Spiral Health C.I.C

Spiral Health Preston Unit

Quality Report

2nd Floor
Avondale Building
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston
PR2 9HT
Tel: 01772 647100
Website: www.spiralhealthcic.co.uk/

Date of inspection visit: 5 August 2015
Date of publication: 17/11/2015

This report describes our judgement of the quality of care at this hospital. 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

There were sufficient staff on duty and the skill mix met the need of patients. Staff were given opportunities to improve their clinical competencies and skills.

Nursing staff and allied health care professionals were positive about the culture of the service and demonstrated that they provided person centred care.

Patient feedback was positive, particularly in relation to diet, medication, and the availability of staff.

The provider took action when concerns were raised and risks highlighted.

However, we found that more diligence was required in respect of completing and recording audits and making sure changes concerned with quality were embedded.

We found gaps in safety concerning the disposal of medication. The provider had not ensured that senior operational staff followed the medication policy because nursing staff did not manage service user's medication correctly on admission and discharge. Medication was not disposed of efficiently. Medication audits were aimed at ensuring the safe administration of medication, however the safe disposal and storage of medication was overlooked. ineffectual because they had not highlighted that the policy was not being adhered to.

The senior management team were in the process of reviewing governance systems to ensure the safe and effective running of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Spiral CIC Health ensured that actual and potential patient harm incidents were reported and investigated. Staff were provided with sufficient information about the needs of patients to promote safety and deliver effective care.

We had concerns about the management and storage of medicines. We found three medication bins overflowing with discarded medications which was contrary to organisations medication policy. We also had concerns around the effectiveness of audits completed by the service.

The admission criteria was not being adhered to specifically in relation to patients being admitted to the unit before the correct pressure redistribution equipment was available for them. This meant that patients were at increased risk of developing pressure sores.

The service was provided by a team of permanent staff supported by agency staff who were well integrated.

Patients were provided with an opportunity to influence the development of the service. The senior management team was accessible and ensured staff at all levels were aware of and able to voice an opinion and give ideas about plans and service development and delivery.

Are services effective?

Not reviewed at this inspection

Are services caring?

Not reviewed at this inspection

Are services responsive?

Not reviewed at this inspection

Are services well-led?

Systems to ensure effective governance, manage risk and measure the quality of the service had been introduced and work was being completed to improve the governance and quality control measures.

Documents confirmed the outcomes for the direct care and safety of patients were audited and reviewed, however checks relating to the daily running of the unit were not recorded to show what areas were looked at and any findings.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care		

Spiral Health Preston Unit

Detailed findings

Services we looked at
Medical care

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Spiral Health Preston Unit	4
Our inspection team	4
How we carried out this inspection	4
Facts and data about Spiral Health Preston Unit	4
Findings by main service	7
Areas for improvement	14
Action we have told the provider to take	15

Background to Spiral Health Preston Unit

Spiral Health CIC (Community Interest Company) provides Nurse Led Therapy units and the Royal Preston hospital site is one of three facilities in the North West. The others are based at Bispham Hospital near Blackpool and Rossall Hospital near Fleetwood.

Spiral Health is a Community Interest Company and is a not-for-profit organisation.

The Spiral CIC Preston service is situated at the Royal Preston hospital on the Avondale Unit and was registered with the Care Quality Commission (CQC) on 3 March 2015.

There are 24 beds at the nurse led Preston unit.

We inspected the provider's performance in the key questions: Is the service safe and well led?

Our inspection team

Two inspectors carried out an unannounced inspection on 5 August 2015 between 9am and 5.45pm. This inspection was in response to concerns that the number of patient with pressure sores had increased and to assess the criteria for admission to the unit. We inspected the service to answer two of the five key questions;

Is the service safe?

Is the service well led?

How we carried out this inspection

We reviewed information sent to us by the service, service users and their representatives and other statutory services such as the local authority or NHS trust staff before the inspection. This information told us about significant events that had occurred such as safeguarding investigations, falls and medication errors, complaints and concerns.

Whilst on site we talked to the registered manager, the quality manager for the service, the chief executive and the chief Nurse. We also interviewed five members of the nursing and health care staff, including agency staff, and four patients.

We reviewed a number of documents in relation to the running of the service to assist with the inspection

Detailed findings

process. We inspected the unit and spent time observing the way in which patients were cared for and supported. We observed how equipment was used and maintained and we checked the general environment.

We reviewed eight sets of patient records in relation to care and treatment.

As this inspection was a focussed responsive inspection in due to raised concerns no rating has been applied but regulatory action has been taken.

Facts and data about Spiral Health Preston Unit

The unit is a nurse led unit. It is operational 24 hours per day. Medical cover is provided 9am to 5pm by a doctor who works across two sites. Out of hours cover is provided through a contract with a medical agency and through the NHS 111 and 999 systems.

The unit has a contract with Lancashire Teaching NHS Foundation trust and accepts referrals made from hospitals governed by the trust.

Rehabilitation services are provided by nurses, physiotherapists and occupational therapists.

Are services safe?

Our findings

Summary

Spiral CIC Health ensured that actual and potential patient harm incidents were reported and investigated.

Staff were provided with sufficient information about the needs of patients to promote safety and deliver effective care.

We had concerns about the management and storage of medicines. We found three medication bins overflowing with discarded medications which were against the medication policy.

The admission criteria was not being adhered to specifically in relation to patients being admitted to the unit before the correct pressure redistribution equipment was available for them. This meant that patients were at increased risk of developing pressure sores.

The nursing team of permanent and agency staff worked well together, the same agency nurses were used and well integrated into the service.

Incidents

- Incidents were raised via an electronic incident reporting system and a policy was in place to support staff in this regard. Staff were familiar with reporting procedures and could provide examples of incidents they had reported
- An analysis of incidents reported was requested but this was unavailable on the day of inspection. However, although data about incidents was not available, the notes from the quality and patient safety meeting, team meeting records and action plans showed that the provider was able to identify key issues and that lessons were learnt from the information collected. An example of this included a team meeting in June 2015 where the number of falls was highlighted as a concern and risk reducing strategies were discussed during the meeting.
- We were informed by the matron that deaths and the reasons why people were readmitted to the acute services were discussed and reviewed so that changes could be made if appropriate. Records were not available to confirm what conclusions were reached.
- The matron needs to ensure patients are advised if a concern is raised and an investigation carried out in relation to their care and treatment.

Safety thermometer

- Nursing care quality indicator dashboards had been completed for April, May, June and July 2015 and looked at falls; nutritional assessment, pressure ulcers; moving and handling; medication and completion of activity of daily living assessments. The overall scores awarded indicated the level of risk:- 95% and above was Green (very low to no risk); 94-85 scored amber (low-medium risk) and below 85 scored red (medium to high risk). The overall score for the ward in July 2015 was 81% red (medium to high risk).
- Although patient's safety and quality meetings were held regularly, audits were not consistently robust. An example of this was the medication audits highlighted a need to improve medication management, which was discussed by senior managers at the quality and safety committee meeting on 8th July 2015 and this information was shared at the ward team meeting on 16th July 2015, however the checks introduced were not thorough and did not highlight all of the problems.
- The service audits also highlighted a concern in relation to the number of falls although the document did not stipulate the numbers the subject was addressed at the safety and quality meetings and ideas put in place
- At the Preston unit meeting held on 10th June 2015 it was identified that a regular plan of audits needed to be developed to include hand hygiene, commodes, nursing care intervention, record keeping and controlled drugs.

Cleanliness, infection control and hygiene

- Staff were diligent in hand hygiene techniques and therefore subsequently promoted effective infection control. Hand gel was readily available at all beds and within each bay.
- There was ample supply of personal protection equipment such as gloves and aprons. These were readily available in the bays and other areas of the unit.
- Staff used these items appropriately.
- Clean commodes and chairs were labelled with a date and time of when they had been cleaned.
- All of the rooms were visibly clean and furniture was well maintained and looked easy to clean.

Environment and equipment

- Resuscitation equipment was kept near the nurse's station and was easy to access.

Are services safe?

- We found that the equipment had not been checked daily for three days in early July 2015 and three days in mid-July 2015. Daily checks had been completed between the 16th July 2015 and the day of inspection.
- Walking aides and wheelchairs were readily available and labelled with the patient's name.
- Moving and handling equipment including two specially adapted baths were available.
- Handrails were strategically placed in the toilets and bathrooms.
- The signage for the toilets and bathrooms had a brightly coloured yellow background with large dark lettering and symbol which made iteasy to read.

Medicines

- Patients received their medication in the correct dose, at the right time and as prescribed.
- Assessments were completed so patients could manage their own medication when possible.
- Controlled medication was stored safely and was all accounted for.
- The nurse giving out medication wore a tabard during the medication round. This gave a signal to staff and patients that this person should not be distracted without a good cause.
- The medication fridge was not always checked daily and between April 2015 and the date of the inspection this was omitted on approximately 25 occasions.
- The fridge checks also recorded periods when the fridge was not running at the recommended temperature on 22 and 25 July 2015 the minimum temperature was recorded at 0.3 degree Celsius and between the 1 July 2015 and 24 July 2015 the maximum temperature recorded was 9c. These readings were outside the required range of 2c minimum and 8c maximum.
- The records did not indicate that these readings had been identified as a problem and reported so that remedial action could be taken.
- Medication no longer required was not disposed of in keeping with the Spiral CIC Health medication policy. The medication policy stated that there should be a record of medication to be disposed of and we were told that no record was kept.
- There were more than 120 packets or bottles of medication stored in three large medication return buckets. Two of the buckets were overflowing with medication and were in the locked clinic room, however one was not in a secure area but in the main ward outside the door of the clinic room. None of the buckets were secure and so the contents of those in the clinic room could be accessed unhindered by staff and others who entered that area. The medication bucket in the ward area was accessible to patients and visitors. The Spiral policy stated excess medication should be sent to the trust's pharmacy. No specific trust was named in the policy.
- The matron told us that patients were sent home with seven days medication and their personal medication was taken from them and discarded. This action was taken even when no changes had been made to the patient's prescription. This was contrary to the Spiral medication policy which said: 'All medication held in the unit for the individual patient should be transferred with the patent unless they give their written consent for the disposal of any which is no longer required.'

Records

- Patient records were found to be well organised and information was easy to find. We found the records were contemporaneous and reflected the treatment provided to the patients.
- The appropriate risk assessments had been completed to a high standard for each of the patients reviewed.
- We found that, although the names of health professionals providing care or treatment were documented, staff did not always include the person's professional role or designation.
- The provider was updating the admission assessment record to include questions about a patient's resuscitation status.

Safeguarding

- The training matrix (record) showed that all staff had up to date safeguarding adult training due for update in 2016.
- Staff described the different types of actions and omissions which they would report as a safeguarding concern.
- The matron described the safeguarding referral processes and these linked into local authority procedures.
- We reviewed safeguarding investigation documents and found the processes robust and transparent.

Are services safe?

- Not all staff had completed mental capacity act and deprivation of liberty training. However the interactions observed showed staff promoted the patient's right to consent and be in control of their care.
- The matron was uncertain about the relevance of the mental capacity act and deprivation of liberty safeguards for the patient on the unit.
- We saw that the service was provided to people who experienced varying degrees of confusion and also evidence that people did not always readily co-operate with their rehabilitation plan. The mental capacity act and deprivation of liberty safeguards applies to people in these categories.

Mandatory training

- The training matrix (record) showed that staff had access to and were up to date with mandatory training. Topics included: fire safety, basic life support, moving and handling and information governance.
- Staff stated they were provided with opportunities to improve their knowledge and learn new skills.
- Training records also confirmed that staff had received additional training in managing medication and pressure area care. These were areas where risks to patient safety had been identified.
- The service had developed a new role of 'practice development sister', who provided practical supervision and training in the clinical setting. The nurse employed was identifying priorities, defining the parameters and developing the systems required to complete the role.
- Documents and completed workbooks confirmed that all staff including agency staff completed comprehensive induction training before taking on their responsibilities in full.
- Agency staff confirmed they accessed the same training as permanent staff.

Assessing and responding to patient risk

- We reviewed the risk assessment and treatment plans for four patients paying particular attention to the admission process and pressure area care assessments.
- The admission process included gathering information from the discharging ward and visiting the patient. An initial care plan was introduced.
- We found that there could be delays in getting the correct pressure redistribution equipment to help with the prevention and management of pressure ulcers because it could take between 12 and 48 hours before the correct mattress was provided by the supplier. However, the admission criteria stated that patients should only be admitted to the unit if all the equipment required was already available. Senior staff were aware that this criteria was not always adhered to.
- The senior management team described plans to have a rolling stock of pressure redistribution mattresses kept on the unit. However, there was no documented time-frame for when this was to be achieved.

Nursing Staff

- The expected and actual staffing was displayed on the ward. The actual number of staff available on the day of the inspection was more than, and subsequently better, than the expected number. Staff and patients said the ward was usually well staffed.
- There were 20 patients supported by the four qualified nurses, including the matron, one physiotherapist and one occupational therapist. This was a ratio of almost one registered staff to 4 patients. In addition there were four health care assistants and one therapy technician.
- A house keeper and clerical staff were also employed.
- A handover took place at the change of each shift and this was thorough and promoted effective continuity of care. At handover staff were provided with a printed sheet describing the needs of each patient, this included information relating to areas such as allergies, risks and specific care requirements.
- In addition to a team of permanent trained nurses the service used a core of regular agency nurses and health care assistants to make up the nursing team.

Medical staffing

- The resident medical officer (RMO) was supplied through an agency who also arranged medical cover when the regular doctor was on leave.
- The RMO was timetabled to work at the Preston Unit each Monday and Wednesday, although this arrangement was flexible so the needs of patients across the local Spiral services could be met.
- The doctor was able to refer patients directly to the assessment unit at the Royal Preston Hospital.

Major incident awareness and training

- Major incident contact details were displayed on the wall at the nurse's station.

Are services safe?

- There was a business continuity plan identifying potential threats to service provision. This detailed the actions staff were to take in the event of occurrences which could disrupt normal operations.
- Staff were able to describe their role in relation to dealing with staff shortages,
- The training records provided did not indicate whether staff had received specific business continuity training.

Are services well-led?

Our findings

Summary

Patients had the opportunity to influence the development of the service. The senior management team was accessible and made sure all were able to voice an opinion and give ideas about plans and changes to the service.

We found that there was very little documented evidence to show that regular ward level checks were completed on the unit. The senior management described the checks completed but could not confirm this through records.

Senior managers described the systems introduced and available to ensure effective governance, manage risk and to measure the quality of the direct care provided by the service.

Vision and strategy for this service

- The provider was working towards improving governance and quality control and in June 2015 employed a chief nurse of operations to lead the development of governance and quality monitoring systems.
- The chief nurse described plans to improve the performance of managers which included training in human factors, resilience and coaching.

Governance, risk management and quality measurement

- The quality of governance and risk management was inconsistent, in relation to direct care this was good, however in relation to the direct running of the unit more evidence was needed to confirm that systems were robust.
- There was not enough documentation to confirm the checks described by the matron. For example the matron described a process of daily 'walk around' checks. The outcomes of these 'walk arounds' were not recorded.
- We were also informed that patient's records were audited, however, there was no record made of the findings. This meant the provider could not confirm which areas were looked at, what was found during the checks or the actions taken to promote good practice or make improvements when required. Trends could not be identified. We requested records of the daily medication audits and these were not made available.
- Notes from quality assurance meetings showed that quality and governance concerns were discussed at the highest managerial levels of the organisation; however deadlines for improvement to auditing were not identified.
- Processes put in place by the provider were not clear and could potentially cause confusion particularly in relation to policies and procedures. On reviewing a printed version of the HS01 accident and incident reporting policy in the communication file provided to staff we found the information differed from the electronic version. Even though both had been updated on the same date of 16th December 2013. The provider was unaware that this was the case.
- According to the information provided many of the policies had not been reviewed for a number of years and no review dates were planned. Examples were the health and safety policy last updated 18th December 2013; the medical emergency policy last updated 1st June 2013 and the record keeping policy last updated 1st June 2012. Each policy identified that it should be reviewed annually but there was no evidence seen that this had been completed.

Leadership of the service

- Members of the management team explained it was easy to make changes to systems because it was a small service with three executive directors and three non-executive directors.
- From discussion with the chief executive officer, it was evident that she had an awareness of the plans in place to provide a safe service at Preston.
- Staff from all levels knew the chief executive and other members of the management team and the chief nurse attended ward level team meetings.

Culture within the service

- We found the culture of the staff was to demonstrate dedication, compassion and professionalism.
- Nurses, health care assistants and allied health professionals confirmed that changes were made to training and systems when problems were identified and their ideas and opinions were respected.

Are services well-led?

- Agency staff felt team work was effective and experienced no differences in their treatment when compared to permanent staff.

Public engagement

- The senior management team explained that as a community company resources were dedicated to benefit the local community through actions such as sponsoring school football teams.
- The service used the 'working together' model for engaging with patients and their families which involved completing a questionnaire partway through an episode of care.
- The July 2015 patient feedback report identified changes were needed to improve food supplies, time taken to respond to the nurses call bell and activities. Improvement plans were in place to deal with these issues and the review date had been identified as 10th August 2015.

Staff engagement

- Staff reported they had regular team meetings with dates prearranged for a number of months in advance. The dates were displayed in the nurse's office.
- The senior management team was visible and staff stated meetings with the chief executive were held approximately bimonthly.

Innovation, improvement and sustainability

- The Spiral Health CIC Preston unit at Lancashire Teaching hospitals NHS Trust Preston site had been operating for approximately 24 weeks at the time of the inspection and still developing operating systems that would promote innovation, improvement and sustainability.

Medical care

Overall

Information about the service

Summary of findings

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must make sure the service adheres to policies and procedures for the safe disposal of medication.

Action the hospital SHOULD take to improve

- The provider should ensure a daily check of resuscitation equipment is sustained.
- The provider should address the backlog of medication for return to pharmacy.
- The provider should consider providing all staff with mental capacity act and deprivation of liberty training to enable them to take the correct action in promoting the rights and best interests of the patient.
- The provider should ensure a timescale by which patient's pressure redistribution equipment is in place before transfer to the unit.
- The provider should have clear records about the training and information staff have received in relation to the business continuity plan.
- The leadership team needs to provide more evidence there is sufficient scrutiny to ensure quality governance and monitoring systems are fully implemented and used appropriately.
- The provider should make sure policies and procedures are up to date and reviewed as appropriate.

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	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (2) (g) the proper and safe management of medicines. The regulation was not been met because a record was not kept of discarded medication and large quantities of waste medication was inappropriately and unsafely held on the ward. The provider had also not ensured staff followed the Spiral medication management policy.

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.