Tarporley War Memorial Hospital

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

Overall summary

Tarporley War Memorial Hospital was founded in 1919 by local subscription; it is funded by a small NHS grant, which covers one third of its operating costs. The remaining funding is achieved through private self-paying patients, one off payments from NHS commissioners and charity fundraising. The hospitals registered charity fundraises through a local charity shop and other charitable initiatives. The In-patient unit specialises in the rehabilitation of the elderly, intermediate care and supporting terminally ill and palliative patients. There is also a day care facility, they offer respite care and deal with mini minor injuries.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury.

The hospital director is the registered manager, supported by a senior management team.

A warning notice was issued to the provider on 1 February 2017 setting out improvements that were required.

During our focussed follow up inspection on 11 September 2017, we found the provider was compliant with the requirements of the warning notice.

The warning notice issued 1 February 2017 highlighted areas where the provider was required to make improvements. These included:

- Ensure effective correct control measures are in place to mitigate the risk of pressure damage for those persons deemed at risk of pressure ulcers, such as monitoring and implementing a repositioning regime, these should be clearly documented in patients' records.
- 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms must be quality assessed to ensure they are correctly completed.
- Ensure the hospital undertake a comprehensive and effective auditing programme.
- Ensure the hospital implement a policy and procedure that meets 'duty of candour' requirements.

Summary of findings

- Ensure compliance with the Mental Capacity Act legislation and must ensure that the two stage mental capacity assessment is completed and clearly documented in patients' records.
- Health care assistants acting as second checker for medicines must receive appropriate training and be assessed as competent to carry out the role. This process should be clearly documented.
- Ensure to ensure robust policies, procedures and guidelines are in place, including; equality and diversity issues are considered and addressed for patients, guidelines are in place and followed in relation to meeting the needs of people in vulnerable circumstances and the complaints policy is accessible and provides accurate information about the next step if patients are not satisfied with the outcome of an investigation.
- The risk register must be robust and identify clear processes for mitigating risks and ongoing monitoring with given time scales. The process for staff to escalate local level ideas and risks must be clear.

We found the following areas of improvement:

- The hospital had reviewed a number of policies, which they deemed high priority, for example the duty of candour policy, mental capacity policy and deprivation of liberty policy. These were in line with national guidance and good practice. There were actions in place to ensure all policies had been reviewed by end of October 2017.
- There was now a process in place to ensure that policies were developed and reviewed to reflect changes in practice and the management team had identified leads for each policy.
- All appropriate staff had completed level three safeguarding training and there were plans in place to ensure all registered nurses had received this training by end of October 2017.
- There were improvements in the safe care and treatment to patients who were at risk of developing pressure ulcers, by introducing a skin care bundle, repositioning regime and documentation package and staff had undertaken appropriate training.
- Implementation and monitoring of audits and evidenced based care had improved. Audit results were displayed for staff and actions to improve standards had been identified where required.
- The management team had identified leads for specific topics of any current evidenced based practice, legislation and National Institute For Health and Clinical Excellence (NICE) guidance.
- Health care assistants had undertaken appropriate competency training to act as a second checker for medicines administered in the absence of a second registered nurse.
- We found improvements in the completion of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.
- There was now a more robust and reliable on call system in place, which included how staff would escalate incidents to a senior member of staff.
- Improvements had been made in the management of risk at the hospital. The risk register accurately reflected all the clinical risks within the hospital and now included the condition, cause and consequence of the risk.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Contents

Tarporley War Memorial Hospital

Services we looked at:
Community health inpatient services

Summary of this inspection

Background to Tarporley War Memorial Hospital

Tarporley War Memorial Hospital was founded in 1919 by local subscription; it is funded by a small NHS grant which covers one third of its operating costs. The remaining funding is achieved through private self-paying patients, one off payments from NHS commissioners and charity fundraising. The hospitals registered charity fundraises through a local charity shop and other charitable initiatives.

We undertook a focussed follow up inspection on 21 September 2017 to review action taken by the provider in response to the warning notice and found them to be compliant.

During this inspection we spoke with five staff including; the hospital director, senior sisters, registered nurses and health care assistants. We reviewed six sets of patient records.

Our inspection team

The team that inspected the service comprised of a CQC lead inspector and a CQC team inspector. The inspection team was overseen by Jacqui Hornby, inspection manager.

Information about Tarporley War Memorial Hospital

The hospital has 16 inpatient beds (separate male and female wards; five private side rooms and one double room); mainly cater for NHS 'step-down' patients who do not require acute care, (e.g. a fall, but no fracture) and patients transferred from an acute hospital who are waiting for a package of care to return home.

The hospital provides as 'step up' services for people who needed extra care and help and 'stepdown' services for those who no longer required an acute hospital bed. They also provide rehabilitation, respite care and palliative care.

The hospital also has a "mini minor injuries" drop in service and an outpatient's service operated by external providers but using hospital facilities and nursing staff.

Community health inpatient services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

At our focussed follow up inspection, we found the provider compliant with the requirements of the warning notice because:

- The hospital had reviewed the duty of candour policy and we saw evidence that his had been implemented.
- The management team had arranged for the staff covering the mini minor injuries department to have face-to-face safeguarding level three training and had a clear action plan in place to ensure that all registered nurses in the hospital received this training by the end of October 2017.
- We found improvements in the safe care and treatment to patients who were at risk of developing pressure ulcers, the hospital had introduced a documented skin care bundle and repositioning regime, which enabled staff to monitor the position of patients to ensure and evidence the adequate relief of pressure areas on a regular basis.
- Implementation and monitoring of audits and evidenced based care had improved. Audit results were displayed for staff and actions to improve standards in care were shared at the monthly quality care group.
- The management team had identified leads for specific topics of any current evidenced based practice, legislation and National Institute For Health and Clinical Excellence (NICE) guidance.
- We saw evidence that the competency of health care assistants was assessed and recorded when acting as second checker for medicines administered in the absence of a second registered nurse.
- We found improvements in the completion of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.
- The hospital had revised the policy for the application and management of deprivation of liberty safeguards (DoLs). It was a comprehensive policy based on national guidance which informed staff of the requirements and their legal duties.
- There was now a more robust and reliable on call system in place, which included how staff would escalate incidents to a senior member of staff.
- The procedures and processes for updating and monitoring policies had improved. Lead staff members had been allocated to ensure that policies were reviewed regularly in line with any changes in practice or national guidance. A number of policies had been prioritised and reviewed and there were actions in place to ensure all had been reviewed by end of October 2017.
- Improvements had been made in the management of risk at the hospital. The risk register accurately reflected all the clinical risks within the hospital and now included the condition, cause and consequence of the risk.

Community health inpatient services

Are community health inpatient services safe?

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The hospital had reviewed the duty of candour policy and we saw evidence that his had been implemented as a result of an incident at the hospital in May 2017. This included meeting with the family to discuss the incident., The hospital carried out a root cause analysis (RCA) investigation of the incident and we saw that t the findings and learning were discussed at the monthly Quality Assurance group (QAG).

Safeguarding

- The Intercollegiate Document 'Safeguarding Children and Young People: Roles and Competences for Health Care Staff', states that healthcare staff "who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person" require safeguarding training and competencies to level 3 standards.
- Staff in the mini minor injuries department were assessing and treating children and young persons but had not previously received the required level 3 training. The management team had arranged for the staff covering the department to have face-to-face training at a local trust so that they were compliant. The hospital had a clear action plan in place to ensure that all registered nurses in the hospital were trained by the end of October 2017.

Medicines

- We saw that the policy for medical devices and drug alerts procedure had been reviewed and was up to date, this ensured staff were more aware of any changes affecting their practice.

Assessing and responding to patient risk

- We found improvements in the safe care and treatment to patients who were at risk of developing pressure ulcers. The hospital had introduced a new fully documented skin care bundle and repositioning regime. Repositioning charts enabled healthcare staff to monitor the position of patients to ensure and evidence the adequate relief of pressure areas on a regular basis. It also enabled staff to record what they have done and if a patient opts not to follow advice on pressure area relief. At the time of the inspection an audit had not yet been completed. However, this was completed shortly after the inspection.The audit showed a compliance rate of 98%.
- On reviewing four sets of skin care and repositioning documentation, we found that staff were not always reporting what movement the patients had undertaken during the day but just monitoring what they saw at the time.When we raised this with the management team, they immediately made improvements and amended the hospital quality indicator to include this.
- Patient information leaflets had also been developed by the hospital informing patients and relatives on the prevention and treatment of pressure ulcers. This enabled the patients and relatives to be better informed and to actively participate in the prevention of pressure ulcers.

Are community health inpatient services effective?
(for example, treatment is effective)

Evidence based care and treatment

- Implementation and monitoring of audits and evidenced based care had improved.
- We saw evidence of a hospital audit programme; the quality indicator summary showed the monthly results for the compliance of areas such as falls assessment tool, pressure areas and cleaning. Actions for improvement also identified persons responsible and timeframes for the actions to be completed.
- Five patients were randomly selected each month and the standards of nursing documentation were audited on areas such as: falls, medication, pressure area care,

infection control, nutrition, pain, nurse cleaning, transfer and discharge, continence and DNACPR. The audit tools were reviewed regularly by the clinical quality assurance group to ensure key priorities remain the focus of the audit.

- The audit results were disseminated and displayed each month on the staff quality notice board. All required actions were shared with nursing staff at the monthly quality care group meeting to ensure lessons learnt were disseminated and all actions were completed.
- The management team had identified champions for specific topics of any current evidenced based practice, legislation and National Institute For Health and Clinical Excellence (NICE) guidance. Information was then disseminated to relevant members of staff. The matron had overall responsibility for the management of the champions and keeping abreast of new guidance and practices.
- The hospital discussed any new guidance, updates, or best practice at the monthly quality care group, which fed into the clinical quality assurance group. We saw minutes to evidence this. The hospital called this information; field safety alerts.
- New forms had been implemented regarding mental capacity assessments; however no audit had yet been undertaken. We did however see evidence that this was included in the quality performance indicators.

Competent staff

- At the last inspection there were concerns that health care assistants undertaking checks of medication had not had their competencies assessed.At this inspection, we saw evidence that the competency of health care assistants was assessed and recorded when acting as second checker for medicines administered in the absence of a second registered nurse.
- Since our last inspection, additional staff training on pressure ulcers had been implemented and staff had undergone electronic training and completed workbooks to assess their knowledge. At the time of the inspection 87% of staff had completed the training.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard (DoLs)

- We found improvements in the completion of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.We looked at three patient notes all of which were correctly completed. We found that there was not a process in place if DNACPR forms did not arrive with the patient, if they had completed one with their GP prior to admission.However, immediately following the inspection a process was identified.
- The process also outlined that if this did not happened then an incident must be logged and the issue escalated to senior staff to ensure that relevant forms were completed or obtained.
- A new policy had been put in place, which outlined how and when mental capacity assessments were to be carried out and followed national guidance. The Mental Capacity Act policy also contained a template appendix for the two-stage test, including a flow chart for the best interest decisions, assisting staff to become competent at completing the forms.
- However we found that a capacity assessment had not been implemented on one occasion when it should have been.Staff we spoke with told us that they knew the patient limitations and was a regular patient.However, the patient capacity may have changed.
- At the last inspection we found that the Deprivation of Liberty Safeguard (DoLs) policy was not in line with national guidance.The hospital had revised the policy for the application and management of DoLs and it had been approved at the quality assurance group meeting. It was a comprehensive policy based on national guidance which informed staff of the requirements and their legal duties.

Are community health inpatient services caring?

Not inspected.

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

Community health inpatient services

(for example, to feedback?)

Not inspected.

Are community health inpatient services well-led?

Governance, risk management and quality measurement

- At the last inspection the on call system had been conducted in an informal manner. Improvements had been made and a more robust and reliable on call system was now in place. A flow chart assisted staff in making a decision on whether there was a requirement to escalate the incident to a senior member of staff.
- There had been a restructure in the administration, procedures, processes and monitoring of policies. This enabled staff to locate policies and the system identified when a policy was due for review. We saw that the policy for the development of trust policies, protocols and procedures had been reviewed and was up to date.
- Leads had been identified for each policy to ensure that it was up to date and reviewed regularly in line with any changes to practice or national guidance.
- We found that a number of policies had been updated since the last inspection and the senior management team had prioritised the policies to be reviewed. Senior management staff told us that all policies would be reviewed by the end of October 2017.
- We saw an example of the process being implemented by observing that the medicines management policy had been reviewed and updated and was in the final stages of review by the pharmacist.
- At the last inspection we raised concerns about the complaint policy not providing guidance to patients on who to escalate concerns if they were unsatisfied with the response from the hospital. The policy still did not include this information but the patient leaflet did. Senior staff told us that this was an error and would be rectified after the inspection.
- On reviewing the risk register accurately we found that this reflected all the clinical risks within the hospital and now included the condition, cause and consequence of the risk. The risk register identified the name of the person responsible for managing the risk, the governance group responsible and the timeframe for any actions to be completed. The risk register also included details of any progress.
- The use of the skin care bundle and repositioning chart was included the risk register. We saw that there was an action for nursing staff to be involved in the hospital quality indicators audit to facilitate familiarity of the audit tool and to identify and benchmark the standards of specific activities within the hospital.
- We found that there had been improvements of the monitoring of pressure ulcers. There was improved incident reporting for all grade two, three and four pressure ulcers and they also captured incidences of new pressure ulcers. Root cause analysis investigations were conducted in each case and monitored at the weekly management meetings, the quality assurance group and the trustee board.