Ashfield House - Ashby-de-la-Zouch

Quality Report

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

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

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

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

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

Overall summary

Services we do not rate

We regulate independent community health services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Staff were aware of their roles and responsibilities in the reporting and management of incidents.
- The service had not reported any incidents from March 2016 to March 2017.
- Staff were knowledgeable about the duty of candour policy and could describe what actions needed to be taken when applying this legislation.
- The service ensured the health and safety of its employees. The office premises were well maintained and visibly clean. We observed security arrangements that protected the staff and premises.
- We saw there was an effective system in place to protect patient information.
- The provider had an infection control standard operating procedure which staff were knew and followed

Summary of findings

- There were effective risk assessment processes in place.
- The service had a 'travel emergency response' plan which identified actions to manage any risks in the event of a disaster or a major event where the provider's ability to provide the infusion service was severely compromised. The managers and staff we spoke with were aware of the Travel Emergency Response plan.
- Patients attending the service were assessed on referral and the times and dates for the infusion regime identified.
- All patient details were stored on an electronic patient record system (EPRS) and were also available off-line.
- Staff had regular clinical supervision with their peer group.
- The service had access to all the information needed to deliver effective treatment. This included risk assessments, care plans, case notes and test results
- The provider had a standard operating procedure (SOP) for obtaining consent. This provided clear guidance on the on the legal and practical implications of consent to examination or treatment by an Ashfield Healthcare employee, and the recording and use of patient confidential information.
- Patients we spoke with said they were treated with compassion and respect and staff were caring in all interactions we observed.
- Staff took time to explain the treatment to patients.
- Staff were responsive to the emotional wellbeing of patients, allowing additional time for support to patients.
- Relationships between people who used the service, those close to them and staff were strong, caring and supportive.
- The service had an equal opportunities policy and a standard operating procedure to define the process for the delivery of healthcare services to patients who did not speak English as a first language.
- Patients we spoke with told us the service was flexible and met their needs. Appointments for treatments were arranged to suit the patients and could be reorganised within reasonable limits and different geographical locations within the United Kingdom.
- Patients were seen within their homes following three completed risk assessments before each infusion.
- There were no complaints for this service for the period January 2016 to January 2017.
- The organisation had a clear strategy for the service.
- The organisation had clear vision and values. Managers developed the vision and values in consultation with staff through a series of workshops and events. All staff we spoke with knew about and demonstrated enthusiasm for the vision and values.
- Staff we spoke with spoke positively about managers.
- There were high levels of staff satisfaction and engagement. Staff were proud to work for the organisation and spoke highly of the culture.

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

- There was no programme of specific infection or prevention control audits. We requested information from the provider about infection and prevention control audits and their outcomes but did not receive these.
- The service issued nursing staff with blood pressure monitoring equipment, thermometers for checking patients' temperatures and scales for weighing patients. The system for checking this equipment was not effective
- Whilst medicines for infusion were appropriately managed, we were not assured that there was a proper and safe process for the management of epi-pens and anaesthetic spray.
- Whilst staff were knowledgeable about how to protect patients from abuse, we could not be assured staff had received the correct level of training according to the intercollegiate document competency framework, which is a national recommended guidance.
- Ashfield Healthcare were initially not able to provide us with a complete overview of this service and the detailed information we requested before the commencement of the inspection.
- The service did not routinely monitor the outcomes of people's care.
- Clinical performance audits were not undertaken, which meant Ashfield Healthcare could not benchmark their service against similar providers or identify areas for improvement.
- The service undertook four organisational audits; however, these audits were not relevant to the service we were inspecting.

Summary of findings

- Although there was a clinical governance structure in place we were not assured the service leads were managing all of the risks to the service due to there not being any specific infection and prevention control audits or audits of equipment used.
- Prior to and during our inspection, the information provided to us by senior leaders was not always correct and consistent. We were concerned the senior leaders did not appear to understand how their service came under the scope of regulation.
- Following this inspection, we told the provider that it should make improvements to help the service improve. Details are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults		The service we inspected is an infusion therapy service. The medication is used to treat Crohn's disease, ulcerative colitis and rheumatoid arthritis. The infusion therapy helps to decrease inflammation associated with inflammatory bowel disease and rheumatoid arthritis. The patients were all NHS patients referred to a pharmaceutical company who then outsourced the referral to Ashfield Healthcare. When patients begin receiving treatment, they are usually prescribed treatments at eight week intervals after the first infusion.

Summary of findings

Contents

Ashfield House

Services we looked at:
Community health services for adults;

Summary of this inspection

Background to Ashfield House - Ashby-de-la-Zouch

Ashfield Healthcare Limited is a countrywide service providing specialised nurses and clinical nursing services to the National Health Service (NHS), independent hospitals, primary medical services and care homes. Nursing service and education can be provided within a patient's home. Ashfield Healthcare Limited is commissioned to deliver a range of health care programmes to people in their own homes or remotely (via telephone) only one of which is regulated by the Care Quality Commission. The registered service we inspected was the infusion service administered to patients in their own home or their own choice of treatment location.

The provider recruits and employs qualified nurses to deliver the specialist nursing care and treatments countrywide.

Ashfield Healthcare has been registered for diagnostic and screening procedures, nursing care, and the treatment of disease, disorder and injury since October 2010.

The service we inspected is an infusion therapy service. The medication is used to treat Crohn's disease, ulcerative colitis and rheumatoid arthritis. The infusion therapy helps to decrease inflammation associated with inflammatory bowel disease and rheumatoid arthritis.

The medication is injected into a vein, a procedure called an infusion. Infusions take place for approximately two to three hours in the patient's home. The infusions are typically given every eight weeks.

When patients begin receiving treatment, they are usually prescribed treatments at eight week intervals after the first infusion.

The patients were all NHS patients referred to an external home care company who then referred them to Ashfield Healthcare. The homecare company also delivered the medication to the patients home.

The patient remained under the care of the NHS consultant at the local acute NHS trust. All patients had a named nurse within the NHS trust. We carried out a comprehensive inspection between 21 and 29 March 2017 to review the service arrangements for independent community health services. This was a routine planned inspection.

There had been one previous inspection of this organisation in February 2014. This inspection was part of our previous inspection programme and was rated overall as good. Although we continue to regulate this service we do not currently have a legal duty to rate it.

This organisation has one location: Ashfield House, Ashby-de-la Zouch, which serves as the administrative location for Ashfield Healthcare Limited.

The intravenous infusion service was for any patient over 12 years of age, who had been prescribed it by their hospital consultant and had already received five or more infusions in hospital without any complications.

Our inspection team

The team that inspected the service comprised a CQC Inspection Manager, two CQC inspectors and one specialist advisor.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive community health inspection programme.

Summary of this inspection

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

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

Before the inspection visit, we reviewed information that we held about the location.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005 and other legislation.

During the inspection we looked at a range of policies, procedures and other documents relating to the running of the service. We reviewed four care records and spoke with six patients, two relatives and 11 staff including nurses, managers and senior managers. We also received nine 'tell us about your care' comment cards which patients had completed prior to our inspection.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate independent community services.

We found the following areas of good practice:

- Staff were aware of their roles and responsibilities in the reporting and management of incidents.
- The service had not reported any incidents from March 2016 to March 2017.
- Staff were knowledgeable about the duty of candour policy and could describe what actions needed to be taken when applying this legislation.
- The service ensured the health and safety of its employees. The office premises were well maintained and visibly clean. We observed security arrangements that protected the staff and premises.
- We saw there was an effective system in place to protect patient information.
- The provider had an infection control standard operating procedure which staff were knew and followed
- There were effective risk assessment processes in place.
- The service had a 'travel emergency response' plan which identified actions to manage any risks in the event of a disaster or a major event where the provider's ability to provide the infusion service was severely compromised. The managers and staff we spoke with were aware of the Travel Emergency Response plan.

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

- There was no programme of specific infection or prevention control audits. We requested information from the provider about infection and prevention control audits and their outcomes but did not receive these.
- The service issued nursing staff with blood pressure monitoring equipment, thermometers for checking patients' temperatures and scales for weighing patients. The system for checking this equipment was not effective
- Whilst medicines for infusion were appropriately managed, we were not assured that there was a proper and safe process for the management of epi-pens and anaesthetic spray.

Summary of this inspection

- Whilst staff were knowledgeable about how to protect patients from abuse, we could not be assured staff had received the correct level of training according to the intercollegiate document competency framework, which is a national recommended guidance.

Are services effective?

We do not currently have a legal duty to rate independent community services.

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

- Ashfield Healthcare was not taking an overview of this service and therefore was not able to provide detailed information.
- The service did not routinely monitor the outcomes of people's care.
- Clinical performance audits were not undertaken, which meant Ashfield Healthcare could not benchmark their service against similar providers or identify areas for improvement.
- The service undertook four organisational audits; however, these audits were not relevant to the service we were inspecting.

However we also found the following areas of good practice:

- Patients attending the service were assessed on referral and the times and dates for the infusion regime identified.
- All patient details were stored on an electronic patient record system (EPRS) and were also available off-line.
- Staff had regular clinical supervision with their peer group.
- The service had access to all the information needed to deliver effective treatment. This included risk assessments, care plans, case notes and test results
- The provider had a standard operating procedure (SOP) for obtaining consent. This provided clear guidance on the on the legal and practical implications of consent to examination or treatment by an Ashfield Healthcare employee, and the recording and use of patient confidential information.

Are services caring?

We do not currently have a legal duty to rate independent community services.

We found the following areas of good practice:

- Patients we spoke with said they were treated with compassion and respect and staff were caring in all interactions we observed.

Summary of this inspection

- Staff took time to explain the treatment to patients.
- Staff were responsive to the emotional wellbeing of patients, allowing additional time for support to patients.
- Relationships between patients who used the service, those close to them and staff were strong, caring and supportive.

Are services responsive?

We do not currently have a legal duty to rate independent community services.

We found the following areas of good practice:

- The service had an equal opportunities policy and a standard operating procedure to define the process for the delivery of healthcare services to patients who did not speak English as a first language.
- Patients we spoke with told us the service was flexible and met their needs. Appointments for treatments were arranged to suit the patients and could be reorganised within reasonable limits and different geographical locations within the United Kingdom.
- Patients were seen within their homes following three completed risk assessments before each infusion.
- There were no complaints for this service for the period January 2016 to January 2017.

Are services well-led?

We do not currently have a legal duty to rate independent community services.

We found the following areas of good practice:

- The organisation had a clear strategy for the service.
- The organisation had clear vision and values. Managers developed the vision and values in consultation with staff through a series of workshops and events. All staff we spoke with knew about and demonstrated enthusiasm for the vision and values.
- Staff we spoke with spoke positively about managers.
- There were high levels of staff satisfaction and engagement. Staff were proud to work for the organisation and spoke highly of the culture.

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

Summary of this inspection

- Although there was a clinical governance structure in place we were not assured the service leads were managing all of the risks to the service due to there not being any specific infection and prevention control audits or audits of equipment used.
- Prior to and during our inspection, the information provided to us by senior leaders was not always correct and consistent. We were concerned the senior leaders did not appear to understand how their service came under the scope of regulation.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

Safety performance

- The service did not use any internal or external information to monitor safety performance. There were no safety goals, records of safety related practices or audits of compliance. This meant the service could not compare themselves to similar services.

Incident reporting, learning and improvement

- The service reported no serious incidents and no never events from March 2016 to March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- However the service provided other services not regulated by the Care Quality Commission. We saw the reporting of incidents through those processes.
- Staff were aware of their roles and responsibilities for raising concerns, recording and reporting safety incidents and near misses.
- We observed nurses discussing safety issues with a patient and recording any identified concerns or actions taken.
- The service had a risk management framework which staff were knowledgeable about, as well as a clinical service risk register form for recording all clinical risks and a risk register.
- The service reported no serious incidents and no never events from March 2016 to March 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff we spoke with were aware of how and when to report incidents through the electronic reporting system. Staff told us of an open, 'no blame' culture when reporting incidents. However, nobody we spoke with could remember when an incident had last happened.

Duty of Candour

- Staff were knowledgeable about the duty of candour policy and could describe what actions needed to be taken when applying duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. However, both staff and managers reported they had not had an incident which might fit into the scope of the 'duty of candour' principles.
- We asked staff and managers of their understanding of the principles and they understood the principles of their duty. We also asked staff about the principles of openness and transparency and they stated this was part of the culture of the service.

Safeguarding

- The Care Quality Commission received no safeguarding alerts or concerns in relation to the provider from January 2016 to January 2017.
- The service had a standard operating procedure (SOP) for both vulnerable adults and child protection. The child protection SOP detailed how the provider would work with the local safeguarding authority and families to promote the welfare of children.

Community health services for adults

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. Staff confirmed they had not had reason to report any safeguarding concerns at the time of our inspection. They were able to describe incidents that may require a referral to the local safeguarding authority and detailed what actions would be taken to ensure patient safety.
- The service had a safeguarding lead who was also trained to the equivalent of level two for safeguarding children and adults. Level two safeguarding training is the minimum level required for non-clinical and clinical staff who have some degree of contact with children and young people and their parents or care givers.
- Staff said they had received mandatory training in safeguarding children and vulnerable adults. Data showed 100% of staff were trained to level two in adult and children's safeguarding. The training included children and vulnerable adults. The syllabus covered topics such as child sexual exploitation, modern day slavery, female genital mutilation (FGM) and PREVENT (anti-terrorism training). FGM is also known as female genital cutting and female circumcision and is the ritual removal of some or all of the external female genitalia. This normally happens in children, but can also happen to adults.
- However, the service gave us conflicting information regarding the numbers of patients under the age of 18 on the programme. At the time of our inspection we believe there was one young person receiving treatment under a pilot scheme in England. As the requirements for safeguarding training differ according to the age of patients we could not be assured staff had received the correct level of training according to the intercollegiate document competency framework.

Medicines

- The service provided an intravenous infusion (medicine infused directly into a vein) service to patients in their home or chosen place of treatment of a specific medication, which had been prescribed by their NHS consultant. The patient remained under the care of the consultant at the local acute NHS trust. All patients had a named nurse within the NHS trust.
- An external homecare company delivered the intravenous medicine direct to the patient's chosen place of treatment. Patients told us the medication was delivered direct to their homes at the time and date arranged. A prescription chart was sent with the medication from the external home care company in order for the infusion to be administered. The service did not directly manage any medications or prescriptions. These were provided by the patient's consultant and the external home care company who would ensure delivery of the medication to the patient prior to the patient's appointment on the day of the intravenous infusion. The medication had to be administered within 12 hours of delivery otherwise it would need to be disposed of. None of the staff we spoke with were able to recall a time when the drug had not been infused as planned.
- The only medication nurses routinely carried were epi-pens for treatment of anaphylaxis (allergic reactions), anaesthetic spray (for numbing the skin prior to inserting cannulas) and small vials of saline used to flush cannulas to make sure they were working properly. A cannula is a fine plastic tube approximately two inches in length that is placed into the patient's' vein where an infusion is administered, using a needle to introduce it in. The needle is then removed leaving the cannula in the vein, held in place with a dressing. The infusion is then attached to and administered through the cannula.
- We checked the equipment stored in the boot of a nurse's vehicle. We found three items had expired; a paediatric epi-pen, a can of anaesthetic spray and a vial of saline. We escalated this to service leads at the time of the inspection, who disposed of the items and commenced an investigation. We received an update from the service regarding this investigation and were assured that an effective process had been created to ensure the proper and safe management of these items of medication.
- Staff directly corresponded with a patient's named nurse at the local hospital if they identified any need for variations to the medication. For example, if a patient's infusion regime needed to be changed.

Environment and equipment

- The organisation's business base was in Ashfield House, Leicestershire. The premises was an administration centre only. Patients were seen in their own home, place of work, chosen place of treatment or other clinical establishments, for example GP surgeries.

- The service ensured the health and safety of its employees. The office premises were well maintained and visibly clean. We observed security arrangements protected the staff and premises.
- The service owned four infusion pumps, which allowed the medication to be given at a controlled rate. We checked one of these pumps and saw it had been recently safety checked and calibrated. This meant staff could be confident it was safe to use. Staff told us they could hire additional pumps from an equipment company if required.
- The service issued nursing staff with company cars, mobile phones and tablet style computers. In addition they carried blood pressure monitoring equipment, thermometers for checking patients' temperatures and scales for weighing patients. We checked the equipment carried by one of the nursing staff and saw the equipment appeared visibly clean. However, there was no indication of when the equipment was last calibrated or checked. This meant we were not assured the equipment was working properly. We escalated this to the provider who commenced an immediate investigation, which resulted in corrective and preventative actions for staff to adhere to.
- The provider undertook annual observed practice audits on all nursing staff administering the infusion service. The provider gave us evidence of four examples of these dated February to April 2016. As part of the audit there was a question on the correct care of equipment. All of the audits were ticked as compliant. The provider told us from May 2017 they were planning to carry out observed practice audits on a monthly basis instead of annually.
- The external home care company provided patients with bins for the safe disposal of sharps and arranged for their collection.

Quality of records

- We saw there was an effective system in place to protect patient information. Nursing staff did not carry paper records for their patients. All patient details were stored on an electronic patient record system (EPRS) and were also available off-line. This meant if nurses were unable to access the internet in a patient's home, they were still able to access all essential information to enable them to undertake the infusion.
- The EPRS system was password protected and nursing staff were only able to access records of those patients allocated to them.
- Patients had a copy of their treatment record supplied by the pharmaceutical company. This was left with the patient, so other staff would be aware of the treatment plan.
- We saw that patients' consent to treatment was also recorded on EPRS using an electronic pen. Staff told us of very rare occasions when this was not able to be completed electronically. When this happened, paper copies of the consent form were completed and stored in locked boxes in the boot of the nurse's car until the earliest opportunity to take them to the main office.
- All records we reviewed were legible, up to date and detailed the name of the person completing them. Records were descriptive of actions taken and treatment administered.
- Patients we spoke with confirmed nursing staff completed their computerised records contemporaneously whilst still in the home. We also observed staff completing computerised records during a home visit.
- The provider did not carry out any audits of the quality of people's care records.

Cleanliness, infection control and hygiene

- The service had a SOP to define the correct use and disposal of needles and other sharp items to reduce the risk of unintentional inoculation of healthcare workers. Staff we spoke with were knowledgeable about this SOP.
- Staff followed effective infection prevention and control principles. They were arms 'bare below the elbow' when attending patients, wore no jewellery except a wedding ring, and long hair was tied back.
- The service had a uniform policy. Staff washed their own uniforms at home using a hot cycle (above 60 degrees). Staff told us they wore uniform on patient visits which included being bare below the elbows.
- We saw all equipment was appropriately cleaned after use. This reduced the risk of passing infections between patients.
- We observed nursing staff using personal protective equipment including aprons and gloves, for direct patient care. These items were disposed of in the patient's own waste bin.

- During a home visit, we observed staff disposing of needles in the appropriate way using the sharps box at a patient's home.
- We observed staff washing their hands and using hand cleansing gel prior to, and after patient contact. Patients we spoke with confirmed that nursing staff washed their hands and used cleansing gel prior to commencing any procedures. The provider did not routinely audit hand hygiene practices.
- At the time of our inspection, there was no infection control lead for the organisation. Staff said they would always ask their regional manager for advice or support as necessary.
- The service did not routinely carry out specific infection or prevention control audits. However, annual observed practice audits did include elements of infection prevention control. We did not see evidence of action planning as a result of these audits. This meant the provider was potentially missing opportunities to make improvements. We requested information from the provider about infection and prevention control audits but they did not provide any.

Mandatory training

- Staff we spoke with confirmed they had completed all required mandatory training.
- The majority of mandatory training was provided through electronic learning and completed during induction. Staff told us they were given time to complete the training.
- Senior managers told us mandatory training was completed annually to ensure competence and maintain up to date knowledge, however when we asked to see staff training records the provider did not produce them.
- Mandatory training included a number of subjects, for example consent, confidentiality, manual handling and duty of candour.

Assessing and responding to patient risk

- Potential risks were taken into account when planning the service. We saw a home risk assessment protocol completed before the infusion commenced. The form included the geography of where the person lived and any animals at home.
- Nurses did not provide any other service to the patient apart from the prescribed infusion. If the nurses observed another issue they would contact the patient's named nurse or GP. For example, if a patient had developed a pressure ulcer, the nurse would refer the patient for treatment but would not treat the condition themselves.
- Due to the type of service, staff were able to spend quality time with the patients and form relationships. This meant that any changes in physical or mental health were easily identified.
- Staff told us they undertook a risk assessment seven days, 72 hours and just before the infusion commenced to make sure the person was well enough to receive the infusion. If the nurses had any concerns they would seek support and advice from the nurse manager, specialist nurse or consultant at the local NHS trust responsible for their health and treatment.
- We observed during our visit the electronic records were updated when people's needs changed or new risks were identified.
- The service had a standard operating procedure SOP for cardiac or respiratory arrest. The purpose of this procedure was to provide guidance on the actions required to ensure cardiopulmonary resuscitation (CPR) was attempted correctly in the event of a patient suffering from a cardiac arrest, in the presence of an Ashfield Healthcare clinical professional.
- Staff told us they used the DAS 28 (measure of disease activity in rheumatoid arthritis) and Harvey Bradshaw Index (a research tool used to quantify the symptoms of patients with Crohn's disease) when assessing patients. They also monitored conditions related to the medication for example leg ulcers or ulcers.

Staffing levels and caseload

- At the time of our inspection, there were 12 nursing staff working within the infusion programme across the UK including Scotland, Wales, England and Northern Ireland. In addition, there were two regional managers, one for the north of England, and one for the south. There were 84 patients throughout the United Kingdom on the infusion programme. Documentation showed the nursing teams were working at a 77% capacity level and were able to accept new referrals.
- The service had a team of nurses located in different areas of the country. People who required treatment were referred to the team from the named consultant and/or specialist nurse from the local NHS trust.

- All of the nurses on the infusion programme were fully qualified. The service employed nurses with the relevant specialist qualifications and experience that were required for the role.
- Staff told us specific training, competency assessment and validation were supplemented by continuing education as required by each programme and training needs analysis.
- Nursing staff, who were all home based, looked after patients within their region instead of having a caseload.
- Staff were able to cover each other's patients during periods of absence either planned or unplanned and staff working outside of England might also look after patients in England and Wales on occasion.
- All of the nurses were permanent staff. The provider told us they did not use agency or bank staff.

Managing anticipated risks

- Patients receiving home treatment remained under the care of the referring NHS health care professional (HCP). Staff told us they would always contact the HCP after the infusion and also in the event of any concerns regarding the patient or their treatment. For example, we observed during our visit the electronic records were updated when people's needs changed or new risks were identified.
- There were exclusion criteria for the nursing service offered. Each patient referred into the service must have had at least five infusions within the hospital setting so the HCP responsible for their care would have assurance the patient's condition was stable.
- Nursing staff phoned the patient seven days prior to the treatment date to check the patient was well and to confirm blood tests had been taken. They told us if the patient had been unwell, or if blood tests were abnormal, the treatment would not proceed and the referring HCP would be contacted.
- We saw patients' observations were monitored before, during and after infusion. Observations were taken at least half hourly during the infusion. Nursing staff followed the individual procedures for the hospitals prescribing the treatment. This would dictate the length of time of the infusion and how long the nursing staff stayed after the infusion was finished to check if the patient had undergone any reaction to the treatment.
- The service had a lone working policy which staff were knowledgeable about.

Major incident awareness and training

- The service had a 'Travel Emergency Response' plan which identified actions to manage any risks in the event of a disaster or a major event where the provider's ability to provide the infusion service was severely compromised. For example, in the event of adverse weather, or a terrorism incident where staff were unable to attend the planned appointments, staff would ring the patient and the pharmaceutical company. Managers and staff we spoke with were aware of this plan.

Are community health services for adults effective?

(for example, treatment is effective)

Evidence based care and treatment

- Due to the small size of the service, there were a limited number of service specific policies in place. We saw policies that referenced guidance to ensure patient and staff safety.
- The standard operating procedures (SOPs) adhered to the Association of British Pharmaceutical Industry (ABPI) Code of Practice 2016. The Code sets standards for the promotion of medicines to health professionals and other relevant decision makers in the UK. It includes requirements for the provision of information to patients and the public and relationships with patient groups.
- We saw documentation and staff told us they used the DAS 28 (measure of disease activity in rheumatoid arthritis) and Harvey Bradshaw Index (a research tool used to quantify the symptoms of patients with Crohn's disease) when assessing patients. They also monitored conditions related to the medication for example leg ulcers or sores.
- Staff who worked remotely had working access to advice about guidelines and protocols via the electronic system.
- Staff told us they used the SOPs and guidelines when planning care for each patient and gave verbal examples of how they ensured each patient received treatment based on current best practice. Patients were treated without discrimination, and this was evident from the variety of patients treated by the service.

Pain relief

- Staff assessed pain during each treatment and advised patients accordingly. For example, patients were encouraged to take pain control prior to their appointment. Pain and pain medicine was recorded within the patient's records on each visit. One patient told us the nurses always asked if they wanted to take any pain relieving tablets before the infusion commenced.
- Staff had anaesthetic sprays (used for numbing the skin prior to inserting cannulas). These were used before commencing the infusion as required.

Nutrition and hydration

- Due to the nature and location of the treatment, nutrition and hydration was not routinely assessed however, on a home visit, we did observe staff asking the patient if they wanted a cup of tea and something to eat before the infusion.

Technology and telemedicine

- All patient details were stored on an electronic patient record system (EPRS) and were also available off-line. This system was password protected and nursing staff were only able to access the records of those patients allocated to them.
- A copy of the patient's treatment record was left with the patient, so other staff would be aware of the treatment plan.
- Patients' consent to treatment was also recorded onto the EPRS using an electronic pen. Staff told us of very rare occasions where this was not able to be completed electronically, then paper copies of the consent form could be completed in this instance

Patient outcomes

- Ashfield Healthcare was not able to provide detailed information about the service we were inspecting
- The service did not formally measure patient outcomes; however, it recorded information relating to the total numbers of patients seen. There were 16 new patient referrals for England for the service during 2016.
- The service did not routinely monitor the outcomes of people's care, or benchmark themselves against other providers.
- Clinical performance audits were not undertaken, which meant the service could not benchmark their service against similar providers or identify areas for improvement.
- There were no national audits applicable to this service.

Competent staff

- All the nurses on the infusion team were governed by the Nursing and Midwifery Council (NMC) Code of Practice and were subject to registration, qualification and reference checks, pre-employment medical screening and Disclosure and Barring checks (enhanced disclosure) on employment and every two years thereafter.
- We saw evidence that demonstrated nurses and nurse managers ensured their professional registration by maintaining their continuous professional development through training, attending conferences, reading new guidance and participating in relevant research into clinical excellence. This meant people using the service could be confident that the quality of treatment they received was monitored and provided by qualified professionals. Staff were required to validate their qualification to undertake infusions every year. Validation ensured staff were up to date with competencies and mandatory training.
- The service had a standard operating practice for clinical supervision. Staff told us they had regular clinical supervision with their peer group. This was done as a group session on a three monthly basis where possible. Staff told us they performed a 'mock' infusion at the last meeting so they could be assured of consistency of clinical skills.
- Staff told us they received regular (at least monthly) field development check visits from their managers to support and confirm their competence. We reviewed two field development check visit assessments as part of our inspection.
- Staff told us they received a comprehensive induction and mentorship programme over the space of three months. We reviewed the corporate induction programme from which staff received information and guidance on topics including accessing policies and procedures, information governance, incident and adverse event reporting and health and safety including safe driving and lone working.
- All staff we spoke with confirmed they had received a meaningful appraisal within the previous 12 months. We checked the appraisals of three staff members and saw they were fully completed and up to date.

Community health services for adults

Multi-disciplinary working and coordinated care pathways

- The patient's NHS consultant had overall responsibility for the management of the patient's condition and their treatment. The service liaised with the patient's consultant and nominated NHS nurse when necessary, informing them of any changes to their clinical condition, any identified concerns or when treatment was completed. Ashfield Healthcare Nurses were involved with the planning of the treatment only. For example, administering the infusion and planning for the next infusion.
- The nurses coordinated care with specialist nurses and medical staff at the NHS hospital responsible for the patient's care. Staff told us they would ring the hospital if they identified any concerns relating to the wellbeing of the patient.
- Nursing staff would visit the hospital where newly referred patients were having their final infusion in order to receive a comprehensive handover from the specialist NHS staff responsible for the patient's care.
- Nursing staff had a nominated contact nurse at their local NHS hospital who they liaised with on a regular basis concerning patient care.
- Staff described effective collaborative working and communication with their NHS counterparts.
- Patients we spoke with confirmed the Ashfield Healthcare nursing staff coordinated care with specialist nursing and medical staff at the NHS hospital responsible for their care. One patient told us "I know my nurse is always on the phone to the staff at the hospital, to check it's ok for my treatment to go ahead".
- We requested feedback from three providers who used Ashfield Healthcare as a third party provider. The one service that responded gave very positive feedback about the care and service provided by the service.

Referral, transfer, discharge and transition

- The service received referrals from the NHS via the external home care company. The service recorded how many referrals were received each year.
- The service worked collaboratively to plan on-going treatment in a timely way. Patients were referred and discharged to their NHS consultant when their clinical condition allowed.
- All patients received the service in their own homes or place of work and therefore the decision to discharge from the service was not affected by the time of day.

Access to information

- The service had an information system policy and SOP, which outlined actions staff should take to ensure they were able to access relevant patient information safely.
- The service had access to all the information needed to deliver effective treatment. This included risk assessments, care plans, case notes and test results.
- Patients had their own hand held notes; these were held where the treatment was delivered, either at work or their home or the patient's own place of treatment choice.
- All patient details were stored on an electronic patient record system (EPRS) which nursing staff in the community could access.
- Staff felt they had access to sufficient information for the patients they treated. If they needed additional information or had any concerns, they spoke with the nominated nurse at the local NHS trust.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The service had an SOP for obtaining consent. This provided clear guidance on the on the legal and practical implications of consent to examination or treatment by an Ashfield Healthcare employee, and the recording and use of patient confidential information.
- Staff understood the relevant consent and decision making requirements in law. They told us they obtained consent from patients prior to starting any treatment. The consent was recorded electronically using the electronic patient record system (EPRS).
- Staff told us they would refer back to the health care professional responsible for the patient if there were any concerns about the patient's capacity to consent to treatment.
- Patients we spoke with told us nurses always asked for consent before proceeding with treatment.
- Nurse managers we spoke with told us they made regular field visits with nursing staff. Nursing staff sought and obtained consent from the patients before taking managers on visits with them.
- We observed staff obtaining consent from a patient for the commencement of the infusion during a home visit.

Community health services for adults

- There were no patients under a Deprivation of Liberty Safeguards order (DoLS) during our inspection. The provider reported no DoLS applications in the six months at the time of our inspection.

Are community health services for adults caring?

Compassionate care

- The patients and relatives we spoke with were all very positive about the way staff treated them. Patients considered the care they received met or exceeded their expectations.
- Without exception, the patients and relatives we spoke with told us staff were exceptionally kind and caring. One patient told us 'my nurse always delivers a personal and efficient service, always friendly and caring.'
- Staff treated all patients and their relatives in a respectful and considerate manner.
- Several patients we spoke with told us 'I love my nurse'. Another patient told us that the nurse treated them 'like a friend and not just another person sitting in a chair.'
- One patient we spoke with told us they felt very comfortable discussing personal issues with their nurse. The nurse had helped the patient understand medical terms in a hospital letter for an unrelated condition.

Understanding and involvement of patients and those close to them

- Patients and those important to them told us staff gave them enough information about their care and treatment.
- We saw staff communicated with patients in a manner they understood. Time was taken to ensure patients and their relatives understood the treatment.

Emotional support

- Relationships between people who used the service, those close to them and staff were strong, caring and supportive. We observed at one home visit how a family member made a cup of tea and offered a biscuit to both the patient and the nurse, stating they always had a cup of tea when the treatment was being undertaken.
- A patient's relative told us staff encouraged them to make contact if ever they needed additional support, or had a question about the service, which gave them peace of mind. Staff contact numbers were provided to patients, with instructions to call them at any point to discuss any concerns.
- Staff demonstrated a clear understanding of the impact of complex medical conditions on their patients, care givers and family and were able to signpost or refer for emotional or mental health support as required.

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

Planning and delivering services which meet people's needs

- Nurses provided treatment programmes for patients with chronic autoimmune diseases, for example, Crohn's disease or rheumatoid arthritis. The health professional responsible for their care within the NHS referred patients into the provider's nursing service. Patients received a visit from the nurses and an intravenous (IV) infusion every eight weeks.
- Patients attending the service were assessed on referral and the times and dates for the infusion regime identified. Staff planned implemented and evaluated care regularly to ensure effectiveness. When necessary treatment was changed to address any changes in clinical condition.
- The infusion service was available to children under the age of 18, but at the time of our inspection there was one child children still within the programme, nationwide.

Equality and diversity

- The service had an equal opportunities policy and a standard operating procedure to define the process for the delivery of healthcare services to patients who did not speak English as a first language.
- The service provided treatment to any patient requiring it as long as they fitted the referral criteria, without regards to their gender, religious beliefs or ethnicity.
- The service had access to telephone translator services; however, staff reported there had been no occasions where this had been used.

Community health services for adults

- Patients receiving the service were offered written information about their treatment and care plans, which could be translated into non-English languages if necessary.
- All staff had received equality and diversity training as part of their mandatory or induction training

Meeting the needs of people in vulnerable circumstances

- The service was for any patient over 12 years of age, and who had been prescribed the infusion by their hospital consultant. Due to the nature of the infusion, people classed as vulnerable were not accepted onto the regime. For example, patients who had a diagnosis of dementia, patients with tuberculosis or other severe infections and patients with moderate or severe heart failure.
- Nurses worked Monday to Friday from 9am to 5pm or 9am to 6pm. Staff gave patients information cards with contact details of their named nurse. Staff provided patients with telephone numbers of services outside of working hours to ensure patients and care givers knew whom to contact in an emergency.
- The service offered a bespoke appointment system which enabled additional time to be spent with patients.
- Patients we spoke with told us the service was flexible and met their needs. Appointments for treatments were arranged to suit the patients and could be reorganised within reasonable limits. One patient told us they had planned to be away from home in another region of the country at the time of one of the planned treatments. Their nurse had organised for the treatment to be carried out by another colleague in that region in order to suit the patient's travel plans.
- One patient we spoke with told us they had difficulty getting up on the morning of their planned treatment. When learning of this, the nurse had arranged for the patient to always receive a text message one hour prior to the delivery of the medication, which the patient greatly appreciated and found helpful.
- We saw a service user guide which was a leaflet containing information to help the patient and care giver understand the service they would be receiving and how the provider would work with the local NHS trust.

Access to the right care at the right time

- The service provided was through NHS health professional referral only. There was no national referral to treatment time measures for this service.
- Patients referred to the service were deemed fit and therefore prioritisation of treatment was not necessary.
- The treatment was administered every four, six or eight weeks. The next appointment was made with the patient at the end of every treatment and recorded on the patient electronic patient record system (EPRS) as well as the patients hand held notes.
- Patients had the number of their NHS health care provider, as well as the number of their Ashfield healthcare provider nurse should they need to contact them.

Learning from complaints and concerns

- There were no complaints for this service during the past year for the period January 2016 to January 2017.
- The service had a standard operating procedure in place for recording complaints or concerns, and also had a process whereby patient feedback was collected.
- Patients were given a service user guide which detailed the service that was being provided to them and told them how to complain should they be dissatisfied with the service. Patients we spoke with confirmed they had received information about how to make a complaint during their first contact with nursing staff.

Are community health services for adults well-led?

Leadership of this service

- There was a clear structure of leadership within the organisation, overseen by a board of directors. The managing director had overall responsibility and worked closely with the legal, clinical and quality service teams.
- All staff were positive about the senior leadership team and told us they felt supported and respected in their work and were encouraged to participate in career progression. Staff said both the regional managers were approachable and visible, and they motivated and cared about staff.
- Managers were available and were visible. Staff told us they could speak in confidence with the managers about any issues of concern.

- The organisation had a fit and proper person requirement (FPPR) policy, which contained the criteria and processes for checking whether current and newly recruited board members were fit for their role. This included a checklist of evidence required and a self-declaration form. The FPPR places a requirement on providers to ensure directors and board members are fit and proper to carry out these roles.
- We checked the employment files of three directors. We saw the organisation had collected evidence in order to assess the fitness of directors to undertake the role. We noted the pre-employment health section had been ticked; however, evidence of this was not on the employee files we reviewed. We raised this with the Human Resources director who advised she would address this immediately
- Service leads contributed positively to the inspection process by identifying patients who were willing to allow us to accompany nurses on home visits and by providing a list of patients who were happy for us to telephone them to discuss their experience of the service. This meant we could talk to more patients and relatives and obtain a wider range of feedback about the service.
- Prior to and during our inspection, the senior leaders did not appear to fully comprehend their responsibilities to provide information to the inspection team, or define the service in a timely way. The information provided to us by senior leaders was not always correct and consistent. We were concerned the senior leaders did not appear to understand how their service came under the scope of regulation.

Service vision and strategy

- The provider's strategy of Quality, Partnership, Ingenuity, Expertise and Energy: 'The Ashfield Way' were displayed throughout the headquarters. This was an effective and realistic strategy, which prioritised the core mission which was 'to improve lives' and incorporated the values which defined how the provider undertook care and treatment.
- The strategy outlined details of the strategic focus, mission statement, purpose, goals, target customers, healthcare professionals, medicines, knowledge and support.
- The 'Ashfield Way' strategy was also available as a short animation programme for both staff and for the public on social media.
- Staff were knowledgeable of the provider's strategy and the values involved.

Governance, risk management and quality measurement

- There was a clear organisational structure and systems in place to ensure the service operated effectively.
- The provider had a number of detailed standard operating procedures (SOPs). For example health and safety, administration of medicines, complaints and incident reporting and a lone workers policy.
- There was a clear governance structure in place with committees such as clinical governance, operations delivery and legal and quality.
- Clinical governance meetings took place on a monthly basis. The issues discussed at the meetings included quality, safety, safeguarding, and patient experience and complaints. All of these issues were then referred to the provider's Quality and Compliance department for review.
- Documentation showed that all clinical incidents for both the regulated and unregulated services were reviewed and analysed by the head of quality and compliance and the registered manager. All such incidents were reviewed on a three monthly basis at the clinical governance meetings. There were no incidents for this service at the time of our inspection.
- There was a feedback mechanism from governance meetings which included monthly bulletins highlighting learning from incidents. Staff told us they received these electronically.
- All patients were provided with the opportunity to feedback on the quality of the service they had received from the provider. The feedback was collated by each respective project manager and both analysed and discussed during every clinical governance meeting.
- The provider had a quality department manager, who was responsible for the maintenance, review and implementation of the quality management framework across the UK and Ireland.
- The provider had an anti-bribery policy, a conflict of interest policy and an ethics in practice code of conduct policy to ensure that business was conducted in an open, honest and ethical way.
- We reviewed the clinical governance meeting minutes for November 2106. The meeting identified an infection control lead was urgently required. At the time of our

inspection, this post had not been filled. There was also no infection control internal audit programme for the infusion treatment regime. We checked on the risk register, but could not see where this was recorded.
- Staff and managers worked with the patients and NHS trust to improve care and outcomes for patients. However, they had not benchmarked their outcomes. This meant the provider was unable to provide evidence of any treatment results.
- Although there was a clinical governance structure in place we were not assured the service leads were managing all of the risks to the service due to there not being any specific infection and prevention control audits or audits of equipment used.

Culture within this service

- The service had a clear vision and strategy based on patient centred care and the quality of patient care. We saw that the philosophy referred to the delivering of treatment within the patient's home.
- All staff we spoke with had an awareness of the values that were being promoted.
- Nursing staff reported an open and transparent culture within the organisation. They reported good engagement with managers and felt they were able to raise issues and these would be acted on.
- There was a sense of friendliness and companionship within all grades of staff.
- All of the managers we spoke with said they were proud of the nursing teams..
- Staff were passionate about providing good experiences for patients and building relationships with patients using the service regularly.
- Staff told us how they were proud to work for the service. They wanted to make a difference to patients and were passionate about performing their role to a high standard.
- Staff were aware of the provider's whistleblowing procedures and what action to take if they had concerns.
- Data from a staff survey for the whole company commissioned in October 2014 indicated; 82% of nursing staff felt proud to work for the organisation. This was the most up to date survey provided by the service.

Public engagement

- Due to the nature of the infusion service, the organisation had limited public engagement pathways. This meant the provider was unable to facilitate or undertake any local patient representative groups. However, all patients were provided with the opportunity to feedback on the service they had received from the Ashfield Healthcare nurse advisor. The feedback was collated by each respective project manager and analysed and discussed during every clinical governance meeting.
- We saw that the service collected patient feedback through regular questionnaires. The information collected was very positive about the service.
- The service provided the inspection team with a list of patients, relatives and caregivers who were willing to receive telephone calls from a care quality commission inspector. We spoke with six patients and three relatives of patients who were all very positive about the service provided.

Staff engagement

- Managers engaged with staff about the infusion service and the organisation on a regular basis. Staff said they felt involved and could contribute to the way their services and the organisation was run. Managers engaged staff through team meetings, emails, briefings and face to face contact.
- Nurses we spoke with told us there were regular monthly staff meetings and that they were able to contribute to these meetings and their views were taken into account.
- Data from the staff survey for the entire organisation commissioned in October 2014 indicated; 60% of nursing staff felt they were motivated in their current role. 80% felt supported by their managers, 78% felt the senior leaders inspired them. This was the most up to date survey provided by the service.

Innovation, improvement and sustainability

- The provider was in the process of installing an internet based patient management system which would include patient identification, scheduling and a staff tracking system. This system was being piloted during our inspection. The provider was the first organisation in the United Kingdom to procure and use the service.

Outstanding practice and areas for improvement

Outstanding practice

- The provider was in the process of installing an internet based patient management system which would include patient identification, scheduling and a staff tracking system. This system was being piloted during our inspection. The provider was the first organisation in the United Kingdom to procure and use the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider how they comply with the requirements of the intercollegiate document for safeguarding training of their staff involved with the care and treatment of young people under the age of 18 years.
- The provider should consider a programme of infection and prevention control audits to assure patient safety and to identify any areas for improvement.
- The provider should commence equipment audits to ensure equipment is appropriate and safe for use.
- The provider should designate an infection control lead.
- The provider should consider how they can be assured epi-pens and anaesthetic sprays are in date and safe for use.
- Consider a review of the clinical governance structure in place to seek assurance the service leads are managing all of the risks to the service and that there is a full understanding of the scope of registration for the service.