Foxbury Ward

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services well-led?	

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 two CQC inspectors.

Why we carried out this inspection

We inspected this core service as a follow up to the Section 29A Warning Notice issued in February 2017.

How we carried out this inspection

We carried out an unannounced visit on 8 June 2017. During the visit, we focused on the areas of concern identified in the warning notice, to see what improvements the provider had made. 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 and spoke with the Registered Manager and the lead nurse.

Information about Foxbury Ward

This is a report on the focused inspection we undertook on 8 June 2017. The purpose of this inspection was to follow up on a Section 29A Warning Notice, which we issued in February 2017, following a comprehensive inspection of the ward in January 2017.

Bridges Healthcare Limited leases Foxbury ward from a local NHS trust. It is a dedicated 28-bedded ward managed for medically fit/stable patients who have previously received acute medical care at a hospital. The unit is commissioned by two local clinical commissioning groups (CCGs) for use as a winter pressure unit.

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. 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.

At the time of our follow up inspection, the ward had been expecting to close, ready to re-open the following winter. However, the two CCGs had unexpectedly extended their commission of the service for an indefinite period.

We checked whether the ward was meeting the requirements of the Warning Notice. There is no rating of this inspection. The Warning Notice required Bridges Healthcare to make significant improvements in certain areas because:

- 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.

Summary of this inspection

- 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 staff roles 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.

We found that the service had made some progress in meeting the requirements of the Section 29A Warning Notice, however, there were still some outstanding actions that needed to be completed or embedded. In addition, we identified additional concerns relating to documentation, patient care and medicines management.

Detailed findings from this inspection

Community health inpatient services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

As this is a follow-up inspection on a warning notice, no ratings have been given.

Are community health inpatient services safe?

Detailed findings

Incident reporting, learning and improvement

- During our inspection in January 2017, the Registered Manager provided us with a copy of the ward's incident form. The 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.
- At this inspection, we found the incident forms had been updated, and were no longer divided into four sections, meaning that all incidents could be reported. The Registered Manager provided us with a folder containing completed incident forms. However, there were two different reporting forms in the folder. Following our inspection, the registered manager explained that they had updated the form twice since our inspection in January: once to address the CQC's concerns in respect of the limitation of the variety of incidents that could be reported and once again following a discussion with the CCGs commissioning the service. As such, there were not two forms in use at the same time, but historic forms were being stored as a record of the incidents.
- In the "reported by" section of the forms, only the individual's job title was recorded, for example "staff nurse", rather than their name. This could make follow-up of incidents difficult. The lead nurse told us that she would recall who had reported the incident, and therefore this was not an issue. However, she accepted that were the incident to be discussed

sometime after it was reported, she may not recall who had reported it. Following our inspection, the Registered Manager informed us that she had addressed this, and that "all nurses have been advised verbally and by e-mail that all future incidents reported must be completed fully and then signed by themselves with their full name and job title."

- During our inspection in January none of the pressure ulcer incidents recorded on the safety thermometer data and highlighted within patients notes were identified as incidents. The incident report forms reviewed at this inspection demonstrated that staff now reported pressure ulcers as incidents, in line with Bridge Healthcare's incident policy.

Safeguarding

- The provider reported no safeguarding incidents reported since the unit reopened in November 2016.

Medicines

- During our inspection in January, medicines were stored safely and securely. Medication cupboards including controlled drugs (CD) cupboards were locked. We observed that staff checked CDs on a daily basis and recorded this in the CD register. However, during our follow-up inspection, we found an out of date CD in the CD cupboard, namely Temazepam 10mg. We brought this to the attention of the nurse in charge, who disposed of the medication appropriately.

Quality of records

- During our inspection in January we found that the provider did not maintain accurate, complete and contemporaneous records in respect of all patients. Our review of nursing notes, during this inspection, indicated that care plans were not always detailed, review plans were not always in place, and bed rail assessments had not been completed.
- At this inspection, we requested a particular patient's nursing notes. The notes were completed on Bridges Healthcare headed paper. In the notes, the staff had continued not to maintain accurate, complete and contemporaneous records. In particular, in one of the patients' notes there were contradictions between the mobility level recorded for the patient, and the support needs they required.
- During our inspection in January, 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 used despite the assessment indicating that bed rails were not required. In another case, the patient was not assessed but had been given bed rails.
- During this inspection, we observed a patient with bed rails in use for whom staff had not completed a bed rails assessment, despite this having being raised by us as a concern at the last inspection. We asked the lead nurse why a bed rails assessment had not being completed for this patient and she was unable to tell us. She was aware that an assessment should have been completed but said that the rails were for the patient's own safety.
- The lead nurse told us that at the time of the patient's admission to the ward, their family had spoken with staff about the patient's care preferences. This discussion had not been documented, despite there being a designated space to do so in the nursing notes. As such, staff could not provide the patient with appropriately individualised care to suit their needs. Following our inspection, the Registered Manager informed us that she had reminded all nursing staff of the need to make clear, contemporaneous records.

Cleanliness, infection control and hygiene

- During our inspection in January, we identified that 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 or methicillin-resistant staphylococcus aureus . Following the inspection, the provider informed us they had developed hand hygiene audit templates and provided us with a copy. However, during our follow-up inspection we asked both the Registered Manager and the lead nurse for evidence of hand hygiene audits having been completed. We were not provided with any. The lead nurse told us that there had been no hand hygiene audits since the unit had reopened in November 2016.

Are community health inpatient services effective?

Community health inpatient services

(for example, treatment is effective)

Detailed findings

Evidence based care and treatment

- Guidelines were available in paper format kept within folders on the ward. During our inspection in January, 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.
- During this inspection, we requested copies of policies and were provided with a folder containing the exact same policies. Policies had not been amended as required by the Warning Notice. Furthermore, policies had not been reviewed in line with their review dates. We asked the Registered Manager whether these were the most up-to-date policies. She told us that there were some other policies within Bridges Healthcare which had been written recently, however, these related to other aspects of Bridge's work. She accepted that no new or amended policies had been adopted on the ward since our inspection in January. Subsequent to our inspection, however, the Registered Manager informed us that the provider had developed new policies both for Bridge Healthcare generally and Foxbury Ward specifically, albeit that the policy folder on the ward had not been updated. She told us that the policy folder on the ward was updated following our inspection, and that staff had been made aware of this update in particular in respect of the infection prevention and control policy.

Patient outcomes

- At the time of our inspection in January, the Ward did not participate in any external audits and there were no ongoing audit programmes in place to monitor patient care. During our follow up inspection we requested evidence of audits. We were provided with a folder entitled cleaning audit. However, this was not an audit, but a checklist for housekeepers to complete to indicate and ensure they had undertaken all required aspects of cleaning. After our follow up inspection, however, we were provided with copies of a monthly "safety thermometer" document which included an audit of certain aspects of care and patient outcomes, specifically: instances of pressure ulcers, patient falls, urinary tract infections (UTIs), use of catheters, completion of Venous thromboembolism (VTE) assessments, use of VTE prophylaxis, treatment of VTE.

Are community health inpatient services caring?

Caring did not form part of this follow up inspection.

Are community health inpatient services responsive to people's needs?

(for example, to feedback?)

Caring did not form part of this follow up inspection.

Are community health inpatient services well-led?

Detailed findings

Governance, risk management and quality measurement

- At the time of our inspection in January, 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.
- During this inspection the Registered Manager provided us with documented action points from senior staff meetings, indicating that they were taking place.
- At the January inspection, 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 our initial inspection, and at this inspection the Registered Manager provided us with a folder entitled risk register. However, this was not a risk register in the sense of a system used to identify, review and mitigate risks to the service and provision of care as a whole, but a list of reported incidents on the unit with actions against the incidents. As such, the provider was not proactively manging risk.
- At the January inspection, there were no formal contracts with the GP practice that provided medical cover to the ward. Nor was there a formal contract with 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. At the follow up inspection, the Registered Manager provided us with final, signed and dated contracts with the GP and pharmacist.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- Ensure that full bed rail assessments are completed and documented for all patients where bed rails may be necessary to prevent harm. This must be completed in line with the provider's policy, national guidelines, the provisions of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). This assessment should be contemporaneously documented in the patient's care record.
- 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, including detailing the name of the individual reporting the incident and ensuring that all risks related to the provision of care are recorded with actions to mitigate them.
- Ensure audit and monitoring systems are in place to monitor compliance with local and national guidelines.
- Ensure all policies and procedures are up-to-date and developed to reflect the specific needs and capacity of the service. This includes encouraging adherence with guidelines through the development of the ward's own care specific templates.

Action the provider SHOULD take to improve

- Ensure all patient records are complete and comprehensive. This includes ensuring every patient has an adequate, appropriate, and individualised care plan following admission.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider did not ensure that patients were protected from improper treatment by failing to adequately assess that acts intended to control or restrain patients were necessary to prevent harm or were a proportionate response to a risk of harm to the patient.** During both of our inspections, we saw patients with bed rails in use where bed rail assessments had not been completed or documented. **The provider must take action to:** Ensure that full bed rail assessments are completed and documented for all patients where bed rails may be necessary to prevent harm. This must be completed in line with the provider's policy, national guidelines and the provisions of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). This assessment should be contemporaneously documented in the in the patient's care record.

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**

This section is primarily information for the provider

Enforcement actions

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 an effective risk register and there was no system in place for identifying, reviewing and mitigating risks.

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.

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.

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, including detailing the name of the individual reporting the incident and ensuring that all risks related to the provision of care are recorded with actions to mitigate them.

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

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.