward 'board rounds' and at multi-disciplinary team meetings.
SM-701	**Data Collection and Monitoring** Each ward should have access to data on its own performance and comparative information for other wards covering: a. Proportion of patients achieving their expected date of discharge b. Proportion of patients 'home for lunch' c. Key quality and performance indicators agreed with commissioners	Y	
SM-702	**Audit** Each ward should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Patients re-admitted within 28 days who did not have a 'Patient Passport' or equivalent patient-held record *c.* Proportion of further investigations or follow up appointments arranged within five days of transfer from acute hospital	N	A systematic audit process was not yet in place and many guidelines were not in place in order to be audited.

Ref	Standard	Met?	Comment
SM-797	**Health and Social Care Review and Learning** Each ward should have a mechanism for influencing, and receiving feedback from, the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	Wards did not have a clear mechanism for influencing, and receiving feedback about, transfers of care from acute hospitals and intermediate care via a health and social care review and learning mechanism. A three-tiered approach to sharing information across the health economy was in place: A system resilience group: which included Chief Executives An Urgent Care Working Group which included Directors An Urgent Care Operational Group which included operational staff such as Matrons and General Managers.
SM-798	**Multi-disciplinary Review and Learning** Each ward should have multi-disciplinary arrangements for the reviewing of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' relating to transfer of care from the acute hospital.	Y	Capacity hub and ward review and learning was in place led by Capacity Managers and Matrons.
SM-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Some policies were out of date and were not available on the intranet.

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Intermediate Care Service: Netherton Green – Saltwell House, Tiled House

These Quality Standards apply to intermediate care provided in community hospitals, care homes and patients' own homes.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	Leaflets seen at the visit had relevant information, including contact details and how to arrange meetings.	N	Information seen did not have out of hours contact details and did not appear to reflect the Intermediate care service provided. There was no version control on the leaflet.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	Y	Personalised care plans were in place for each resident. Assessments and goal setting was achieved within 24 hours of arrival to Unit. Residents also had a daily review with Staff Grade. Daily Board rounds were in place and the weekly multi-disciplinary team meeting was clinically led.	N	Care plans were available but were not personalised and were not reviewed regularly. Most residents only had a monthly review of their care plans.
SN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, weekly. This review should involve the patient, their carer, where appropriate, and appropriate members of the multi-disciplinary team. The outcome of the review should be recorded in the Care Plan.	Y	Weekly multi-disciplinary team meetings took place and the outcomes and any progress were shared with family or carers. The consultant saw every family on arrival to Unit.	N	There was no weekly review of care plans.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear, and advice on what to do in an emergency should be given. Response times should be no longer than the end of the next day.	Y	Leaflets had relevant information and included contact details, how to arrange meetings and raise queries. The consultant also ensured that all patients and relatives received an information leaflet about the service during the ward round prior to transfer.	N	Information leaflets did not have contact numbers and did not cover how patients, carers or families could raise queries and access advice.
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	N	Residents did not have a nominated Care Co-ordinator.	N	Residents did not have a nominated Care Co-ordinator.
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y	Residents' communication needs were assessed on arrival on the unit.	Y	Residents' communication needs were assessed on arrival on the unit.
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passports were not in place in the Dudley area. Staff who met the reviewing team were not aware that some patients were using patient passports.	N	Patient passports were not in use across the health economy.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	After Intermediate Care Plans' were in development. Some information was contained in a nursing discharge summary letter.	N	After Intermediate Care Plans' were in development. Some information was contained in a nursing discharge summary letter.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y	Access to all support services was available if required. The home also provided support for carers.	N	Support available was not clear. Social care workers did not attend the multi-disciplinary team meetings so it was unclear how residents were 'signposted' to relevant information.
SN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access advice on these c. Services available to provide support	Y	Good communication with families was evident. Each family was seen by the consultant on admission and goals discussed. The Unit Manager had systems to support carers and to 'signpost' to relevant information.	N	It was not clear how multi-disciplinary team (MDT) meeting outcomes were discussed with carers and families as the MDT meeting was only held monthly. Processes for the involvement of families and carers was not structured.
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y	Visiting was from 2pm to 7pm to allow for therapies and nursing care to be delivered in the morning. Families were encouraged to visit at mealtimes and to stay with their relatives if required. The Staff Grade doctor and Consultant were proactive in their communication with family members.	N	Visiting consisted of two hours twice a day (although the leaflet said two hours three times a day). Reviewers were told there was often an influx of relative and carer queries on Wednesdays and Thursdays because families knew that some discussions about their relative may have taken place on those days.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-201	**Lead Clinician and Lead Manager** A nominated lead clinician and a lead manager should be responsible for the effective delivery of the service, including staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	Excellent leadership of the service was evident from the Consultant, Staff Grade doctor, Home and Unit Managers.	N	A Registered Manager, Care Manager and Therapy Lead were in place but management responsibilities were not clearly defined.
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Netherton Green had 30 intermediate care beds. Staffing was as follows: Early shift: two trained nurses and five carers. Late shift: two trained nurses and four carers. Night shift: one trained nurse and three carers. Staffing could be increased to cover 1:1 supervision if required. The home was unable to meet the standard (i) at night as only one registered nurse was on duty. Therapist support was available only Monday to Friday. Access to speech & language therapy was limited. Access to social services to undertake social care assessments was not possible within 24 hours of request.	N	Staffing did not appear to be sufficient for the number of residents usually cared for by the service and the usual case mix of residents especially overnight. Reviewers were told that during the day there were two senior carers on duty for the 47 beds, with two carers on each of the six units. Other staff available included a Band 5 Nurse (1 wte), Band 6 Nurse (1wte), Activity Coordinator for those with dementia, Occupational Therapists (1.6wte) and Physiotherapy support (1.3wte). Overnight three carers covered the two floors and the six beds allocated to residents with dementia. Access to social services for social care assessments was not possible within 24 hours of request.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	A service competence or training plan was not yet in place. Staff did have access to mandatory training. It was not clear to reviewers how staff training was monitored. The unit did not provide intravenous therapy or VAC therapy.	N	Some training was undertaken by the Local Authority. There was no evidence of a service competence or training plan.
SN-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Resuscitation b. Safeguarding vulnerable adults c. Recognising and meeting the needs of vulnerable adults d. Dealing with challenging behaviour, violence and aggression e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Privacy and dignity g. Infection control h. Information governance, information sharing and awareness of any local information sharing agreements i. Local enabling agreements (QS SZ-602)	N	Evidence of competences was not provided to reviewers during the visit. In practice, there was evidence that staff had sufficient knowledge of and were adhering to 'b', Safeguarding Adults, 'c' recognising the needs of vulnerable adults, ‘e’ Mental Capacity Act and Deprivation of Liberty Safeguards, 'f' privacy and dignity and 'g' infection control.	N	Reviewers did not see any evidence of staff competences during the visit. Staff were unaware if competences and training were monitored by the CCG or Local Authority. Reviewers were not confident that basic infection control guidelines were in place. See main report for more detail.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-205	**Medical Staff** The service should have the following medical staffing: a. A nominated lead doctor with responsibility for coordinating medical input to the service b. A doctor available for emergencies 24/7 c. A doctor or other registered health professional with authorisation to prescribe who can attend within two hours of request, for conditions where hospital admission may be avoided d. Medical review of patients: i. Community hospitals: Daily (7/7) ii. Other intermediate care services: As appropriate for the usual case mix of patients and at least weekly.	Y	Consultant cover was available two days a week and there was five days a week cover by the Staff Grade Doctor. Prime Care provided an emergency out of hours service.	N	A nominated lead doctor was in place for one of the units, provided by The Dudley Group NHS Foundation Trust. For the other units, two sessions a week were available from a visiting GP who undertook medical reviews. PrimeCare provided an emergency out of hours service. The multi-disciplinary team meeting did not include any medical input.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y		N	There was no administrative or data collection support. Plans to recruit a business manager to oversee data collection and audits were in place.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	Tissue viability and continence advice was not available seven days a week. Access to other services was via the medical staff.	N	The Falls Prevention service was not available to Tiled House residents. Staff who met the visiting teams did not know the process for accessing urgent mental health support. Staff were expected to transport blood and other samples to the relevant laboratory.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	N	The service was unable to meet a, c, d, f, g, h, i or j. Medication 'to take out' was available Mondays to Fridays via a local Chemist.	N	It was not clear how new equipment was accessed for residents. Access to dressings and aids was possible within the defined timescales.
SN-401	**Facilities and Equipment** Facilities and equipment available should be appropriate for the assessments, care and therapeutic interventions offered by the service for the usual number and case mix of patients.	Y		N	See main report.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	IT services were not integrated. Most communication was in paper form apart from electronic discharge summary following acute admission. Consultant staff did have access to patient records when based in Russells Hall Hospital.	N	IT services were not integrated and some visiting staff did not have access to IT when working at Tiled House. Most communication was in paper form apart from the electronic discharge summary following acute admission.
SN-501	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use that ensure that an initial assessment is undertaken within 30 minutes of transfer to the intermediate care service, or within four hours if intermediate care is provided in the home, covering at least: a. Assessment of pressure ulcers, nutrition, hydration and cognition b. Initial review of the Transfer of Care Plan to ensure its appropriateness for the intermediate care service	N	Formal guidelines were not in place. There was no transfer of care policy for intermediate care. Initial assessments were completed on arrival at the intermediate care beds at Netherton Green The discharge summary and photocopy of records from Russells Hall Hospital were sent with the patient on transfer to the service.	N	Formal guidelines were not in place. Reviewers were told that assessments completed in Russells Hall Hospital were not always used and were re-done by staff at Tiled House.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	Access to some Dudley Group NHS Foundation Trust policies was available. Guidelines covering sensory loss, spasticity management and health promotion were not available.	N	Clinical guidelines as defined by the Quality Standard were not yet in place. A Dudley PCT community services and integrated care guideline for continence care was available.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	Guidelines on planning transfers of care from intermediate care (bi, biii, bvi) were not yet in place.	N	The self-assessment suggested that guidelines were in place but these were not available to the reviewers. Guidelines on planning transfers of care from intermediate care (bi, biii, bvi) were not yet in place.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not yet in place.	N	Guidelines covering more complex transfers of care were not yet in place.
SN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable adults should be in use covering, in particular: a. Identification and care of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care j. 'Do not resuscitate'	N	Evidence for c, d, g, h, l or j was not available. A safeguarding adults policy was in place and staff had good links with the safeguarding team if needed. Staff had a good understanding of Mental Capacity Act and Deprivation of Liberty Safeguards.	N	Guidelines for the care of vulnerable adults were not yet in place. Some information was covered in care plans. See also main report about the care of residents with dementia.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least, arrangements for: a. Admission of patients to the service who meet the agreed criteria b. Initial assessment within 30 minutes of transfer, or within four hours if the patient has returned home c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission d. Agreement of Care Plan within 24 hours of transfer to intermediate care e. Start of therapeutic interventions within 24 hours of transfer to intermediate care f. Setting and reviewing expected date of discharge from the service g. Daily review of all patients h. Review of Care Plans at least weekly, including medical review i. Allocation of a care coordinator for each patient (QS SN-106) j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey k. Responding to patients' and carers' queries or requests for advice l. Multi-disciplinary discussion of appropriate patients m. Developing and agreeing an 'After Intermediate Care' Plan for each patient (QS SN-196) within seven days of admission n. Ensuring that an 'After Intermediate Care' checklist (or equivalent) is included in each patient's notes showing their stage on the transfer of care pathway and actions required o. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available p. Communication with the patient's GP q. Maintenance of equipment (QS SN-401) r. Responsibilities for IT systems (QS SN-499)	N	Evidence of an Operational Policy for Intermediate Care or discharge to 'step down' was not available to reviewers.	N	An operational policy covering the requirements of the Quality Standard was not in place. Reviewers were told that a service specification was in place but this was not available on the day of the review visit.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	N	Some data were collected but there was no evidence of recording and monitoring as expected by the Quality Standards.	N	Regular collection and monitoring of data were not in place. Some data on referrals and outcomes were being collected by therapists.
SN-702	**Audit** The services should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Compliance with evidence-based clinical guidelines (QS SN-500s) c. Compliance with standards of record keeping	N	An audit programme covering length of stay, readmission rates and reason for re-admission had been undertaken. Audits covering 'b' and 'c' were not yet in place.	N	A rolling programme of audits was not yet formalised.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Reviewer were told that some key performance indicators (KPIs) were in place covering the number of patient transfers, referrals and assessment, but reviewers saw no evidence of monitoring or reviews of these KPI's.	N	Reviewer were told that some key performance indicators (KPIs) were in place covering the number of patient transfers, referrals and assessment, but reviewers saw no evidence of monitoring or reviews of these KPI's.

Ref	Standard	Netherton Green – Saltwell House		Tiled House	
		Met?	Comment	Met?	Comment
SN-797	**Health and Social Care Review and Learning** The service should have a mechanism for influencing and receiving feedback from the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	See main report.	N	See main report.
SN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of, and implementation of learning from, published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Arrangements for multi-disciplinary review and learning as defined the Quality Standards were not yet in place.	N	Arrangements for multi-disciplinary review and learning as defined the Quality Standards were not yet in place.
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Some documentation seen by the reviewers was not document-controlled.	N	Some documentation seen by the reviewers was not document-controlled.

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INTERMEDIATE CARE SERVICE: HOLLYCROFT NURSING HOME

These Quality Standards apply to intermediate care provided in community hospitals, care homes and patients' own homes.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service b. Care and therapeutic interventions offered by the service c. If beds: routines, visiting times and how to get refreshments d. Staff and facilities available e. How to contact the service for help and advice, including out of hours f. Who to contact with concerns about the service g. 'After intermediate care', including information about the length of time for which the service will be provided and the options for, and process of transfer to, longer-term care (if required) h. Sources of further advice and information	Y	Leaflets seen at the visit had relevant information, including contact details and how to arrange meetings.
SN-103	**Care Plan** Each patient and, where appropriate, their carer and appropriate members of the multi-disciplinary team should discuss and agree their Care Plan and should have easy access to a written record covering at least: a. Agreed goals, including life-style goals b. Self-management c. Medication d. Planned care and therapeutic interventions e. Early warning signs of problems, including acute exacerbations, and what to do if these occur f. Expected date of discharge from the service g. Name of care coordinator h. Name of doctor taking medical responsibility for their care i. Who to contact with queries or for advice j. Planned review date and how to access a review more quickly, if necessary	Y	Personalised care plans were in evidence. Assessments and goal setting were achieved within 24 hours of arrival. This included individualised goal setting. Review of care was also covered during the daily reviews at board rounds with each shift and within the weekly multi-disciplinary team meeting.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-104	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned and, at least, weekly. This review should involve the patient, their carer, where appropriate, and appropriate members of the multi-disciplinary team. The outcome of the review should be recorded in the Care Plan.	Y	Weekly multi-disciplinary team meetings took place and were documented in personalised plans. The outcomes were shared with the family or carers.
SN-105	**Contact for Queries and Advice** Each patient and, where appropriate, their carer should have a contact point within the service for queries and advice. If advice and support is not immediately available then the timescales for a response should be clear, and advice on what to do in an emergency should be given. Response times should be no longer than the end of the next day.	Y	Leaflets had relevant information.
SN-106	**Care Coordinator** Each patient should have a nominated individual responsible for planning and coordinating their care, including planning their longer-term care.	N	Residents did not have a nominated Care Co-ordinator.
SN-107	**Communication Aids** Communication aids should be available to enable patients with communication difficulties to participate in decisions about their care.	Y	Residents' communication needs were assessed on arrival on the unit.
SN-108	**Patients at High Risk of Re-Admission** Patients at high risk of re-admission should have their 'Patient Passport' or equivalent patient-held record (QS SA-101) updated during the course of their intermediate care.	N	Patient passports were not in use across the health economy. Some GPs in Stourbridge were updating the patient passports that were in place.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-196	**'After Intermediate Care' Plan** Patients and, when appropriate, their carers should be involved in discussing and agreeing the plan for their care after leaving the intermediate care service, and should be given a written summary of their 'After Intermediate Care' Plan, which should include: a. Expected date of discharge from the intermediate care service b. Care after leaving intermediate care, including self-care c. Medication d. Who is taking medical responsibility for care after leaving intermediate care e. Further investigations, treatment, rehabilitation and re-ablement to be carried out after leaving intermediate care, and who will arrange these, including separately identifying any of these which the GP is expected to arrange f. Possible complications and what to do if these occur, including in an emergency g. Transport (if required) h. Equipment supply or loan i. Dressings and continence aids j. Who to contact with queries or for advice k. Date by which their care should be reviewed, who is expected to undertake this review and how to access a review more quickly if required This 'After Intermediate Care' Plan should be copied to the patient's GP and to all services involved in providing ongoing care.	N	After Intermediate Care Plans' were in development. Some information was contained in a nursing discharge summary letter.
SN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services, and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. *HealthWatch* or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y	Access to all support services was available if required. The home also provided support for carers.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. Benefits available, including carers' allowance (if applicable), and how to access advice on these c. Services available to provide support	Y	There was evidence of post-multidisciplinary team meeting decisions being shared with relatives and carers. Staff were actively involved in arranging carer assessments and could signpost carers and families to benefits information.
SN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about the treatment and care they receive b. Examples of changes made as a result of the feedback and involvement of patients and carers	Y	Hollycroft had open visiting for their residents. Decisions from multi-disciplinary team discussions were shared with the families after the meeting.
SN-201	**Lead Clinician and Lead Manager** A nominated lead clinician and a lead manager should be responsible for the effective delivery of the service, including staffing, training, guidelines and protocols, service organisation, governance and liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service.	Y	There was good GP support for residents at Hollycroft and strong leadership from the Care Home Manager and Unit Manager.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-202	**Staffing Levels and Skill Mix** Sufficient health and care staff with appropriate competences should be available for: a. The number of patients usually cared for by the service and the usual case mix of patients b. The service's role in the patient pathway and expected timescales c. The assessments, care and therapeutic interventions offered by the service Staffing should include: i. At least two registered healthcare professionals at all times the service is operational ii. A registered nurse available 24/7 in bedded units and daily (7/7) in other services iii. Appropriate therapists for the needs of the patients daily (7/7) iv. Access to social services staff available to undertake social care assessments within 24 hours of request v. Medical staff (QS SN-205) Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	Hollycroft had 20 intermediate care beds. Staffing was assessed by using the Rhys Herne acuity tool. During the day there were two registered nurses and five un-registered carers. Overnight there was one trained nurse and 3 untrained carers. Staffing could be increased to cover 1:1 supervision if required. The home was unable to meet the standard (i) at night as only one registered nurse was on duty. Therapist support was available only Monday to Friday. Access to social services to undertake social care assessments was not possible within 24 hours of request.
SN-203	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place. If provided by the service, the competence framework should cover: a. Intravenous therapy b. PEG feeds c. Care for patients with dementia or significant cognitive impairment d. VAC therapy and other complex wound care	N	A service competence or training plan was not yet in place. There was a training plan for the care of those requiring PEG feeding. The home did not provide intravenous therapy or VAC therapy.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-204	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Resuscitation b. Safeguarding vulnerable adults c. Recognising and meeting the needs of vulnerable adults d. Dealing with challenging behaviour, violence and aggression e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Privacy and dignity g. Infection control h. Information governance, information sharing and awareness of any local information sharing agreements i. Local enabling agreements (QS SZ-602)	N	Evidence of competences was not provided to reviewers during the visit. In practice, there was evidence that staff had sufficient knowledge of and were adhering to 'b', Safeguarding Adults, 'c' recognising the needs of vulnerable adults, 'e' Mental Capacity Act and Deprivation of Liberty Safeguards, 'f' privacy and dignity and 'g' infection control.
SN-205	**Medical Staff** The service should have the following medical staffing: a. A nominated lead doctor with responsibility for coordinating medical input to the service b. A doctor available for emergencies 24/7 c. A doctor or other registered health professional with authorisation to prescribe who can attend within two hours of request, for conditions where hospital admission may be avoided d. Medical review of patients: i. Community hospitals: Daily (7/7) ii. Other intermediate care services: As appropriate for the usual case mix of patients and at least weekly.	Y	There was good support from the GP practice five days a week. PrimeCare provided an emergency out of hours service.
SN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y	

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-301	**Clinical Support Services** Timely access to an appropriate range of clinical support services should be available, including: a. Imaging b. Pathology, including microbiology c. Pharmacy, including medication supply and medicines management advice d. Appropriate staff to undertake a home assessment within 24 hours of request e. Infection control (7/7 and on call 24/7) f. Tissue viability (7/7) g. Falls prevention (next working day) h. Continence service (7/7) i. Mental health team (crisis response within four hours) j. Counselling	N	The Falls Prevention Service was not available to Hollycroft residents. Tissue viability and continence advice was not available seven days a week. All other aspects could be met through therapists and other services.
SN-302	**Support Services for Patients Returning Home** Access to the following support services for patients returning home should be available daily (7/7): a. Appropriate staff to undertake a home assessment within 24 hours of request b. Medication 'To Take Out' available within four hours of request c. Patient transport able to respond within four hours of request d. 'Simple' equipment available within four hours of request e. Supply of sufficient dressings and continence aids for 72 hours available within four hours of request f. All equipment, including beds and hoists, available within 24 hours of request g. 'Simple' adaptations available within 24 hours of request h. Additional health and social care support within four hours of request, comprising up to four visits per day for up to 72 hours after return home i. Voluntary sector 'settling home' support able to respond by the end of the next working day and continue for up to five days j. 'Simple' assistive technology available within 24 hours of request	N	Beds and hoists were not usually available within 24 hours. Simple adaptations took longer than 24 hours to facilitate. The service was unable to meet a, b, c, d, f, g, h, i or j.
SN-401	**Facilities and Equipment** Facilities and equipment available should be appropriate for the assessments, care and therapeutic interventions offered by the service for the usual number and case mix of patients.	Y	

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-499	**IT System** IT systems for storage, retrieval and transmission of patient information should be in use for patient administration, clinical records, outcome information and other data to support service improvement, audit and revalidation.	N	IT services were not integrated. Most communication was in paper form apart from electronic discharge summary following acute admission.
SN-501	**Initial Assessment Guidelines** Guidelines on initial assessment should be in use that ensure that an initial assessment is undertaken within 30 minutes of transfer to the intermediate care service, or within four hours if intermediate care is provided in the home, covering at least: a. Assessment of pressure ulcers, nutrition, hydration and cognition b. Initial review of the Transfer of Care Plan to ensure its appropriateness for the intermediate care service	N	Formal guidelines were not in place. There was no transfer of care policy for intermediate care. Initial assessments were completed on arrival at the intermediate care beds at Hollycroft. The discharge summary and photocopy of records from Russells Hall Hospital were sent with the patient on transfer to the service.
SN-502	**Clinical Guidelines** Guidelines on management of the usual case mix of patients referred to the service should be in use covering at least: a. Pain b. Depression c. Skin integrity d. Falls and mobility e. Continence f. Delirium and dementia g. Nutrition and hydration h. Sensory loss i. Medicines management j. Catheter care k. Spasticity management l. Care of patients with diabetes, COPD, heart failure and other long-term conditions m. Activities of daily living n. Health promotion, including smoking cessation, healthy eating, weight management, exercise, alcohol use, sexual and reproductive health, and mental and emotional health and well-being	N	Clinical guidelines as defined by the Quality Standard were not yet in place. A Dudley PCT community services and integrated care guideline for continence care was available.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-597	**Transfer of Care Guidelines** Transfer of care guidelines for both simple and complex discharge pathways should be in use covering at least: a. Ensuring each patient has an expected date of discharge from the service b. Planning transfers of care from intermediate care including: i. Discussion with patients and carers about the 'After Intermediate Care' Plan ii. Availability for patient and carer queries iii. Multi-disciplinary review for complex or uncertain discharges iv. Single assessment process v. Transport options including patient transport service, relatives, taxis or care home transport vi. 'After Intermediate Care' Plan (QS SN-196) c. Agreement of 'After Intermediate Care' Plan and handover to services providing long-term care (if required) d. Informing the GP, the person taking medical responsibility for the patient and any other relevant services that the patient has left intermediate care, ideally within four hours of transfer of care	N	Guidelines on planning transfers of care from intermediate care (bi, biii, bvi) were not yet in place.
SN-598	**More Complex Transfers of Care** Guidelines should be in use covering: a. Transfer of care to other local authority or Clinical Commissioning Group areas covering at least social care assessments, intermediate care services available, patient transport and equipment supply or loan b. Transfer to a care home for long-term care c. NHS continuing care assessments and place-finding d. Liaison with palliative and end of life care services e. Patients and/or carers who do not agree an 'After Intermediate Care' Plan or who unreasonably delay their transfer of care	N	Guidelines covering more complex transfers of care were not yet in place.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable adults should be in use covering, in particular: a. Identification and care of vulnerable people b. Individualised care plans for people identified as being particularly vulnerable c. Restraint and sedation d. Missing patients e. Mental Capacity Act and Deprivation of Liberty Safeguards f. Safeguarding g. Information sharing h. Palliative care i. End of life care j. 'Do not resuscitate'	N	Evidence for c, d, g, h, l or j was not available. A safeguarding adults policy was in place and staff had good links with the safeguarding team if needed. Staff had a good understanding of Mental Capacity Act and Deprivation of Liberty Safeguards.
SN-601	**Operational Policy** The service should have an operational policy describing the organisation of the service including, at least, arrangements for: a. Admission of patients to the service who meet the agreed criteria b. Initial assessment within 30 minutes of transfer, or within four hours if the patient has returned home c. On admission: i. Requesting a Summary Medical Record from the patient's GP if this is not sent with the patient (QS SA-601) ii. Identifying agencies involved in the patient's care and, if necessary, informing them of the admission d. Agreement of Care Plan within 24 hours of transfer to intermediate care e. Start of therapeutic interventions within 24 hours of transfer to intermediate care f. Setting and reviewing expected date of discharge from the service g. Daily review of all patients h. Review of Care Plans at least weekly, including medical review i. Allocation of a care coordinator for each patient (QS SN-106) j. Giving the patient and, where appropriate, their carer information at each stage of the patient journey k. Responding to patients' and carers' queries or requests for advice l. Multi-disciplinary discussion of appropriate patients m. Developing and agreeing an 'After Intermediate Care' Plan for each patient (QS SN-196) within seven days of admission n. Ensuring that an 'After Intermediate Care' checklist (or equivalent) is included in each patient's notes showing their stage on the transfer of care pathway and actions required o. Updating the 'Patient Passport' (QS SA-101) for people at high risk of re-admission or issuing one if not available p. Communication with the patient's GP q. Maintenance of equipment (QS SN-401) r. Responsibilities for IT systems (QS SN-499)	N	An operational policy covering the requirements of the Quality Standard was not in place.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-701	**Data Collection** Regular collection and monitoring of data should be in place, including: a. Referrals to the service, including source and appropriateness of referrals b. Number of assessments and therapeutic interventions undertaken by the service c. Outcome of assessments and therapeutic interventions d. Length of care by the service e. Proportion of patients achieving their expected date of discharge from the service f. Number and destination of transfer of care from the service g. Key quality and performance indicators	N	Regular collection and monitoring of data were not in place.
SN-702	**Audit** The services should have a rolling programme of audit of: a. Achievement of expected timescales for the patient pathway b. Compliance with evidence-based clinical guidelines (QS SN-500s) c. Compliance with standards of record keeping	N	A rolling programme of audits was not yet formalised.
SN-703	**Key Performance Indicators** Key performance indicators (QS SN-701) should be reviewed regularly with Trust (or equivalent) management and with commissioners.	N	Reviewer were told that some key performance indicators (KPIs) were in place covering the number of patient transfers, referrals and assessment, but reviewers saw no evidence of monitoring or reviews of these KPI's.
SN-797	**Health and Social Care Review and Learning** The service should have a mechanism for influencing and receiving feedback from the local Health and Social Care Review and Learning Group on transfer of care from acute hospitals and intermediate care (QS SZ-798).	N	See main report.
SN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for a. Review of, and implementation of learning from, positive feedback, complaints, outcomes, incidents and 'near misses' b. Review of, and implementation of learning from, published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	N	Arrangements for multi-disciplinary review and learning as defined the Quality Standard were not yet in place.

Ref	Standard	Hollycroft Nursing Home	
		Met?	Comment
SN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	N	Some documentation seen by the reviewers was not document-controlled.

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COMMISSIONING

Ref	Standard	Met?	Comment
SZ-601	**Commissioning of Services** Commissioners should commission intermediate care services for people at home and intermediate care services with beds sufficient for the needs of their population and should specify: a. Criteria and arrangements for acceptance by each intermediate care service, including the use of 'Trusted Assessors' (QS SM-202) b. Time limit for provision of intermediate care service c. Type of care, rehabilitation and re-ablement provided, in particular, whether care is available for patients needing: i. 24/7 on-site care (community hospital or care home) ii. Overnight care (night-visiting or night sitting) iii. Intravenous therapy iv. PEG feeds v. Care for dementia or significant cognitive impairment vi. VAC therapy and other complex wound care d. Arrangements for supply of medication, dressings and continence aids, equipment, adaptations and assistive technology within expected timescales (QS SM-301 and SN-302) e. Short-term health and social care support comprising up to four visits per day for at least 72 hours after returning home (QS SM-302 and SN-302) f. Key performance indicators for each service g. Any specialist care not normally available in the local area for which specific funding decisions are required	N	Evidence for this Quality Standard was not available during the visit but was provided to WMQRS following the review. a; was met with the exception of the use of Trusted assessors. Criteria were in place for step down from the Acute Trust into Intermediate care beds and Intermediate care at home. A referral pathway was in place for GP's to access Intermediate care beds or Intermediate care at home. b; the time limit for ITC was set at two weeks. c; rehabilitation and re-ablement was provided in the step down facilities. d; the operational policy in place clearly states the requirements for arranging medication and other supportive equipment to ensure a proactive re-ablement plan for Intermediate care patients. e; reviewers were unable to ascertain if this element of the standard was consistently accessible for Intermediate care patients at home. f; there were no key performance indicators for each service collated.

Ref	Standard	Met?	Comment
SZ-602	**Local Enabling Agreements** Health and social care commissioners should have local enabling agreements covering: a. Care package continuity during hospital admission b. Flexibility of re-start following hospital admission c. 'Discharge to assess' d. Cross-boundary agreements e. Single assessment process f. Arrangements for assessment and transfer of care for patients not resident in the local area, and reciprocal arrangements for local patients admitted to hospitals outside the local area	N	Pathways to ensure continuity of care packages were in place. A referral pathway for Dudley GPs to refer to intermediate care 'step down' patients in Dudley was also available. Similar processes for cross boundary arrangements were not yet in place. 'Discharge to Assess' was starting to be used across the health economy but there was no evidence of a single assessment process. 'f' was not met and protocols for managing 'out of area' patients were not clear.
SZ-701	**Quality Monitoring** Commissioners should monitor key quality and performance indicators for: a. Transfer of care from acute hospitals (QS SM-701) b. Intermediate care services (QS SN-701)	Y	A report was collated monthly which detailed all the patients transferred from acute hospital care to intermediate care. A detailed report on patients referred into specific intermediate care facilities was also available.
SZ-798	**Health and Social Care Review and Learning Group** Arrangements for transfer of care from acute hospitals and intermediate care should be discussed with all relevant local services at least annually in order to review positive feedback, complaints, outcomes, incidents and 'near misses', identify and address problems, and identify improvements that could be made.	N	A robust process for review and learning with all relevant local services was not yet in place. Reviewers were told that review and learning was covered by the 'Better Care' Fund work but this did not appear to meet the requirements of the Quality Standard. See also main report.

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