

Villa Care Limited

Warfedale Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Inspected but not rated



Are services effective?

Requires Improvement



Are services caring?

Inspected but not rated



Summary of findings

Overall summary

Our overall rating of this service went down. We rated this service as requires improvement.

We rated the service requires improvement overall because:

- Staff and managers could not demonstrate that they understood and effectively managed the use of Deprivation of Liberty Safeguards.
- We observed a lack of meaningful activities taking place on the wards and nearly all patients remained in their night clothes throughout the day without any encouragement to get dressed.
- Staff did not store or dispose of medication and emergency medical equipment safely and securely.
- There were no robust arrangements in place to provide clinic oversight of the administration of medicines.
- The process for sharing lessons learnt with all staff was not robust. It was therefore difficult to evidence if this process was effective.
- Care plans, discharge plans, risk assessments and risk management plans lacked detail and personalisation. Care records were stored in different places using a combination of paper and electronic systems. This made it difficult to ensure that all staff were supporting patients consistently.
- Patients told us that they did not know what their discharge plans were and what goals they needed to achieve to work towards their discharge.
- Capacity assessments in relation to bed rails appeared to lack any detail, personalisation or input from patients. The use of bedrails was common practice and lacked rationale.

However:

- All ward areas were clean, well-furnished and well maintained.
- We received positive feedback from patients and carers. They said staff were kind and caring and worked hard to meet people's needs.
- Staff had undertaken all elements of mandatory training to ensure that they could deliver care safely.
- Leaders were visible and approachable, and staff felt they had the right support.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to Warfedale Hospital

We last inspected this service in February 2019. During the last inspection, the service was rated as good overall and good in all key questions apart from safe which was rated as requires improvement. We issued two requirement notices in relation to regulation 12, safe care and treatment.

We carried out this inspection because of an increase in the reporting of safeguarding concerns and because of intelligence about the provider, Villa Care Limited.

Bilberry and Heather wards at Wharfedale Hospital are operated by Villa Care Limited who provide nursing care to patients under a service level agreement with a neighbouring trust. At the time of this inspection the wards were operating to a capacity of 48 patients. The majority of the beds were occupied.

Patients admitted to these wards were medically optimised for discharge from acute hospital wards. The provider worked with the local clinical commissioning group (CCG) to ensure patients received and could access care and treatment from a multi-disciplinary team of professionals, some of whom are employed by the trust such as therapy staff. Medical cover was provided by local GP's in accordance with agreed contracts.

What people who use the service say

We spoke with 7 patients and three carers.

Patients told us that overall they were happy with the care and treatment that they received. They said they felt safe and had their needs met. They said that staff worked hard but sometimes they had too much work to do to be able to respond as quickly as they might hope.

Patients said the food on the wards was okay but sometimes it arrived lukewarm. They said they could get drinks and snacks when they wanted.

Patients also said that they did not know much about their discharge plans and they said that they would like to be more involved in this process.

Carers told us that they were very impressed with the care and treatment that the staff delivered. We were told the wards were always very clean and well looked after. Two of the carers we spoke to said that it was the best treatment that they had ever experienced for the people they cared for.

One carer said it was sometimes difficult to contact the wards by phone but whenever they were on the wards staff worked hard to keep them informed about those that they cared for.

How we carried out this inspection

We inspected Bilberry ward and Heather ward at Wharfedale hospital over two days on 21 and 22 June 2022. The team included two inspectors and two nurse specialist advisors. We carried out the following activities:

Summary of this inspection

- We carried out a tour of both wards, clinic rooms, kitchens, side rooms and store rooms.
- We spoke with thirteen members of staff, these included health care assistants, nurses, therapy staff, leaders and managers.
- We spoke with ten patients and three carers of patients.
- We looked at medicine administration records (MAR) charts and observed two medication administration rounds.
- We looked at care records for ten patients, these included electronic and paper records.
- We observed a multi disciplinary team meeting and a range of other observation and interactions between patients and staff.
- We used the short observational framework for inspection tool (SOFI) to capture patients' experiences of care by observing patient interactions with staff.
- We looked at a range of policies, procedures and other documents relating to the running of the service.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Community health inpatient services

MUSTS

- The provider must ensure that staff can effectively apply the process for assessing and implementing deprivation of liberty safeguards. (regulation 13)
- The provider must ensure that patients are offered a programme of meaningful activities during their stay. (regulation 9)

SHOULD

- The provider should ensure that patients are encouraged to get dressed throughout the day, where this is appropriate.
- The provider should implement a robust system for overseeing the management of medicines.
- The provider should ensure that all medicine and medical safety equipment is stored and disposed of safely
- The provider should ensure that they can evidence a robust system of sharing lessons learnt with all staff.
- The provider should ensure that patient records are detailed enough to provide staff with enough relevant information to deliver high quality care.
- The provider should ensure that all patients are given the opportunity to be part of their care planning and discharge planning processes and that patients can be clear what steps they need to take to work towards discharge.
- The use of bed rails as a blanket restriction should be reviewed and each patient should have a individualised risk assessment identifying personal requirements .




Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Inspected but not rated	Requires Improvement	Inspected but not rated	Not inspected	Not inspected	Requires Improvement
Overall	Inspected but not rated	Requires Improvement	Inspected but not rated	Not inspected	Not inspected	Requires Improvement

Community health inpatient services

Safe	Inspected but not rated 
Effective	Requires Improvement 
Caring	Inspected but not rated 

Are Community health inpatient services safe?

Inspected but not rated 

This was a focused inspection. Because of its limited scope, we did not rate safe at this inspection. You can view previous ratings and reports on our website at www.cqc.org.uk.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing and support staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff.

We reviewed training records and some of the training that staff were expected to complete included safeguarding, first aid, moving and handling and health and safety. There was an overall compliance rate of 97.8% across all staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm. Training records showed that all staff had undertaken training in relation to safeguarding vulnerable adults and vulnerable children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a safeguarding policy and procedure in place for staff to follow when safeguarding concerns had been identified, this included escalation to the local safeguarding authority.

Information about the reporting process was displayed and visible in staff areas.

The provider used an electronic incident reporting system to enable staff to report their concerns. Staff that we spoke to said they had access to this system and made use of it. We reviewed the electronic system and saw examples of safeguarding concerns being raised by staff.

Community health inpatient services

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, a small number of actions that had been raised during routine audits did not appear to have been actioned.

Staff had access to personal protective equipment (PPE) which was positioned in various accessible areas across the wards. We observed staff following infection prevention and control guidance using appropriate PPE, this included face coverings, aprons, gloves and visors where required. Hand gel was also available on entry to and throughout the wards.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

Patients could reach call bells around beds, bathrooms and communal areas and patients told us that staff responded quickly when called.

The design of the environment followed national guidance. There was a range of bays and single rooms available. Bays were spacious and patients could use curtains to help maintain privacy when needed. There was flexibility with the layout of the wards to ensure single sex guidance was able to be followed. When we visited one of the bays was being used as a male only bay and where necessary private side rooms could be used. All bays were single sex and had their own bathrooms.

There was also an area of the ward that was dedicated to carry out therapy sessions with patients to aid their rehabilitation. This was equipped with a range of useful equipment.

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families. Opening times for visitors was spread across the daytime and into the evening which gave flexibility to those that worked. There was a small communal lounge which could be used for patients to meet visitors.

The service had enough suitable equipment to help them to safely care for patients, for example hoists and a range of walking aids.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks but risk management plans sometimes lacked detail.

We reviewed the care records of ten patients.

Community health inpatient services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, because of the different ways in which some information was recorded and stored there was a risk that key information in relation to deterioration could be missed. For example, one part of the care record showed incomplete weight checks, but we saw later that this was recorded in a different part of the care record.

Staff completed risk assessments for each patient on admission, and reviewed this regularly, including after incidents. However, risk assessments and risk management plans lacked detail and appeared to lack input from patients themselves. For example, boxes were ticked indicating 'risk of falls' and 'needs bed rails' but there was no detail to indicate why someone was a risk of falling or why bed rails would help them.

Staff knew about and dealt with any specific risk issues. We reviewed the incident log which detailed incidents such as falls and pressure ulcers. The safety huddle records that we were able to look at also evidenced some discussion around specific patient risks which was shared with staff that were present.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. During the day there were at least three qualified nurses and nine support staff and at night there were 3 qualified nurses and six support staff. The ward was also supported by several senior nurses and senior leaders within the organisation who visited on a regular basis.

The ward manager could adjust staffing levels daily according to the needs of patients. We saw examples of where patients required more intensive support for which the manager was able to bring in additional staff for.

The service had low nurse vacancy rates but there were a number of support staff vacancies, especially for the night shifts. However, managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. We saw that a detailed agency induction checklist was in use and staff told us that the handover was a useful mechanism for keeping staff up to date.

Since our last inspection in 2019, the providers contract with the trust had changed which also meant there were some changes to how patients were supported by other staff including medical and therapy staff.

In accordance with the providers new contract with the local Clinical Commissioning Group, patients received care and treatment from a local General Practitioners (GPs) who conducted regular visits and completed patient reviews where necessary. GPs were part of regular Multi-Disciplinary Team meetings that were held. The wards also had a Resident Medical Officer who was able to provide immediate access to medical treatment whilst they were on site. In the event of an emergency out of hours, staff would access medical input by contacting NHS 111 or emergency services where patients may be transferred to Accident and Emergency.

Community health inpatient services

Therapy staff were provided by a local NHS trust, patients could access support and input from occupational therapists, physiotherapists and speech and language therapists.

Records

Staff kept records of patients' care and treatment however these were not always detailed. Records were accessible and available to all staff providing care but not always stored securely.

Patient records were stored in a combination of places. Some of each patients record were stored electronically and some were kept as paper-based care records which were stored within bays and outside side rooms so that they were easy to access for staff delivering care and treatment. However, this meant that they were not stored securely.

In all the care records we reviewed we found information was not detailed. For example risk assessments were completed for all patients but where we found risk was indicated there was a lack of detail to ensure that staff fully understood the risk and the management of each risk.

We also found that discharge plans lacked detail and in some cases were incomplete. This meant that patients were not aware what steps they would be going through to ensure that they were ready for discharge. We spoke to patients and the majority of them said they were not aware what their discharge plan was. Some patients told us that this was frustrating for them.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always manage clinical areas safely.

Staff followed systems and processes to prescribe and administer medicines safely. However, when we carried out an observation of medication being administered, one patient who was supposed to have their medication at 8.30am had waited until 11.15am to receive it. Two patients also told us that they sometimes had to wait for medication for pain relief to be administered.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date.

Staff did not store all medications safely. Both clinic rooms that we looked at had storage boxes for disposed medications but they were not being used correctly and one was overflowing. The cupboard which contained patients stocks of medications was not able to be secured because the locking mechanism was broken. Storage of gas cylinders was not always done in a safe way. In both clinics small cylinders were lent against big ones without being secured in any way. We raised these issues with staff and they were rectified immediately.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

All nursing staff had been assessed as competent to manage and administer medicines but some of the assessments had not been refreshed within the last year. The provider told us that they were in the process of developing a new competency framework and assessment as a result of the change in processes.

Community health inpatient services

It was not clear how clinical oversight of the medicine's management was being carried out, nobody was designated to carry out this role. When we spoke to the provider about this they informed us that this gap had been raised and actions had been implemented to minimise medication management risks. For example, the provider had employed pharmacy technicians to support them.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. They had access to and made use of an electronic system for submitting incidents of all kinds. Staff carried out this duty in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Staff sometimes received feedback from investigation of incidents, both internal and external to the service. However, a number of staff could not explain how information was fed back to them and they could not provide examples. Managers told us that the wards made use of regular safety huddles to share lessons learnt and in the safety huddles notes we were able to look at we saw examples of lessons learnt that were shared with staff. It was only possible to view the previous months safety huddle notes as they are disposed of beyond this time frame. We also saw examples of bulletins that had been shared with staff which gave a summary of the types of incidents that had occurred.

Senior staff met to discuss the feedback and look at improvements to patient care but we did not see evidence that this was always filtered back to staff working on the wards.

There was evidence that changes had been made as a result of feedback. For example an incident had highlighted the need for staff to better understand the balance between respecting patients privacy and ensuring that they remained safe. Poster were created as prompts for staff and patients to ensure that this was considered.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Are Community health inpatient services effective?

Our rating of effective went down. We rated it as requires improvement.

As we have we have identified a breach of a regulation in this key question the rating is limited to requires improvement.

Community health inpatient services

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients that we spoke to told us that they could always get a drink and snack if they requested them and most people said that the food was of a good standard. However, some patients said that food was sometimes not as hot as they would have liked it to have been.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment. They did not always support patients who lacked capacity to make their own decisions.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw examples in care records of where capacity assessments had taken place but they lacked detail and personalisation, therefore it was not clear that patients had been involved in the process.

Capacity assessments in relation to bed rails appeared to lack any detail or personalisation or input from patients. The use of bedrails was common practice and lacked rationale. When we spoke to managers about their use they explained that the beds were supplied for another organisation and were supplied with the bed rails attached.

Staff that we spoke to could not demonstrate a good understanding of deprivation of liberty safeguards. It was not clear that staff knew when this formal process should be considered in the best interest of the patient.

Managers could not demonstrate that they monitored the use of Deprivation of Liberty Safeguards and that they made sure staff knew how to complete them. We were told that there were patients on the ward that would have been prevented from leaving for their own safety should they have tried to. It was not clear from their care records that a Deprivation of Liberty Safeguards application had been considered or made.

Meeting people's individual needs

Staff did not always encourage patients to maintain or develop their independence. During the inspection we observed that the majority of patients were often in their night clothes either in bed or on chairs. We did not see staff making any attempts to encourage patients to get dressed.

The wards had a patient engagement facilitator to support patients engage in meaningful activities. We did not see any evidence of any structured activities taking place. We observed most patients watching television however patients had no stimulating activity to engage in. In some of the bays there was only one television which was in the centre of the room, this meant not all patients could see or watch at the same time.

The wards contained various information leaflets and advice posters on display. The provider was able to provide and source leaflets in other languages or in other formats such as large print.

Community health inpatient services

Are Community health inpatient services caring?

Inspected but not rated 

This was a focused inspection. Because of its limited scope, we did not rate caring at this inspection. You can view previous ratings and reports on our website at www.cqc.org.uk.

Compassionate care

Staff treated patients with compassion and kindness and respected their privacy and dignity.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients to ensure that their essential needs were met. Although we noted that there was little stimulation provided for patients, it was however clear that staff were working hard to care for patients.

We spoke to seven patients, and they said that staff were caring, kind and treated them well and did what they could to respond in a timely manner when something was asked of them.

The layout of the bays allowed for patients' dignity and privacy to be respected and we witnessed staff taking steps to ensure they made use of the curtains when delivering personal care.

We spoke to three carers and they all said that staff were caring and kind and worked hard to provide support to patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Carers that we spoke to told us that staff were very helpful and when they visited staff always found the time to help keep them informed. Carers also told us that staff were doing their best to help patients and carers prepare for being well enough to leave the ward.

Patients and carers told us that visitors could always access the ward when they wanted to and that they were always made to feel welcome.

Carers told us that the wards were some of the best that they had experienced and overall gave very positive feedback about their experiences. They said the wards were clean and well maintained.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Community health inpatient services

Staff made sure patients and those close to them understood their care and treatment. Although patients told us that discharge planning was poor, carers explained that they felt the staff supported patients well to enable them to make improvements in readiness for discharge. Carers said they felt everyone was clear what the treatment plan was and how everybody was working towards these goals.

Staff talked with patients, families and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw a number of examples of where feedback had been used to make changes. Managers had received feedback about the way that staff were communicating with patients and as a result managers were in the process of delivering sessions to help staff better understand ways in which to communicate with patients and carers.

Carers told us that they knew how to give feedback and they said that they felt they would be listened to if they needed to either make a complaint or offer some feedback.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider had not ensured that patients are offered a programme of meaningful activities during their stay.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

The provider had not ensured that staff could effectively apply the process for assessing and implementing deprivation of liberty safeguards.

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.