Foxbury Ward

Quality Report

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Date of inspection visit: 10 and 18 January 2017
Date of publication: 16/06/2017

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

Overall summary

This service has not been rated. The unit was previously managed by a local trust and had reopened under the management of the current provider two months prior to our inspection.

- Although the service monitored safety thermometer information, we saw no evidence of any actions taken to improve patient safety. Incidents were not reported in line with the provider's policy.
- Patient records were not always complete and comprehensive. Care plans were not routinely reviewed. In addition, some of the templates used including wound assessment charts, drug charts and observation charts were those of the local NHS trust.
- Hand hygiene audits were not carried out and there was no system in place to monitor infection rates.
- There were no ongoing audit programmes in place to monitor patient care. Some of the local guidelines developed by the provider referred to certain committees or positions that were not in place on the ward. In addition, the staff still referred to the policies of a local trust. .
- There were no targets set internally to monitor the service and to ensure it was responsive to patients' needs.
- There was no clear governance structure in place. The unit had no risk register and there were no systems in place to identify, review and mitigate risks. The provider informed us they often held senior staff meetings, but there were no formal notes taken. Therefore, we were not assured of the meetings taking place.
- There were no formal service level agreements with the GP practice that provided medical cover to the unit and the local pharmacy used for supply of medicines.

However:

- The environment and equipment were clean and supported safe care.
- There were safe staffing levels on the unit and most staff had completed their mandatory training. Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently.
- Staff provided kind and compassionate care and we received positive comments from patients. Patient's privacy and dignity was maintained.
- Staff had access to translators when needed, giving patients the opportunity to make decisions about their care, and day-to-day tasks.

Summary of findings

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Foxbury Ward

Services we looked at:
Community health inpatient services.

Summary of this inspection

Our inspection team

Inspection Manager: Margaret McGlynn, Care Quality Commission

The team included a CQC inspector and two specialist advisors.

Why we carried out this inspection

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

How we carried out this inspection

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

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

We carried out an announced visit on 10 and 18 January 2017. During the visit, we talked with people who use services. We observed how people were being cared for and reviewed care records of people who use services. We reviewed the service's records such as policies, procedures and audits.

Information about Foxbury Ward

Bridges Healthcare Limited leases Foxbury ward from a local NHS trust. It is a dedicated 28-bedded ward managed by Bridges Healthcare Limited for medically fit/ stable patients who have previously received acute medical care at a hospital working in partnership with two local clinical commissioning groups.

The unit is commissioned to provide ongoing care and support for patients who are waiting for nursing home placements or packages of care. Five beds are reserved for palliative care patients, and the remaining 23 beds are reserved for patients discharged from local trusts.

Foxbury ward was previously managed by a local trust. Whilst under the management of the local trust, the trust was responsible for the medical cover and pharmacy and nurse staffing, including training, was contracted to an external organisation.

In February 2016, Bridges Healthcare took over responsibility for the ward and became the registered provider. The ward was closed in May 2016 and reopened in November 2016. Between November 2016 and 11 January 2017, 59 patients were admitted to the unit. More than 88% of patients were aged 75 years and above. All the patients were NHS funded.

We inspected Foxbury ward on 10 and 18 January 2017. During the inspection, we observed care and treatment and looked at 22 patient records. We spoke to nine members of staff, four patients and one relative.

Summary of this inspection

What people who use the service say

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

Community health inpatient services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health inpatient services safe?

Summary

- Although the service monitored safety thermometer information, we saw no evidence of any actions taken to improve patient safety. Incidents were not reported in line with the provider's policy.
- Patient records were not always complete and comprehensive.
- The unit still referred to the policies of a local trust. Some of the local guidelines developed by the provider referred to certain committees or positions that were not in place within the service.
- Care plans were not routinely reviewed. In addition, some of the templates in use including wound assessment charts, drug charts and observation charts were those of the local NHS Trust.
- Hand hygiene audits were not carried out and there was no system in place to monitor incidents of healthcare associated infection such as clostridium difficile (C.diff) or methicillin-resistant staphylococcus aureus (MRSA).

However:

- The environment and equipment was clean and supported safe care.
- There were safe staffing levels on the ward and most staff had completed their mandatory training.
- Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Ninety-eight per cent of staff had an appraisal in the last year.

Detailed findings

Safety performance

- The NHS Safety Thermometer is a tool for measuring, monitoring and analysing patient harms and 'harm free' care on one day each month. The service's safety thermometer data showed that between 5 December 2016 and 9 January 2016, pressure ulcer incidents averaged 38%. However, these involved patients who had pressure ulcers before being admitted to the ward. Urinary tract infections during the same period were 7%. There were no incidents of falls or venous thromboembolism (VTE) during the period.
- We noted from the safety thermometer data that pressure ulcer incidents often included category three and four pressure ulcers. For example, the safety thermometer data recorded for the week commencing 9 January 2017 highlighted four pressure ulcer incidents. These included one grade two pressure ulcer, two grade three pressure ulcers and one grade four pressure ulcer. We saw no evidence of any action taken to address the pressure ulcer incidents.

Incident reporting, learning and improvement

- Staff told us incidents were reported on a paper form and escalated to senior staff. We asked the provider for a copy of the incident data and we were provided with a copy of the unit's incident form. The form indicated there had been no incidents since the unit re-opened in November 2016. The incident form was divided into four sections, namely: falls, medicine errors, major incidents and pressure areas. There was no section to record other incidents that fell outside the four categories indicated on the form, which meant some other incidents might not be recorded.
- None of the pressure ulcer incidents recorded on the safety thermometer data and highlighted within

patients notes were identified as incidents. The unit kept data showing the number of re-admissions to acute trusts. We also identified from the provider's admission and discharge data that four patients had died since the unit re-opened in November 2016.

- Bridges Healthcare's incident policy defines an incident as an occurrence, which involves a staff member, patient or visitor to Bridges Healthcare, whether it is to their person or property. The pressure ulcers, patients re-admitted to the trust and deaths were not recorded as incidents contrary to the provider's policy.
- Following the inspection, Bridges Healthcare Limited told us they now have a risk register.

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. Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient.
- Staff told us they followed the duty of candour regulations when the ward was being managed by a local trust. However, they were not sure about any recent incidents requiring the provider to discharge their responsibilities a required under the duty of candour regulations.

Safeguarding

- The provider had a safeguarding adult policy in place and staff were aware of how to access it.

  Staff indicated that they referred safeguarding incidents to the safeguarding lead within the local authority.
- There were no safeguarding incidents reported since the unit reopened in November 2016.
- . Ninety-six per cent of staff had completed level three adult and children safeguarding training; this was marginally below the provider target which stated that all staff were required to complete the adult and child safeguarding training up to level three.

Medicines

- Patients were discharged from local trusts with two weeks supply of 'to take out' (TTO) medication. The service had informal arrangements with an external GP practice and pharmacy for prescriptions and the provisions of medicines once TTOs ran out. Following the inspection the provider told us they now had a formal contract in place.
- Medicines were stored safely and securely. Medication cupboards including controlled drugs (CD) cupboards were locked. We observed that staff checked CDs on daily basis and recorded this in the CD register. Staff also monitored fridge temperatures on daily basis and recorded minimum and maximum temperatures. Staff informed us they contacted the on site pharmacy if temperatures were out of normal range.
- We saw that the allergy statuses of most patients were recorded on their medicine charts. However, one drug chart did not reflect the allergies recorded on the discharging trust's drug chart. Some of the drugs on another drug chart were not signed for. We escalated this to a staff who said she gave the medication but forgot to sign for it.
- Ninety per cent of staff had completed the medication training.

Environment and equipment

- Patients were cared for in four five-bedded bays and eight single side rooms. Two of the bays had en suite shower facilities whilst the other two had shower and toilet facilities beside the bays. Some of the single rooms also hand en suite facilities.
- There was a resuscitation trolley within the unit, however, there were no drugs or anaphylaxis kit available in the trolley. We highlighted this to senior staff and they informed us they no longer used the trolley under the new structure of the ward. They said they admitted only medically stable patients and escalate any deterioration via a 999 call.

Quality of records

- Patients' notes included nursing notes and documentation from the discharging NHS trust. All notes were in paper format and staff kept patient record folders in locked trolleys.
- We looked at a random sample of 22 patient records. Our findings indicated that the provider did not maintain accurate, complete and contemporaneous records in respect of all patients. Our review of nursing notes indicated that care plans were not always detailed and review plans were not always in place.
- Five of the notes showed that bed rails assessments were not completed correctly. No reasons were given for three of the results recorded and in one case, bed rails were implemented despite the assessment indicating that bed rails were not required. In another case, the patient was not assessed but had been given bed rails.
- At least five care plans had no review dates in place. These included care plans for two patients with necrotic heels as a result of pressure ulcers, with no grading in place. In one record, the patient had a cognitive assessment score with no indication of how staff arrived at the score. In another record, there was an incomplete food chart.
- We reviewed five records of patients living with dementia and noted cognitive assessments were documented in two of the records.
- We observed that GP documentation was kept within the patient's folder from the discharging NHS trust. Most of the GP documentation followed on from the trust's notes and we saw one use of an admission proforma.
- All staff members were up to date with information governance training.

Cleanliness, infection control and hygiene

- All areas of the ward were visibly clean and all patients we spoke with were satisfied with the cleanliness.
- Personal protective equipment (PPE), such as gloves and aprons, were available in all clinical areas. All staff observed were bare below the elbow and we observed them using PPE when required. Antibacterial hand gel was available in all areas. Hand-washing facilities were also available in all areas, including the patients' rooms.
- Equipment used on the ward, including commodes and bedpans, were clean, Staff used 'I am clean labels' to indicate an item of equipment was cleaned and decontaminated. Sharps bins were properly assembled, labelled and they were not filled above the line indicated on the bin. Curtains were labelled with the date they were last changed.
- We observed that cleaning staff followed a colour coding scheme for cleaning different areas and for waste disposal. In addition, there was a cleaning schedule for various areas of the unit.
- There were no hand hygiene audits undertaken since the unit reopened in November 2016. There were no systems in place to monitor incidents of healthcare associated infection such as clostridium difficile (C.diff) or methicillin-resistant staphylococcus aureus (MRSA). Following the inspection, the provider informed us they had developed hand hygiene audit templates and provided us with a copy.
- All staff had completed the infection prevention and control training.

Mandatory training

- Most staff were up to date with their mandatory training with staff achieving 100% compliance in 12 out of 22 mandatory training modules. These included: basic life support, clinical observations, fire safety, food hygiene, health and safety, infection control, information governance, lone worker, moving and handling, handling violence, aggression and complaints, safeguarding adults and safeguarding children training.
- Staff achieved 90% compliance with equality and diversity, medication, epilepsy and Control of Substances Hazardous to Health (COSHH). Areas of lower compliance included: dementia, first aid, manual handling, mental capacity act, and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) with 83% compliance.

- The provider had a training and development manager in post who coordinated staff training. Staff informed us they received email alerts when their mandatory training was due.

Assessing and responding to patient risk

- The ward's admission criteria excluded patients requiring active investigations or treatment. Senior staff informed us they often attended the discharging trust to assess patients' suitability for admission on the ward. Senior staff also informed us they avoided admitting patients with pressure ulcers above grade two. They confirmed they sometimes admitted patients with grade three or four pressure ulcers if there was a management plan in place, they had been seen by a tissue viability nurse (TVN) and the TVN was happy for them to be discharged.
- Staff used the National Early Warning Score (NEWS) to monitor deteriorating patients and vital sign observations were recorded in patients' notes. Staff had been trained to carry out clinical observations and staff could escalate concerns when necessary. We reviewed a copy of the escalation protocol for use out of hours. Staff were required to call 999 in the event of a patient's deterioration. If a patient became unwell and it was not life threatening, staff were required to contact a doctor to undertake clinical assessment. If a patient became unwell and staff needed support, they were required to call a senior nurse or the matron.
- Staff informed us they escalated deteriorating patients by calling the emergency services.

Staffing levels and caseload

- A matron who was also the sole director of the organisation led the unit. A ward manager and two ward sisters supported the matron. There were 82 staff employed on the ward. These consisted of four band 7 nurses, 16 band 6 nurses, 30 band 5 nurses and 32 HCAs. There were four permanent staff and the rest were bank staff. Senior staff informed us most staff preferred to work as bank staff as this offered them flexibility. They said they used the same bank staff within the ward.
- In addition to the nurse in charge, three nurses and four health care assistants (HCAs) were required to work during the day. Three nurses and three HCAs were required at night. We observed that staffing on the ward was in line with expected number of staff on the days inspected. The rota showed that staffing levels had increased as the number of patients increased. The provider did not monitor shift fill rates, they informed us that staff were always at the capacity required for the number of patients.
- The provider informed us they have open vacancies and routinely recruit nurses and HCAs.
- The provider had informal arrangement with a GP practice to provide medical cover to the ward. GPs visited the ward twice a week to assess patients and provide any medical cover required. Staff also had access to out-of-hours doctors in the community.

Managing anticipated risks and major incident awareness and training

- The provider had a business continuity plan in place, which set out how the service would respond in the event of a range of scenarios including, power cuts, civil disorder, system failure and staff sickness.
- There were no plans in place for dealing with potential risks involving patients. In response to our request for the winter management plan, the provider informed us that winter management plans were organised by acute trusts or clinical commissioning groups. They provider said they worked with them for the provision of care.

Are community health inpatient services effective?
(for example, treatment is effective)

Summary

- There were no ongoing audit programmes in place to monitor patient care.
- The service still referred to the policies of a local trust. Some of the local guidelines developed by the provider referred to certain committees or positions that were not in place within the service.
- Care plans were not routinely reviewed. In addition, some of the templates used including wound assessment charts, drug charts and observation charts were those of the local NHS trust.

However:

- Staff had received an induction to the ward and achieved specific competencies before being able to care for patients independently. Ninety-eight per cent of staff had an appraisal in the last year.

Detailed findings

Evidence based care and treatment

- Guidelines were available in paper format kept within folders on the ward. We observed that the service still referred to the policies of a local NHS trust, including: "clinical guidelines for symptom control in the adult dying patient", "incident reporting policy and procedure (including serious incidents)", "infection prevention and control policy, major outbreak of infection" and "consent to examination and treatment policy".
- We also observed that some of the provider's policies referred to certain committees or roles that were not in place. The provider's infection prevention and control policy (March 2016) stated: "A quarterly review of the assurance framework will be produced by the Matron for Infection Prevention and Control and received by the Infection Control Committee in January, April, July and October". The provider did not have a Matron for Infection Prevention and Control, or an Infection Control Committee. In addition, there were no systems in place for monitoring compliance with infection control guidelines during our visit.
- The Training and Development Committee policy (March 2016) referred to a 'Training Committee'. However, there was no evidence that a training committee was in place during our inspection.
- Senior staff informed us that they only admitted patients who were medically fit. All patients had a discharge plan in place and would have been seen by social services before they were admitted to the unit. Palliative care patients also had a care plan in place before their admission to the unit.
- Each patient had a nursing assessment booklet, which included a body map, nutritional tool, comfort round and Waterlow assessment. However, our review of patient notes showed that patients' care plans were not routinely reviewed. In addition, some of the templates in use including wound assessment charts, drug charts and observation charts used were those of a local NHS trust.
- Senior staff confirmed they had no tissue viability nurse (TVN) input on the unit and we saw no evidence of any system in place for the management of grade three and four pressure ulcers. For example, whilst reviewing patient notes, we noted there was no grading or plan in place for two patients with necrotic heels as a result of pressure ulcers.

Pain relief

- Staff used a standardised tool to assess patients' pain and recorded pain assessments in patients' notes. Pain relief was prescribed as appropriate by GPs who attended the ward.
- The provider referred to a local NHS trust's policy for management of pain in palliative care patients. The policy had a treatment algorithm for the management of pain in adult dying patients.

Nutrition and hydration

- Staff informed they monitored patients' weight on admission, on transfer and at least once a week. They informed us they referred patients to community dieticians for when necessary.
- Our review of patient records showed that staff carried out nutrition assessment for most patients. They also monitored patients' daily fluid and nutritional intake, and recorded it in their notes. We found one record with an incomplete food chart and admission weights were not recorded in another record.

Patient outcomes

- The unit did not participate in any external audits and there were no ongoing audit programmes in place to monitor patient care.
- The unit kept data showing the number of re-admissions to acute trusts. This showed that four patients were re-admitted to acute trusts between December 2016 and January 2017 for urosepsis, left shoulder pain, swollen leg and fainting episodes.

Competent staff

- All new staff were allocated a mentor and went through a period of induction. They undertook competency based assessments and mandatory training. All nursing staff were up to date with their revalidation and 98% of staff have had an appraisal in the last year.
- Senior staff informed us a number of nurses had worked in hospices before and had palliative care experience. They indicated they palliative patients were relatively new to the service and they would be looking into arranging training for staff.
- The staff survey carried out between November and December 2016, showed that 19 out of 20 staff indicated their training needs were met.

Multidisciplinary working and coordinated care pathways

- Staff reported good working relationships with community teams, GP practices, pharmacy, social workers and local trusts.
- Senior staff confirmed they had a good working relationship with the service's commissioners.
- We saw no evidence of multidisciplinary team meetings occurring since the ward reopened in November 2016. Following the inspection the provider told us that multidisciplinary meetings were conducted via phone calls and e-mails.

Referral, transfer, discharge and transition

- Patients were referred to the ward following discharge from local trusts. Senior staff assessed patients' suitability for admission to the ward.
- All patients had a discharge plan in place and were assessed by social services before they were admitted to the ward. We observed that all patients had an expected discharge date in place.

  Staff liaised with nursing homes for discharge into the homes. We observed staff from nursing homes attending the ward to assess patients for admission into their nursing homes.
- Patients were discharged from the ward to residential /nursing homes, intermediate care beds, hospices or to their homes with a care package in place. The service was not meeting the commissioner's target to discharge patients within 14 days of their admission on the ward. The average length of stay between was 35 days. However, the delays were due to a lack of available nursing /residential beds and packages of care in the community. Bridges Healthcare Limited told us this was a recognised problem by the local trust, CCG's and Social Services and the reason why the number of patients admitted to Foxbury Ward had increased in November 2016 so that beds in the local trust could be made available.

Access to information

- Staff had access to patients' paper and electronic records. Handover notes were circulated to staff every morning. We reviewed the handover notes and found them to be sufficiently detailed with details of patients, dates of admission, expected date of discharge, diagnosis and allergies, acuity score amongst others.
- In addition, patients were discharged with a discharge summary, which was sent to the patient's GP practice and nursing home placement.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Eighty-three per cent of staff had completed the mental capacity act training. Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment.
- The service referred to the consent policy of a local trust. Our review of patient's notes showed that 'do not attempt cardiopulmonary resuscitation' (DNACPR) were put in place by the discharging trust.
- Senior staff informed us that patients were assessed for capacity at the local trust before they were admitted on the ward. Staff said they conducted capacity assessments where necessary and involved the patient's GPs. However, we saw no evidence of capacity assessments carried out by staff on the ward.

Community health inpatient services

Are community health inpatient services caring?

Summary

- Staff provided kind and compassionate care and we received positive comments from patients.
- Patient's privacy and dignity was maintained.
- Patients and their relatives reported they were involved in their care and were given explanations about their treatment.
- Patients' feedback was sought and most patients indicated they would recommend the service.
- Patients were emotionally supported by staff and referrals were made to appropriate community teams.

Detailed findings

Compassionate care

- Patient, family and friends feedback was mostly positive. During all our observations, we saw staff treat patients with care. We observed staff interactions with patients. Staff were courteous, professional and demonstrated compassion to all patients.
- Patients told us staff were helpful and always responded to their calls. They told us staff provided "very good care" and they had no complaints. A relative told us they were happy with the care provided to staff.
- Staff maintained patients' privacy and dignity by drawing curtains when they cared for patients.
- The ward gathered feedback from patients through patient and family experience forms. We reviewed 11 forms completed between November 2016 and January 2017 and all 11 patients indicated they were 'extremely likely' or 'likely' to recommend the service. Patients indicated they got help within one to two minutes of using the call bell. Patients described nurses as "very nice" and "caring". One patient stated, "I had my feet washed daily by my nurse".

Understanding and involvement of patients and those close to them

- Patients and their relatives reported they were involved in their care and were given explanations about their treatment. We observed staff introducing themselves to patients before attending to them. Staff explained the assessments they were about to carry out and obtained consent.
- We saw that staff engaged in conversations with patients, took time to understand patient preferences and provided care in line with them. Feedback from the patients' survey indicated that patients felt staff always listened to them.

Emotional support

- Staff provided emotional support to patients. Relatives had access to visit patients during visiting times. The service had links with religious organisations that provide emotional support to patients when requested.
- Our review of 11 patient experience forms showed that eight patients indicated they found someone to talk to about their worries and fears. A further three patients indicated they had no worries.
- The provider informed us that senior staff would provide initial counselling and bereavement support to relatives. They advise relatives to see their GPs or refer them to local organisations for counselling.

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

Summary.

- There were 40 delayed discharges in the two months preceding the inspection. However this was due to the lack of available nursing home/residential beds and packages of care..
- There were no targets set internally to monitor the service and ensure it was responsive to patients' needs.

However:

- Staff had access to translators when needed, giving patients the opportunity to make decisions about their care, and day to day tasks.

Detailed findings

Planning and delivering services which meet people's needs

- The service was commissioned to provide care by local clinical commissioning groups. Five of the 28 beds were for palliative care patients from Bexley, whilst the remaining 23 beds were for patients discharged from local trusts in Greenwich. The ward's purpose was to provide ongoing care and support to ensure a well-planned discharge process (within two weeks) for patients who were waiting for nursing home placements or packages of care.
- There was a clear eligibility criteria for admitting patients. Patients from the local NHS hospital in Greenwich must have been assessed by a consultant from the discharging trust as medically stable and ready for discharge. The discharge process should have been completed by the trust. In addition, a clear anticipatory management plan must be included with the discharge summary regarding ceilings of care.
- Palliative care patients must have been assessed by a consultant as medically stable and ready for discharge. The trust must have completed the discharge process. A clear anticipatory management plan had to be included with the discharge summary regarding the ceiling of care. The patients must have been assessed as suitable for transfer by the clinical commissioning group (CCG) and hospital consultant.
- Both criteria excluded patients who required active investigations beyond simple blood tests or intravenous antibiotics. It also excluded patients who had an active infection and patients who had a rapidly deteriorating condition, or requiring physiotherapy.
- Senior staff informed us all patients had a care plan in place before their admission to the ward. Palliative care patients were required to have palliative care plans and anticipatory care plans in place before their admission to the ward.
- Most patients admitted to the ward were aged 75 years and above and the service was tailored to address the needs of the elderly population. Care plans were designed to accommodate patients' individual needs, however, they were not always routinely reviewed.
- Patients were provided with a menu offering a variety of meals. The menu had dietary codes including gluten free, vegetarian, vegan, healthier choice and soft. Staff assisted patients with their meals and provided food in line with patient preferences.

Equality and diversity

- Staff had access to telephone translation services for patients and families who had difficulty understanding English.
- Eighty-three per cent of staff had completed dementia training. Patients living with dementia were flagged on the patient board within the ward. We saw passport templates for patients living with dementia. The passport was designed to be completed by patients or their relatives to identify information about the patient that staff needed to know. For example, how they preferred to communicate, how they behaved when anxious or distressed, how they would tell staff if they were in pain and their support needs in aspects of daily living.
- Our review of patient records showed that cognitive assessments were not always documented for patients living with dementia.

Meeting the needs of people in vulnerable circumstances

- The service referred people to relevant organisations that provided support for the elderly. Carers were also referred to organisations that provided carer assessment and support. Patients and their relatives were provided with leaflets relevant to their care.

Access to the right care at the right time

- The service was commissioned to provide care for patients on the unit for 14 days. However, the average length of stay between November 2016 and January 2017 was 35 days. The average bed occupancy rate was 100% by January 2017.
- The number of delayed discharges was 40 (out of 59), between November 2016 and January 2017. However, the delays were due to a lack of available nursing /residential beds and packages of care in the community. Bridges Healthcare Limited told us this was a recognised problem by the local trust, CCG's and

Social Services and the reason why the number of patients admitted to Foxbury Ward had increased in November 2016 so that beds in the local trust could be made available.

- There were no targets set internally to monitor the service and to ensure it was responsive to patient's needs.

Learning from complaints and concerns

- The provider had a complaint policy in place, which sets out the complaint process. The provider informed us there had been no complaints since the unit re-opened in November 2016.
- We noted that the Patient Advice and Liaison Service (PALS) leaflet provided to patients were those of another local NHS trust. This implied patients and their relatives might direct complaints to another service provider. Following our inspection, the provider provided us with a new complaint leaflet, which they had implemented on the ward.

Are community health inpatient services well-led?

Summary

- There was no clear governance structure in place. There were no systems in place to identify, review and mitigate risks during our inspection.
- The provider informed us they often held senior staff meetings, however, there were no formal notes taken. Therefore, we were not assured of the meetings taking place.
- There were no formal service level agreements with the GP practice that provided medical cover to the ward and the local pharmacy used for supply of medicines.
- We did not identify a clear vision and strategy for the organisation.

However, we also found that:

- Staff said management was visible and approachable and they were supported in their role.

Detailed findings

Leadership of this service

- The management team consisted of the matron, the ward manager, a ward sister and a training and development manager. The ward manager reported to the matron, who was also the sole director of the provider organisation.
- All the staff we spoke with confirmed managers were visible and approachable. Staff confirmedthe director was approachable and always provided extra staff when required.

Service vision and strategy

- We did not identify a clear vision and strategy for the organisation. Senior staff said they would like to continue to run the ward and provide the service throughout the year.

Governance, risk management and quality measurement

- There was no clear governance structure in place. The provider informed us they often held senior staff meetings, however, there were no formal notes taken. Therefore, we were not assured of the meetings taking place.
- The provider informed us there had been no risks identified since the unit re-opened in November 2016. There was no risk register in place during the period of our inspection and there was no system in place to identify, review and mitigate risks. The provider said they were working a local trust and clinical commissioning groups and therefore using their policy, procedures and escalation/risk register.
- Following the inspection, the provider confirmed they had completed their own risk register and provided us with a copy of the register. There were eight records on the risk register, which referred to individual patients who became unwell and the actions taken.
- There were no formal contracts with the GP practice that provided medical cover to the ward, or the local pharmacy used for supply of medicines. Senior staff informed us there was an "agreement in principle" which was reiterated in emails. Following the inspection, the provider informed us that the contracts

had been formalised. We were provided with a draft copy of the contract with the GP service, however, this was undated and had not been signed by the GP practice.

- Staff attended bi-monthly team meetings. Notes from the meeting in December 2016 showed they discussed staff training, uniforms, documentation, supervision and appraisals.

Culture within this service

- Staff we spoke with indicated they were happy to work for the organisation. They indicated that there was a culture of openness within the service and the director was concerned about staff wellbeing.
- We were provided with a staff survey questionnaire spreadsheet. The questionnaire was completed between November and December 2016. Of the 20 staff that responded, 14 felt they were valued as a member of staff and were supported in their role. Twelve staff members indicated managers showed a commitment to developing their role. Eleven staff members indicated concerns raised were dealt with effectively, and 12 indicated they received feedback on their performance.

Public and staff engagement

- The ward monitored patient satisfaction through patient surveys and feedback forms. Staff were engaged through a monthly newsletter and staff survey.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Ensure the quality and safety of services provided are assessed, monitored and improved. This includes ensuring incidents are reported in line with the provider's policy and developing systems to investigate and learn from them.
- Ensure that all risks related to patient safety are recorded with actions to mitigate them.
- Ensure audit and monitoring systems are in place to monitor performance and compliance with local and national guidelines.
- Ensure patient records are complete and comprehensive. This includes ensuring every patient has an adequate, appropriate, and individualised care plan following admission. Care plans and risk assessments must be updated at regular intervals by a competent clinician.
- Ensure policies and procedures are developed in line with national guidance and best practice. This includes encouraging adherence with guidelines through the development of the ward's own care specific templates.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1) and (2) (a) (b) (c) **The provider did not have effective systems to assess, monitor and improve the quality and safety of the services provided in Foxbury ward** **The provider did not have systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk in Foxbury ward.** **The provider did not maintain accurate, complete and contemporaneous record in respect of each service user in Foxbury ward.** The ward did not have a risk register and there was no system in place for identifying, reviewing and mitigating risks. There were no formal contracts with the GP practice that provided medical cover to the ward and the local pharmacy used for supply of medicines. Some of the local guidelines developed by the provider referred to certain committees or positions that were not in place within the service. In addition, staff still referred to the policies of a local trust.

This section is primarily information for the provider

Enforcement actions

Incidents were not reported in line with the provider's policy. There were no ongoing audit programmes in place to monitor patient outcomes. Hand hygiene audits were not carried out and there was no system in place to monitor infection rates.

Patient records were not always complete and comprehensive. Care plans were not routinely reviewed. In addition, some of the templates in used including wound assessment chart were those of a local NHS trust. We found GP documentation was kept within the patient's folder from the discharging NHS trust. Most of the GP documentation followed on from the Trust's notes and it was not clear when patients were admitted to the ward.

The provider must take action to:

Ensure the quality and safety of services provided are assessed, monitored and improved. This includes ensuring incidents are reported in line with the provider's policy and developing systems to investigate and learn from them.

Ensure that all risks related to patient safety are recorded with actions to mitigate them.

Ensure audit and monitoring systems are in place to monitor performance and compliance with local and national guidelines.

Ensure patient records are complete and comprehensive. This includes ensuring every patient has an adequate, appropriate, and individualised care plan following admission. Care plans and risk assessments must be updated at regular intervals by a competent clinician.

This section is primarily information for the provider

Enforcement actions

Ensure policies and procedures are developed in line with national guidance and best practice. This includes encouraging adherence with guidelines through the development of the ward's own care specific templates.