Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Brookfields Hospital

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Cambridgeshire Community Services NHS Trust
Overview of the service	Brookfields Hospital is an NHS community hospital which provides support, care and treatment from a range of wards and units for both adults and older people. Lord Byron ward is one of the Brookfields Hospital wards. The ward provides support, care and rehabilitation treatment for older people.
Type of services	Acute services with overnight beds Dental service Diagnostic and/or screening service Hospice services Rehabilitation services
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Brookfields Hospital had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Assessing and monitoring the quality of service provision

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and reviewed information sent to us by other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

The provider had taken effective remedial action to ensure that patients' dignity and privacy were respected. Patients told us that they had the right amount of information about their treatment programmes, were actively consulted about their care and treatment programmes and had positive comments to make about how staff treated them. We found that patients were provided with the right amount of information to make decisions about their care and treatment. We also found that staff respected people's dignity and privacy.

Improvements had been made to ensure patients received safe and quality care. Patients were checked each hour to ensure that they were comfortable and safe. Arrangements were made to ensure that patients were safely discharged from hospital.

Actions had been taken to improve patients' wellbeing by the provision of social activities. Patients also told us that they had not felt bored because they always had something to do.

Following a change in the management arrangements of Lord Byron ward, there was work in progress to improve the internal quality assurance systems, including carrying out audits and carrying out remedial actions if required.

Patients were provided with safer and improved quality of care due to the management changes of the ward. Staff told us that there was improved communication as a result of these management changes which had improved the standard and quality of patients' care

and treatment.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

Improvements had been made to ensure that patients' privacy, dignity and independence were respected.

Reasons for our judgement

Patients understood the care and treatment choices available to them. Patients were given appropriate information and support regarding their care or treatment and their values and human rights were respected.

During our last inspection visit to the ward, on 14 August 2012, we found that patients' privacy and dignity were not fully respected. The provider wrote and told us what remedial action would be taken and when they would be compliant with the regulation associated with this outcome, outcome 1. We carried out a follow-up visit on 04 February 2013 and found evidence to support this.

Patients who we spoke with told us that they knew the reason for their admission to the ward; this, they said, was to rehabilitate and recover following their treatment of a medical condition.

Patients also told us that they were actively involved in the planning, monitoring and reviewing of their agreed rehabilitation treatment programme. Our examination of three out of 12 sets of patients' care records confirmed that this was the case. This included a weekly review by a team of medical, nursing and therapy staff who would collectively discuss patients' progress and response to their rehabilitation programmes. These weekly reviews and discussions were carried out in conjunction with the relevant patient. One patient told us that, "I am kept informed in a very nice way."

We found from all of the patients who we spoke with and observing patients talking to members of staff, that patients were kept informed about their discharge arrangements. These arrangements included the provision of any additional equipment and support with their personal care to ensure that the patient would be safe following their hospital discharge.

In each of the patients' rooms that we visited we noted that patients had access to written information about the ward. This included information to help patients identify the range of

roles of staff by the colour of their uniforms. Other information included, but was not limited to, the times when patients' meals were served and times when patients could receive their visitors.

Patients also had individual leaflets that held summary information about the ward. One patient said, "I found it very, very, useful."

Although all of the patients who we spoke with said that they did not know how to make a formal complaint, they said that they would have no reservation in speaking to a member of ward staff. However, they said that they had no cause to make a complaint because they were satisfied with the standard and quality of their care and treatment. The provider may wish to note that there was no information held in the patients' information leaflet about how to make a formal complaint should they, or their representative, have the need to do so.

In preparation for their discharge from the hospital, patients, where possible, were supported to be independent to self-administer their own prescribed medication. We noted that patients were provided with written information to guide them to safely manage their own medication. Patients told us that they had understood this written information. We saw a patient's understanding of this written information regarding their medication was facilitated and supported by a member of staff and this was carried out on a one-to-one basis. We also noted that a patient was given information in a way so that they could understand about the change made regarding their prescribed medication, and the expected health benefits.

All of the patients who we spoke with said that staff always knocked on their room doors before entering and we observed that this was the case. We also noted that when patients were supported with their personal care, this was carried out in private and behind closed doors.

From our observations of staff working, we noted that patients were offered choices about their support and treatment. These included choice of what they would like to eat and choosing where they would like to be to take their medication, which was to be in the dining room or in their own room.

Our examination of staff training records indicated that 14 members of staff had attended training in respecting patients' dignity and privacy. The ward manager advised us that future training in this topic was to take place sometime in February 2013, for other members of staff to attend.

Our review of minutes of staff meetings (that were held since our inspection visit in August 2012) indicated that staff were reminded about their responsibilities in ensuring that patients' privacy and dignity were respected. In addition, staff had access to information about respecting patients' privacy and dignity, which was presented in notice and poster formats and kept on staff notice boards.

During our other observations of staff working, we found that staff treated patients in a respectful, attentive and kind way. This included when staff spoke with patients and while they supported patients with their breakfast and lunch.

All of the patients who we spoke with had positive comments about the staff. One patient said, "They never talk about other patients in front of you." Another patient said that the

staff have, "A nice rapport with me."

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Improvements had been made to ensure that patients experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

During our last inspection visit to the ward, on 14 August 2012, we found that patients were not always in receipt of safe and quality care and treatment. The provider wrote and told us what remedial action would be taken and when they would be compliant with the regulation associated with this outcome, outcome 4. We carried out a follow-up visit on 04 February 2013 and found evidence to support this.

All of the patients that were spoken with had positive comments about their support, care and treatment. One patient told us, "I've been looked after well here." Another patient said, "I can do things now for myself, which I couldn't do (when they were first admitted to the Lord Byron ward)."

From speaking with patients and examination of their treatment records we found that systems were in place to monitor, review and treat people's skin conditions, including the redressing of these. One patient told us, "My leg always feels much better when it's been done (re-dressed)."

From speaking with patients, our examination of the sample of three out of 12 patients' records and speaking with members of staff, we found that patients had undergone assessments by therapists. These assessments included the ability for a patient to provide their own personal care and their ability to safely stand and transfer from their bed to chair and vice versa. Other assessments included patients' abilities to be independent with drink and food preparation.

The patients' records we reviewed indicated that goals for rehabilitation were set in agreement with the patient. We found patients, where possible, had signed and dated their confirmation and agreement to their treatment programme. One patient who we spoke with said, "I agreed (with the physiotherapist) to try and stand for seven seconds. Then, after that, I managed to stand for nine seconds. I am going for 11 seconds the next time. I feel really good with the progress."

Although there was no formal system in place to provide patients with social activities to alleviate any feelings of boredom, none of the patients who we spoke with said they had felt bored. This was because they had newspapers, books and personal CD players to entertain them. One patient who we spoke with said they enjoyed watching the birds from their own room window.

Most of the patients who we spoke with said that they had enjoyed watching a DVD film of 'The King and I' which was organised by members of staff for patients to watch if they chose to do so. One patient said, "It was a good presentation. Most of us enjoyed watching it."

From our review of the sample of patients' records we noted that there was an hourly checking system in place. This was to ensure patients' comfort and safety were checked at least once per hour.

The sample of patients' records indicated that patients were monitored for signs of ill-health. This included monitoring of their blood pressure, pulse and temperature and records were maintained for these clinical observations. From speaking with a patient and the ward manager, we noted that a patient was receiving treatment for an infection. However, the provider may wish to note that their observations had not been recorded with the expected frequency of four times per day for 27, 30 and 31 January 2013. Furthermore, there were no records to confirm that the patient was also monitored during 01 February 2013. We also found this to be the case for another patient. Their observation records noted that there may have been an omission of monitoring or an omission of recording during 01 February 2013. Fortunately, both patients had observation records that indicated the result of their blood pressure, pulse and temperature monitoring were clinically normal, prior to and following 01 February 2013.

Patients' risk assessments were carried out and measures were in place to manage and minimise these risks. From our examination of the sample of patients' records and visiting the patients in their own rooms, we noted that pressure-relieving equipment was provided for patients who were assessed at risk of developing pressure ulcers.

Although it was unclear how patients' level of risk for falls was determined, we noted that patients' were assessed for this health and safety risk. From the results of an analysis of reported events we noted that the incident of falls occurring in patients admitted to Lord Byron ward had decreased in numbers from August 2012. Senior staff considered this may be due to the increased hourly safety checks on patients.

Members of staff, who were new to the ward, said that they had the right amount of written guidance held in patients' care records so that they knew how to provide patients with individual, safe and appropriate care and treatment.

We noted that there was some improvement in the standard of record keeping, including reviewing and up-dating of patients' risk assessments for malnutrition and developing pressure ulcers.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had a system to regularly assess and monitor the quality of service that people receive. The provider had an improved system in place to identify, assess and manage risks to the health, safety and welfare of patients who use the service.

Reasons for our judgement

There was work in progress that learning from incidents / investigations would take place and appropriate changes would be implemented. The provider took account of complaints and comments to improve the service.

During our last inspection visit to the ward, on 14 August 2012, we found that there were inadequate quality monitoring systems in place to ensure patients were protected from unsafe care and treatment. The provider wrote and told us what remedial action was to be taken to become compliant with the regulation associated with this outcome, outcome 16. We found that there was some delay in improving the auditing of the quality of care, although we found evidence that patients were now safer and had an improved standard of quality of care and treatment.

Since our last inspection visit of 14 August 2012, there has been a change in the management arrangements of Lord Byron ward. Through speaking with staff we found that the change of management has had positive outcomes for patients. This included improved and effective verbal and written communication for all grades of staff. One member of staff said that this improvement meant that patients' admissions and discharge arrangements were not delayed and also that their inter-hospital appointments were not delayed or missed. Other members of staff who we spoke with said that they provided patients with support, care and treatment in a more organised way and saw the positive health benefits for the patients as a result of the management changes.

During our examination of the three out of 12 sets of patients' care records we noted that there was a delay in assessing patients' risks of falls following their admission to the ward. However, in January 2013, the provider had carried out audit of patients' care record and noted that only 27% of patients' care records indicated that patients' risks for falls had been assessed within 24-hours of their admission to the ward. Action plans had been identified to improve upon these failings.

Following the change in management arrangements of the ward, the ward manager explained to us that work was in progress to carry out other audits. These included, but

were not limited to, staff hand hygiene practices and carrying out an analysis to determine the causes of why patients fell.

From our examination of patients' and visitors' information notice boards, we noted that patients were listened to and action taken in response to their suggestions. This included improving information about the menu choices. Our visit to the ward dining area noted that this action had been carried out.

The ward manager advised us that, since they commenced their employment in September 2012, Lord Byron ward had received only one complaint regarding the inadequate heating of patients' own rooms. Responsive action was taken to provide supplementary heating. During our visits to patients' own rooms, we noted that portable heaters were available.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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