Leeds Community Healthcare NHS Trust

Hannah House

Quality 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 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this service — Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Overall we rated Hannah House as requires improvement because:

- There was limited documented evidence of sharing of learning from incidents. Eleven staff we spoke with were unable to provide examples of learning or changes in practice in response to an incident. The trust told us post inspection that learning from incidents takes place during clinical supervision and safeguarding supervision within the unit
- There were concerns over safeguarding training; there was a requirement for staff to be trained to level three and not all staff had received this traininig**.** Safeguarding supervision levels were 82% this was below the trust target of 90%.
- Not all medicines were being transcribed correctly and some medication being used had past its expiry date. Following a discussion with the trust an action plan was developed. This outlined areas for improvement with leads identified and clear timescales for actions to be competed.
- Staff sickness levels were high at 22% and as a result some short breaks had been cancelled. However, safe staffing levels were being maintained at all times.
- Staff appraisal rates were 75% this did not meet the trust improvement trajectory target of 85%.
- There was a lack of evidence in relation to staff skills and competence. The competency documentation was incomplete and some staff expressed concerns over this.
- The bed occupancy targets of 85% had only been met in four out of ten months. This had been impacted by the transition bed being occupied which required a staff to child ratio of 1:1. The unit was also closed on two occasions on the advice of the infection prevention and control team.
- Data was not collected on how many allocation requests were given to individual families and carers. Therefore the trust could not provide evidence that they were fair and equitable in the allocation of short breaks.
- Risks to the service were not clearly identified and escalated. There was a lack of management oversight in the unit because of sickness and vacant posts. There was an interim manager in post at the time of inspection.

However:

- There were detailed and clear escalation plans in place for each child if they became unwell whilst at Hannah House.
- There were clear plans in place to ensure the nutritional and hydration needs of children and young people were met.
- Children and young people's needs were assessed and care was delivered in line with current legislation, standards and recognised evidence based guidance.
- Staff were passionate about the care they provided. Parents gave positive feedback and felt confident their children were safe whilst at Hannah House.
- Emergency access was always available for families if a crisis occurred.
- There were clear vision and values within the organisation and staff were aware of them.
- Staff reported good support from their line manager.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Hannah House

Detailed findings

Services we looked at
Services for children and young people

Detailed findings

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Background to Hannah House

Leeds Community Healthcare NHS Trust was established in 2011 and employs around 3000 staff. The trust serves a population of 850,000 people and staff are based at health centres and community sites across the Leeds area.

An inspection of Leeds Community NHS Foundation Trust was carried out on in November 2014. At this time services for children young people and families were rated as good. Due to information of concern a responsive inspection of Hannah House was planned and this was combined with the planned follow up inspection of the trust.

Hannah House is a purpose built, self-contained facility which provides planned and emergency short break care for children with complex health needs. It is located in a residential area of Leeds.

Hannah House is open 24 hours a day 365 days a year and is accessible to children and young people from birth to 19 years. Those who are registered with a Leeds GP or live within the Leeds geographical boundary and have been assessed and meet the criteria can access the service.

Hannah House had six bedrooms; four of these are used for planned short breaks. One is for emergency short break care and one is used for children who meet the continuing care criteria and require a slow planned transition from hospital care to home. There is a multi-sensory room and an outside play area. Children are cared for by a Home Manager and registered sick children's or learning disability nurses 24 hours a day.

At the time of inspection there were approximately 55 children on the caseload for Hannah House.

During our inspection we spoke with 11 staff, reviewed seven electronic care records and five medication records. We spoke with two parents and a young person; we spoke with three parents by phone after the inspection.

Our inspection team

Our inspection team was led by:

Chair: Carol Pantelli

Team Leader: Amanda Stanford Care Quality Commission

The team inspecting Hannah House included a CQC inspector, two members of the medicines management team and two specialists with a background in children's services.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 31 January and 1 and 2 of February 2017. During the visit we spoke with a range of staff who worked within the service, such as nurses, support workers and managers. We talked with people who use services. We observed how children and young people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 15 February 2017.

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

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

Our ratings for this service

Our ratings for this service are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement

Outstanding practice and areas for improvement

Outstanding practice

- The development of Hannah House as a clinical hub has enabled additional services to be offered which have benefited children and young people and their families. For example home visits to resolve problems with feeding tubes.

Areas for improvement

Action the service MUST take to improve

- The provider must ensure all registered staff have undergone level three safeguarding training and have regular safeguarding supervision which is formally recorded.
- The provider must ensure there is safe management of medicines and there is documentation to support this.
- The provider must ensure staff are appropriately skilled and trained to meet the care needs of children at Hannah House.
- The provider must ensure there are robust governance procedures to ensure risks are identified and escalated appropriately and any actions are shared with staff.

Action the service SHOULD take to improve

- Ensure processes are in place for environmental safety checks.
- Ensure that safeguarding supervision is completed.
- Ensure learning from incidents and complaints is shared with staff.
- Ensure daily records of care are completed.
- Consider Wi-Fi access for children during their stay at Hannah House.
- Consider how the service engages with families to enable them to contribute to service development.
- Reduce the number of cancelled short break stays and review the reasons for cancellations

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (1) Care and treatment must be provided in a safe way for service users; 12 (2) (g) the safe management of medicines. **How the regulation was not being met:** Care and treatment was not provided in a safe way for patients, as medicines were not managed in a safe and proper manner.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17 2 (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. 17 (2) (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of regulated activity, for the purpose of continually evaluating and improving such services. **How the regulation was not being met:** The provider did not ensure systems or processes were established and operated effectively to ensure compliance with the regulation.

This section is primarily information for the provider

Requirement notices

The provider did not have governance systems in place that were of a sufficient quality to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The provider did not act on feedback from relevant persons and other persons on the services provided in the carrying on of regulated activity, for the purpose of continually evaluating and improving such services.