Oxford University Hospitals NHS Foundation Trust

Nuffield Orthopaedic Centre

Quality Report

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

Ratings

Medical care (including older people's care)

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the Oxford Centre for Enablement (OCE) on 8 November 2017; this was an unannounced inspection following up on the previous inspection on 9 August 2017. The previous inspection followed a RIDDOR notification concerning a safety incident that occurred on the 8 July 2017.

During this inspection concerns previously identified were followed up to ensure that the previous risks identified had been addressed. There was also an additional focus on the safe and well led domains. This was to ensure patient care was safe and to review the organisation and leadership of the unit.

The CQC inspected and gathered evidence relating to the safe care of patients and the organisation and leadership of the inpatient ward and to some degree the wider unit. This evidence was collected through observation, staff interviews and document review.

This was a focused inspection with only two domains being reviewed therefore there is no overall rating for this service. This was because this inspection was to follow up on concerns identified at the previous inspection. The two domains safe and well led have been rated as requires improvement.

There were areas of poor practice where the trust needs to make improvements:

- There was variation in the cleanliness of the ward; clinical cleaning at the weekend was inconsistent and hand hygiene audits were not submitted monthly as required by the trust.
- The work to update and change existing door locks, to ensure patients using the service were safe, was still not complete even though the completion date for the work was October 2017.
- The leak in the conservatory roof had not been fixed properly; although in recognition of the risk, during our inspection it was closed to patients.
- There was not an effective system to manage and monitor maintenance issues. There were some outstanding safety tests for equipment from 2016.
- There were some items stored alongside, but not part of the emergency equipment, that were out of date presenting a potential risk.
- Staff were not routinely trained in all key areas of safety. Mandatory training rates were low in some key areas for medical staff and some areas of safety were not deemed essential for staff working in the unit. The unit had started to use a new electronic patient observation and escalation system without staff receiving the full training.
- There was a potential for patients to be placed at risk because staff were not familiar with the trust sepsis pathway.
- There were no personal evacuation plans for patients and there had been no reassessment of the fire evacuation risks following the decision to change the security arrangements for the unit.
- The nurse staffing vacancies were still significant with little improvement since the last visit despite recruitment efforts. The trust had mitigated the risk by reducing the number of beds in October 2017.
- Although the organisation of patient paper records were found to have improved overall, it was still difficult to link them with the electronic system, and therefore a contemporaneous record was not available.
- Pre-printed care plans had not been reviewed to ensure they were reflective of the latest local and national guidance; there was also inconsistency in the staff evaluations and signatures of these documents.

Summary of findings

- There had been no opportunity for a multidisciplinary team event for the promotion of unit working and team development for the last two years, in a department were multidisciplinary working was a key component of providing a quality service for their patients.
- A philosophy and vision paper was produced in November 2017, but there was no evidence who had been engaged in agreeing it or who wrote it. There were no shared values or strategy displayed.
- We were not assured that the monitoring of the service was effective, as the team had not recognised the risks we identified. The rating of risks was not consistent, with some rated lower than the impact would indicate, for example the nurse staffing vacancies, which had led to bed closures. Therefore, where high levels of risk existed there were not recognised and escalated appropriately for consideration.
- There was no local mechanism for patient and relative feedback.
- Staff were not all familiar with the term Duty of Candour and its formal requirements

However:

- There had been good progress in developing a more effective method of tracking and managing the patients' pathway via the use of daily quality board reviews.
- Staff followed the trust policy and assessed their patient's capacity using the Mental Capacity Act. There was documentary evidence to support this.
- Some work on the environment had been completed to help protect the patients from harm. The ward kitchen doors were shut securely for safety. The garden area was now secured with keypad locked gates; the codes were restricted to OCE staff
- There had been changes and development in the way unit managed and considered patient's safety.The patient tagging system, used to alert staff if patients assessed to be at risk, leave the ward area, had been repaired and there was a 24hour helpline in case of breakdown. Patients were risk assessed for their suitability to use bedside rails on their initial admission to the unit.
- Staff were complimentary of the unit's local leadership and the general team.
- Staff were clear about their responsibilities to report incidents and how to do this. There was a process for feedback on incidents, actions and learning.
- Staff managed and administered medicines safely.
- The leadership team were involved in various research projects for improving patient outcomes.

Importantly, the trust must:

- Ensure that all staff are able to describe and apply their responsibilities in relation to the Duty of Candour.
- Review the standard of record keeping ensuring each patient has a multi-disciplinary contemporaneous plan and record of care, which reflects their individual needs taking into account the assessment of safety risks associated with delivering the required level of care.
- Continue to monitor and review the staffing levels on the inpatient ward to ensure they are at the required level with the correct skill mix to meet the assessed needs of the patients.
- Ensure planned work to improve the safety of the ward and the unit in general is completed or escalated, as not completed in the agreed time scales.

Summary of findings

- Review staff education on the sepsis pathway and ensure that staff have received the required training on the use of the new electronic observation and escalation system.
- Review the content of staff mandatory training ensuring it reflects the needs of the unit using feedback from training needs analysis, local and national developments.
- Take action to improve the compliance with completion of mandatory training.
- Review the use of the risk register ensuring staff understand the scoring system so that risks are recognised and escalated in a timely way.
- Review the monitoring of the quality of the service to ensure it is effective.

In addition the trust should:

- Ensure that the new system to monitor application for Deprivation of Liberty Safeguards is understood by staff. Including the need for staff to understand they should track both the application, and the expiry dates of any such applications to ensure they do not unlawfully deprive patients of their liberty.
- Ensure the new process for mental capacity assessments is embedded with completed and documented assessments for all patients considered not to have capacity. Where a patient lacks capacity, consideration must be given to what would be in the patient's best interest and if they are to be deprived of their liberty, safeguards required by legislation must be put in place.
- Ensure regular reviews of all plans of care and immediate reviews when there is a change to the patients' needs to ensure they remain current and relevant to the needs of the individual patient.
- Take action to ensure the conservatory is always a safe area for patients to use.
- Ensure all staff are aware of the importance of closing and securing all doors assessed as needing to be shut for patient safety reasons.
- Ensure the unit is secure and safe out of hours and a local fire risk assessment is carried out to reflect the changes in door security.
- Monitor and sustain the clear guidance as to when patients have the tagging system applied for their own safety.
- Monitor staff compliance with the use of the new guidance and criteria that must to be followed when considering placing patients under one to one supervision.
- Review the effectiveness of the service monitoring and reporting arrangements to ensure risks are identified and mitigated.
- Review the process that the senior teams are expected to follow when they are considering local risks to ensure ownership and oversite of risks is achieved.
- Review the ward's cleaning schedule including the monitoring of cleaning to ensure it is fit for purpose.
- Ensure that clinical cleaning is taking place and monitored.
- Review the use of the pre-printed care plans ensuring they are current and monitor how staff evaluate them and provide evidence that evaluation has occurred.

Professor Edward Baker

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care (including older people's care)		**This was a focused inspection with two domains being reviewed therefore there is no overall rating for this service**. This was because this inspection was to follow up on concerns identified at the previous inspection. To ensure that the previous risks identified had been addressed, and patient care was safe and to review the organisation and leadership of the unit. The two domains safe and well led have been rated as requires improvement. • There was variation in the cleanliness of the unit; some areas were not sufficiently clean, disposable curtains were not always changed every six months as per unit protocol, clinical cleaning at the weekend was inconsistent and hand hygiene audits were not submitted monthly as required by the trust. • The work to update and change existing door locks, to ensure patients using the service were safe, was still not complete even though the completion date for the work was October 2017. • There was not an effective system to manage and monitor maintenance issues. There were some safety tests for equipment due in 2016 that had not been completed. • There were some equipment items stored alongside the emergency equipment that were out of date meaning they could have been inadvertently used. • Staff were not routinely trained in all key areas of safety. Mandatory training rates were low in some key areas for medical staff and some areas of safety were not deemed essential for staff working in the unit. The unit had started to use a new electronic patient observation and escalation system without staff receiving the full training. • Staff we spoke with were not familiar with the trust's sepsis pathway. • There were no personal evacuation plans for patients and there had been no reassessment of the fire evacuation risks following the decision to change the way the security arrangements for the unit.

Summary of findings

- The nurse and medical staffing vacancies were significant with little improvement since the last visit despite recruitment efforts. Although the trust had reduced the risk to patients by reducing the number of beds in October 2017.
- Although the organisation of patient paper records were found improved overall, it was still difficult to link them with the electronic system, and therefore a contemporaneous record was not available.
- Pre-printed care plans had not been reviewed to ensure they were reflective of the latest local and national guidance; there was also inconsistency in the staff evaluations and signatures.
- Managers had not created an opportunity for a multidisciplinary team event for the last two years.
- We were not assured that the monitoring of the service was effective, as the team had not recognised the risks we identified.
- A philosophy and vision paper was produced in November 2017, but there was no evidence who had been engaged in agreeing it or who wrote it. There were no shared values or strategy displayed.
- The rating of risks was not consistent or always accurate and some were rated lower than the impact would indicate, for example the nurse staffing vacancies, which had led to bed closures.
- We were not assured that risks were escalated appropriately for the senior teams to consider.
- Even though staff worked with patients and their relatives on an ongoing basis, there was no local mechanism for patient and relative feedback other than the trust wide friends and family test.
- Staff were not familiar with the term Duty of Candour and its formal requirements.

However:

- There had been good progress in developing a more effective method of tracking and managing the patients' pathway via the daily quality board reviews.
- Staff now followed the trust policy and assessed their patient's capacity using the Mental Capacity Act. There was documentary evidence to support this.

Summary of findings

- Patients were risk assessed for their suitability to use bedside rails on their initial admission to the unit.
- The ward kitchen doors were shut securely for safety.
- The garden area was now secured with keypad locked gates; the codes were restricted to OCE staff.
- The patient tagging system had been repaired and there was a 24hour helpline in case of breakdown.
- Staff were complimentary of the unit's local leadership and the team in the unit.
- Staff were clear about their responsibilities to report incidents and how to do this. There was a process for feedback on incidents, actions and learning.
- Staff managed and administered medicines safely.
- The leadership team were involved in various research projects for improving patient outcomes.

Nuffield Orthopaedic Centre

Detailed findings

Services we looked at
Medical care (including older people's care)

Detailed findings

Contents

Background to Nuffield Orthopaedic Centre

The Nuffield Orthopaedic Centre is part of Oxford University Hospitals NHS Foundation Trust. It has been treating patients with bone and joint problems for more than 80 years and has a world-wide reputation for excellence in orthopaedics, rheumatology and rehabilitation. The Oxford Centre for Enablement (OCE) is also part of Oxford University Hospitals NHS Foundation Trust and is located on the site of the Nuffield Orthopaedic Centre. The Nuffield Orthopaedic Centre was merged with Oxford University Hospitals in 2011. The building housing the OCE is part of the 'retained' estate and is supported by the Private Finance Initiative (PFI) security team and maintenance processes.

The OCE is the Wessex regional enablement centre and is commissioned by NHS England (NHSE) to provide specialist neurological rehabilitation for up to 26 inpatients. The OCE is the only Level 1(1B) unit funded by NHSE for the 'Wessex region'. This area covers a wide area (Oxfordshire, Buckinghamshire, Berkshire, Hampshire, Isle of Wight, and Dorset).

The OCE is commissioned to provide ongoing specialist rehabilitation to high acuity patients. Tertiary 'specialised' rehabilitation services (Level 1) such as this one, are high cost / low volume services, which provide rehabilitation to patients with highly complex needs that are beyond the scope of their local and district specialist services. They are provided in co-ordinated service networks planned over a regional population of 1-5 million through specialised commissioning arrangements.

Specialist rehabilitation is the total active care of patients with a disabling condition, and their families, by a multi-professional team who have undergone recognised specialist training in rehabilitation, led by a consultant trained and accredited in rehabilitation medicine.

Such patients are typically those with a diverse mixture of medical, physical, sensory, cognitive, communicative, behavioural and social problems. They require specialist input from a wide range of rehabilitation disciplines (for example, rehabilitation-trained nurses, physiotherapy, occupational therapy, speech and language therapy, psychology, dietetics, orthotics, social work etc.) as well as specialist medical input from consultants trained in rehabilitation medicine, and other relevant specialties such as neuropsychiatry.

This inspection was a focussed follow up inspection following the previous responsive focussed inspection in August 2017. This was undertaken following the receipt of a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) notification.

From 1 April 2015, the Care Quality Commission (CQC) has been the lead enforcement body for health and safety incidents that have occurred in a health and social care setting, where members of the public are injured or die.

We did not carry out a full comprehensive inspection but a focused follow up inspection, therefore CQC only inspected and gathered evidence relating specifically to the safe and well led domains through observation, staff interviews and evidence gathering.

This inspection was to follow up on previous concerns and complete the inspection of safe and well led

Detailed findings

domains. To ensure that identified issues from the previous inspection had been rectified and changes that had taken place ensured safe care and procedures on the OCE inpatient ward.

Our inspection team

Our inspection team was led by an inspection manager from CQC and consisted of two inspectors from CQC. The inspection was overseen by Nick Mulholland head of inspections for hospitals.

How we carried out this inspection

We inspected the premises of the OCE inpatient ward on an unannounced follow up inspection on 9 November 2017 between the hours of 8.30 am and 7pm.

We spoke with thirteen staff, including senior managers, medical staff, front line clinical staff and contracted support staff. We also spoke with two patients and one visitor.

We inspected nine sets of patient records, various supporting ward documentation and observed a board review handover.

Medical care (including older people's care)

Safe	
Well-led	
Overall	

Information about the service

The inpatient service provides inpatient neurological rehabilitation for patients needing highly specialist rehabilitation from Oxfordshire and surrounding counties. It is part of the Thames Valley Trauma Network rehabilitation network.

The centre's primary goal is to ensure that each person with persisting disability and/or distress arising from disease or damage achieves the best level of social integration possible, whilst also considering equitable, fair allocation of limited resources.

The ward had the capacity to admit up to 26 inpatients at any one time, depending upon staffing levels and the level of dependence of the patients being referred and admitted. Following the previous inspection in August 2017 the centre had voluntarily reduced the patient bed numbers to 18 due to the high level of registered nurse vacancies.

Patients were considered suitable for admission if the patient had a neurological or neuromuscular condition, and would benefit from the specialist neurological rehabilitation service available; would not gain an equal benefit from a more readily available service, and would be safe in the environment. Patients may be admitted for anything between two weeks and several months.

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- There was variation in the cleanliness of the unit; some areas were not sufficiently clean, disposable curtains were not always changed every six months as per unit protocol, clinical cleaning at the weekend was inconsistent and hand hygiene audits were not submitted monthly as required by the trust.
- The work to update and change existing door locks, to ensure patients using the service were safe, was still not complete even though the completion date for the work was October 2017.
- There was not an effective system to manage and monitor maintenance issues. There were some safety tests for equipment due in 2016 that had not been completed.
- There were some equipment items stored alongside the emergency equipment that were out of date meaning they could have been inadvertently used.
- Staff were not routinely trained in all key areas of safety. Mandatory training rates were low in some key areas for medical staff and some areas of safety were not deemed essential for staff working in the unit. The unit had started to use a new electronic patient observation and escalation system without staff receiving the full training.
- Staff we spoke with were not familiar with the trust's sepsis pathway.

Medical care (including older people's care)

- There were no personal evacuation plans for patients and there had been no reassessment of the fire evacuation risks following the decision to change the way the security arrangements for the unit.
- The nurse and medical staffing vacancies were significant with little improvement since the last visit despite recruitment efforts. Although the trust had reduced the risk to patients by reducing the number of beds in October 2017.
- Although the organisation of patient paper records were found to have improved overall, it was still difficult to link them with the electronic system, and therefore a contemporaneous record was not available.
- Pre-printed care plans had not been reviewed to ensure they were reflective of the latest local and national guidance; there was also inconsistency in the staff evaluations and signatures.
- Managers had not created an opportunity for a multidisciplinary team event for the last two years.
- We were not assured that the monitoring of the service was effective, as the team had not recognised the risks we identified.
- A philosophy and vision paper was produced in November 2017, but there was no evidence who had been engaged in agreeing it or who wrote it. There were no shared values or strategy displayed.
- The rating of risks was not consistent or always accurate and some were rated lower than the impact would indicate, for example the nurse staffing vacancies, which had led to bed closures.
- We were not assured that risks were escalated appropriately for the senior teams to consider.
- Even though staff worked with patients and their relatives on an ongoing basis, there was no local mechanism for patient and relative feedback other than the trust wide friends and family test.
- Staff were not familiar with the term Duty of Candour and it's formal requirements.

However:

- There had been good progress in developing a more effective method of tracking and managing the patients' pathway via the daily quality board reviews.
- Staff now followed the trust policy and assessed their patient's capacity using the Mental Capacity Act. There was documentary evidence to support this.
- Patients were risk assessed for their suitability to use bedside rails on their initial admission to the unit.
- The ward kitchen doors were shut securely for safety.
- The garden area was now secured with keypad locked gates; the codes were restricted to OCE staff.
- The patient tagging system had been repaired and there was a 24hour helpline in case of breakdown.
- Staff were complimentary of the unit's local leadership and the team in the unit.
- Staff were clear about their responsibilities to report incidents and how to do this. There was a process for feedback on incidents, actions and learning.
- Staff managed and administered medicines safely.
- The leadership team were involved in various research projects for improving patient outcomes

Medical care (including older people's care)

Are medical care services safe?

- There was variation in the cleanliness of the unit; in some areas the standard of cleanliness was unacceptable, clinical cleaning at the weekend was inconsistent and hand hygiene audits were not submitted monthly as required by the trust.
- The work to change the door locks, to ensure the unit was safe was still not complete even though the completion date for the work was October 2017.
- The leak in the conservatory roof had not been fixed properly; although in recognition of the risk, on this during our inspection it was closed to patients.
- There was not an effective system to manage and monitor maintenance issues. There were some safety tests for equipment due in 2016 that had not been completed.
- There were some equipment items stored alongside the emergency equipment that were out of date meaning they could have been inadvertently used.
- The unit had started to use a new electronic patient observation and escalation system without staff receiving the full training.
- The staff we spoke with were not familiar with the trust's sepsis pathway.
- There were no personal evacuation plans for patients and there had been no reassessment of the fire evacuation risks since the decision to change the way the unit's doors locked. .
- The nurse and medical staffing vacancies were still significant with little improvement since the last visit despite recruitment efforts. However, the trust had reduced the risk of this to patients by a reduction in the number of beds in October 2017.
- Although the organisation of patient paper records were found improved overall, it was still difficult to link them with the electronic system, and therefore a contemporaneous record was not available.
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- The ward kitchen doors were shut securely for safety.
- The garden area was now secured with keypad locked gates; the codes were restricted to OCE staff only.
- The patient tagging system had been repaired and there was a 24-hour helpline in case of breakdown.
- Staff were clear about their responsibilities to report incidents and how to do this. There was a process for feedback on incidents, actions and learning.
- Staff managed and administered medicines safely.
- The leadership team was involved in various research projects for improving patient outcomes.

Mandatory training

- The trust mandatory training included for example fire safety, health and safety, adult and children safeguarding. Some training available had been deemed, by the trust, as not required for this staff group, this included for example; conflict resolution practical and theory, electronic record keeping, health record keeping and consent. We shared this finding with the senior team who were going to investigate why.
- We reviewed the training records of the OCE staff for their compliance with mandatory training up to the end of October 2017; overall, the nursing team was 93% compliant. The lowest staff compliance was for blood transfusion at 59% and resuscitation at 72%. The medical team had the lowest compliance with 46% overall compliance with the lowest compliance of 25% in infection prevention and control and manual handling. The trust told us that the medical team was small, with one member absent which had impacted negatively on the training compliance.

Safety thermometer

- The service displayed local data, relating to safety on a large white board in the dining room corridor, for the attention of staff, patients, and relatives. However, the data on display was in very small font, with no explanation for the reader to understand what it meant and when it was last updated.
- The service contributed data to the national safety thermometer audit. These were combined with the acute site for hospital attributable data. Therefore, an overall harm score was attributed to the trust rather than specific services.
- The data submitted by the trust for OCE in August, September and October 2017 showed that on the days the safety data was recorded there had been one urinary tract infection related to an indwelling catheter. No hospital acquired pressure ulcers, three no harm patient falls and 97% of patients had been risk assessed for a venous thrombosis event

Incidents

- Staff we spoke with were familiar with the process of reporting incidents and confidently explained the process.
- Staff recorded patient incidents using an electronic recording tool. They were discussed at ward rounds, ward meetings and within the ward handover sheets. Staff we spoke with told us there was a high incidence of falls within the unit due to the nature of 'enablement' when patients are encouraged to redevelop mobility skills.
- In the previous twelve months before November 2017, staff reported 104 patient slips trips or falls without harm. There were 26 from a bed, 21 from a chair or wheelchair, 32 whilst the patient was mobilising and 25 various other causes.
- There was an internal trust process for potential serious incidents to be reviewed at a 72 hour incident review meeting. Minutes of these meetings confirmed these meetings were used to decide whether an incident was a serious incident (SI) and required further investigation. At this point, an incident would be confirmed as a case needing to be reported under the RIDDOR.
- A previous review of records relating the RIDDOR incident demonstrated the principles of Duty of Candour had been applied and the family had been informed of the incident. The trust sent a letter asking if they would like to see the investigation report. However, there was no evidence of a written record of any discussions, which we were informed had taken place with the family.

Medicines

- The unit stored and managed most medicines safely, the clinical room was locked with a key pad and controlled drugs were appropriately stored locked in an identified cupboard.
- We inspected the controlled drugs cupboard and saw that the night staff checked them nightly. There were no inappropriate medicines found stored within the controlled drugs cupboard, and there was a list of staff names with signatures for effective identification.
- There were clear disposal routes for unwanted medicines, a one-way bin for pharmacy returns and another for non-hazardous waste.
- The secured medicines refrigerator and the clinical room environment had their temperatures recorded daily, the recording charts were clear with upper and lower acceptable temperature limits to guide staff into taking actions.
- We observed a medicine administration round; staff wore disposable red aprons to indicate that they were engaged in the round. The trust had an electronic medicine administration system, which staff understood and followed, it included allergy warnings to prevent safety incidents. Patients wore identification bands for checking against their prescription.
- The ward pharmacists checked patients' prescription charts regularly for safe prescriptions and ward medicine stocks. The ward staff locked and secured trolleys appropriately when not in use.
- The trust's most recent medicine audit was dated January 2017 and showed some areas requiring improvement, for example; temperature recording of the medicine refrigerator, and we saw that these had been rectified when we inspected.
- The trust audited the appropriate use of antibiotics within the unit (antimicrobial stewardship); the data

supplied showed that from June until October 2017 two of the three patients records who were audited were reviewed appropriately which gave 66% compliance. The OCE employed good antimicrobial stewardship when patients had a urinary tract infection and only treated those who were symptomatic. Trust data showed that from October 2016 until October 2017, 17 of the 44 patients with urinary tract infections received antibiotics.

- An open bottle of liquid pain medicine did not indicate a date of opening which could mean that it was no longer effective, as it should be used within 28 days of opening.
- There was a large store of botulinum toxin used for out patient clinics and inpatients within the clinical room, which was in an unlocked cupboard. The clinical room was only accessible by fobs held by registered nurses. Although we saw no evidence of any logging of its use, the trust told us that the pharmacy monitored it.

Records

- Staff used a combination of paper and electronic patient records in August 2017. At that time, we found the electronic system difficult to navigate when patients had been within the unit for some time. There were issues in locating a contemporaneous record of care and in following the decision-making processes. Each different discipline using the electronic records appeared to use a separate part of the record, which made it difficult to track a day's care.
- On this inspection we found the unit had made significant improvements in the organisation of their paper record keeping, we saw records were organised and easier to follow. However, the combination of paper and an electronic recording system still did not enable a contemporaneous patient record to be accessed.
- Since our last inspection, there had been considerable input from the trust lead nurse for safeguarding to help organise records of the applications and decision making relating to safeguarding and mental capacity assessments. The records showed this input had made reading and following the decision-making records simpler. For example, patients having one to one staff supervision and observations now had an assessment and rationale for 'one to one' supervision easily accessible within the records when appropriate.
- The unit staff undertook a broad range of safety risk assessments when the patients were initially admitted, these included, for example, a falls risk, pressure ulcer risk, moving and handling and nutrition screening which linked to care plans. However, whilst this admission documentation was generally improved, patient care plans were pre-printed and not always individualised, with some needing to be reviewed and updated to reflect current local and national guidance. For example, we saw one care plan in use relating to tube feeding, which was dated 2010.
- We still saw some variation in patient records. Staff did not always evaluate the planned patients care before being signed and dated at each entry. We also found some random sheets of paper which nursing care recorded in some records; following our enquiries, these may have been from bank or agency staff with no electronic system access. Normally, temporary staff had access but it relied upon the shift coordinator to instigate, if they were junior or unaware of the process this may have left a gap.
- The unit had conducted an internal audit of patient records in November 2017. Staff reviewed six records, with the scores of 93% to 97% compliance. Two records of the six did not show a full record of the daily care within the electronic system. The scoring system of compliance did not reflect this deficit. There were seven action points with deadlines following this audit.
- A trust record of the patients' meals taken, skin condition, position, hygiene, elimination, accessibility of their call bell and a care prescription was completed and retained at the patient bedside. We saw these (known as intentional rounding) completed appropriately for patients, however we found some completed ones left in empty rooms following patients discharge.
- There was a confidential waste bin for appropriate destruction of confidential waste.

Medical staffing

- There was one part time consultant (seven sessions) and one full time locum consultant. The locum consultant started in July 2017 initially for six months, but we were told that their contract had been extended for a further nine months. The service required three consultants; recruitment had been ongoing to fill the gaps. The risk had been escalated to the local risk register with actions to advertise for more locums to try to lessen the risk.
- Registrars and rotating senior house officers, plus general practitioner trainees supported the consultant team. Out of hours cover was provided by the consultants with support from the trust stroke team. The unit registrar or senior house officer attended the new daily quality 'board round' and contributed to the discussion and assessment of the patients' progress.

Nursing staffing

- The overall ward staffing establishment was set at 51 whole time equivalents (WTE) for the safe care of 85% Category A level 1 patients (most challenging) within the 26-bedded unit. The trust data in November 2017 showed an overall nursing vacancy rate of 8.17 WTE or 12%. This had been off set slightly by an over establishment of 1.4 in Band 4 and 0.64 in Band 3 posts.
- Following our previous inspection in August 2017 when we raised safety concerns over the level of vacancies, the trust had temporarily reduced the patient numbers by eight in October 2017. We were told the beds would be re-opened incrementally as the trust recruited to posts; for each five patients utilising beds, three WTE registered nurses (RNs) were required to safely provide care.
- The nursing establishment was 26.74 WTE RNs but at the time of the inspection there were 7.07 WTE (26.4 %) vacancies which had improved by one WTE since August 2017. The senior nurses had tried to fill the vacant RN posts with alternatives such as registered learning disability nurses and Band 4 posts, however this diluted the RN skill mix and made the off duty more challenging to do. This also meant there were challenges in managing some clinical issues such as patient tracheostomies with a lower skill mix. The increased RN vacancies were on the unit's local risk register with actions to try to reduce the risk. Senior staff told us that the unit hoped to receive some new overseas nurses from a cohort starting soon.
- The unit shift patterns were normally five RNs and one band 4 registered learning disability nurse and four health care assistants (HCAs) in the morning. The afternoon shift was usually staffed with five RNs, one band 4 and three HCAs. There were three RNs, and two HCAs overnight. Any patients requiring one to one supervision had an additional staff member requested on top of these numbers.
- These numbers were reduced in October 2017 to reflect the lower bed occupancy. The new numbers for 18 beds were four RNs and five HCAs in the morning, four RNs and four HCAs in the afternoon and three RNs and two HCAs overnight. Matron also reviewed the unit's skill mix and patient workload or dependency weekly.
- The inspection team reviewed the adjusted planned nurse staffing against the actual staffing for August, September and October 2017. There was only one day in August, no days in September and four days in October that the planned and actual numbers of RNs on duty were achieved; despite the reduction of beds and reduction in staffing requirements in October 2017. We saw that in October 2017, there were five days with one RN short, twelve days with two RNs short, seven days with three RNs short and three days with four RNs short. This was following the reduction in occupied beds and where requests for temporary bank and agency staff to fill the gaps had not been successful.
- A review of the trust's electronic record of patient dependency and staffing in October 2017 indicated that none of the early, late and night shifts flagged as red 'at risk' despite the ten days when there were three or four RNs short. For the same time 37% (23/62) were rated as amber at minimum numbers, the remaining 53% (33/62) were green at agreed numbers. This meant that although on some days numbers of RNs were short, the were still considered to be not 'at risk' by the trust. There were six shifts in October, which would have had a surplus of health care assistants; however, these were moved elsewhere in the trust to work.

- The ward displayed the planned numbers of staff for the daily shifts, so that patients or visitors were informed, however we did not see the 'actual' numbers displayed whilst we were on inspection.
- The unit nursing staff were divided into three teams, known as Chestnut, Oak, and Elm teams. Each covered one of three corridors and moved as a team to cover a different corridor every three months. This was to ensure staff worked with different levels of patient acuity and helped to prevent staff burnout.

Assessing and responding to patient risk

- Since we last inspected in August 2017, staff had introduced a new quality board in October 2017, this was located confidentially within the ward office. It displayed patients' names with progress of their treatment pathway, their current risks and whether there was any mental capacity, DoLS or safeguarding issues to consider. The patients' specific named therapy and nursing staff were listed and the board was updated daily. The multidisciplinary team including nursing, occupational and physiotherapists, doctors, speech and language therapists and psychologists started to use the board for a daily board round in the morning where each patient was discussed. It was easy to see the progress of any patient's DoLS application, when assessments were due and ultimately their discharge plans. Patients who needed one to one supervision or tagging were clearly identified.
- When we inspected, we saw that seven of the eight paper records we reviewed had patient safety risk assessments fully undertaken when the patient was first admitted. These included for example, the patients' risk of falling, risk of developing a pressure ulcer and a nutritional risk assessment. We saw improvements in the reassessment of risk and the linking of the risks to plans of care.
- For patients requiring bedside rails we saw that risk assessments had been used to inform the decision to use them.
- If a patient was considered to be at risk of wandering, staff we spoke with told us they would be considered for one to one supervision or a tagging system would be used. If the patient did not consent to this high level of supervision then a Deprivation of Liberty Safeguards (DoLS) application would be made. OCE staff decided when a patient became at risk from wandering, using their professional judgment supported by local guidelines.
- Patients, assessed by the medical team, at risk of harm could have formal one to one supervision implemented. On other occasions if staff were concerned about a patient's safety they would implement, what was referred to as, intermittent one to one supervision. When we reviewed records we could follow how the OCE staff had made the decision to use one to one supervision on at risk patients.
- Shortly before we inspected the unit in November 2017, the unit had adopted the use of the trust wide electronic patient escalation tool. Staff inputted their patient's observations, for example of pulse, blood pressure, respirations into an electronic system and responded to any instructions given. It was based on the nationwide early warning system (NEWS). Staff we spoke with were generally positive about the system but felt they were not totally clear about its use, as they did not receive any formal training prior to its implementation.
- The senior team were asked about the training for the new system and they confirmed that they had missed the trust programme of training. The senior team were therefore relying on staff that had used it elsewhere in the trust, to teach their colleagues. They had no practice educator in post to undertake training before it was rolled out. There was no risk assessment undertaken prior to the unit starting to use the system without staff having any formal training.
- In a trust audit of the NEWS escalation tool, compliance was 100% for patients having a minimum set of daily observations every 24 hours. However, due to the nature of the OCE unit with therapy and other activities taking place, the audit showed there were between 17-33% observations being completed on time. There were 54 sets of patient observations that were incomplete with 33 with missing patient consciousness scores and 13 with missing respiratory data.
- Staff we spoke with told us that when patients were transferred out of the unit, a paper copy of their observations was made to ensure continuity of care.

- The trust audited the OCE unit for its compliance to the trust sepsis pathway, as since January 2017 the unit followed the pathway. Prior to this, three patients' who had care during 2016 for sepsis were audited, two were compliant with the pathway, and one not compliant as the antibiotic in use was not within the pathway. In 2017, to date there was one patient with sepsis whose treatment was compliant with the trust sepsis pathway.
- Staff we spoke with, when asked about the sepsis pathway, were not familiar with it. When further discussion took place, however staff could describe monitoring patients for infection and previous occasions when concerns were escalated to positive patients' outcomes.
- There were no personal evacuation plans for the patients in the event of an emergency. There was no evidence this had been considered as a tool to use in an emergency to assist in the safe management of patients.

Environment and equipment

- Since the August 2017 inspection, there had been work on-going with the PFI contractors to make the building more secure, which was not yet complete. The main entrance doors to the ward were accessed securely through a 'fob' control at all times, however exit from the ward was still through a push button control. The doors led to the lift lobby area where a second set of doors, led to the ward. These doors were no longer propped open (as they had been previously) and staff and patients had to navigate through them to the lifts. This meant there was less opportunity for patients to leave the unit unobserved.
- Patients could still gain access to the lift. Within the lift, large illuminated indicator buttons had directional arrows to guide the user. The ward staff explained that the free access was to enable some patients, assessed as safe to do so, could make their own way to their therapy appointments, which were located on the first floor. The first floor was accessible by the lift and opened into a first floor lobby with staff fob only access through the doors, however these doors were propped open at the time of inspection, which was deemed acceptable by the senior staff during the working day.
- We were shown the work diagram to change many of the doors to fob locks at our previous inspection, the time scales for completion in the original plan was October 2017, however in November 2017 they were still incomplete. We were told this was because of the challenges of having three contractors working on the project. The expectation was for the work to be completed by the end of 2017.
- The ward kitchen doors were closed throughout our inspection, which was a positive response following our last inspection when concerns were raised about patient safety when the doors were open. This meant the risk of burns, scalds and injury to wandering patients had been removed.
- The internal ward conservatory lounge had unsecured wheelchair accessible push button access to the outside of the building. Following the safety issues highlighted in our August 2017 inspection, the outside area was now secure with a keypad lock on one gate and a new wooden barrier and locked gate on the other side. This was a positive response, as whilst it made the outside space slightly smaller it meant that it was completely secure with only OCE staff having the codes to the locks. Patients could safely access the outside space without the risk of them wandering into the car park or onto a main road.
- On the day of our inspection, the conservatory was closed for repairs to the outside doors, which although repairs had been undertaken; the previous day's heavy rain had caused leaking to occur again which was a slip hazard to staff and patients.
- Following our previous inspection in August 2017, a health and safety risk assessment of the area was completed. In November 2017, we asked if an updated fire risk assessment had been undertaken to cover the changes to the unit's security, but it had not.
- Since our previous inspection when we found the patient tagging system was not functioning properly, the system had been repaired and a 24-hour support service implemented in case of any future failings. We observed a clear phone helpline number for staff to contact if there was a breakdown displayed in the office. There had been no further incidents reported of the tags not functioning properly.

- The site security team previously undertook regular rounds to check for example, doors and windows were locked and there were no unauthorised people on site. The security patrols also now inspected the internal environment of the unit at least once during the night. Whilst this system was still being embedded, there had been no further security incidents reported.
- There was sufficient equipment available to help manage the patients' rehabilitation safely; this included specific wheelchairs, high low beds, crash mats and bedside rails.
- We inspected the electrical clinical equipment to ensure that it had been recently serviced and appropriately safety tested. Trust data showed that all of the patient hoists were in a service programme and servicing was current. The trust data showed that safety testing had last been carried out in the unit in November 2015 for over 1500 pieces of electrical equipment, some equipment was identified as due for an annual test in 2016 but there was no evidence that this had been done.
- Staff reported equipment breakdowns or maintenance issues via a telephone helpline; manually recording them in a centrally located folder. The ward's support coordinator monitored the jobs. However, there were no timescales for completion of the jobs or any indication of which jobs had been completed which meant that monitoring was difficult. Staff we spoke with were not aware of the maintenance expected response timescales. They did not know when to escalate outstanding jobs. The trust shared data, which indicated that there were sixteen maintenance jobs started, and two yet to start.
- The unit had a centrally stored resuscitation trolley; this was tamper-evident and was checked daily. We also inspected an additional storage box marked 'seizure box', which contained some items, which were out of date. There were additional supplies of blood glucose monitoring strips in another box; these were also out of date. They were not part of the checking system but there was a risk items would be used in an emergency. There were additional wall mounted emergency resuscitation facemasks for patient's emergency use located at strategic points in the ward.
- At our previous inspection in August 2017 we saw there were variable door security measures within the ward, some doors had release buttons, some were secure requiring a 'fob' to gain access and some allowed free access. Most doors were fire doors and were fitted with centrally controlled closers when the fire alarm was sounded. If the fire alarm was activated the doors would close automatically to reduce the risk of a fire spreading.
- There was open public access to the building from Monday to Friday between 8am and 5pm when the reception desk was manned. At other times, including weekends the reception desk was unmanned; and a staff fob was needed for access or visitors used the ward's intercom.

- The unit declared zero bacteraemia (hospital acquired blood infections) over the past twelve months. There were no MRSA or C Diff infections during the past twelve months.
  - The Private Finance Initiative (PFI) contractors undertook the environmental cleaning within the OCE, which was classed as a 'high risk' area for the frequency and depth of cleaning. The trust provided details of the monthly cleaning audit scores between October 2016 and 2017. These showed that between 92% (for six audits) and 100% (for one audit) scores were achieved, with a target of 95%.
  - The relatively positive audit scores did not reflect the reality of what was seen by inspectors. There were areas where the standard of cleaning was unacceptable.
  - For example, there was a build-up of dust and dirt between the wall and the bedpan washer and between the wall and the laundry machines. In one storage room a large number of dead woodlice were seen in the corners of the room, in another storage room a lack of a window handle meant that dirt and debris was scattered all over the window sill through the unsecured window.
  - Within the patient bedrooms, some of the disposable privacy curtains were overdue for the routine six-month change, with the last change dates displayed as February and April 2017. The domestic staff were not able to tell us the time scales when disposable curtains were changed. There were felt

covered notice boards in the patients rooms fitted which could not be cleaned effectively between patients. We raised our concerns over these cleaning issues at the time of our inspection.

- Nursing staff undertook routine clinical cleaning of equipment at the weekend, for example, commodes, dressing trolleys, drip stands and mobile blood pressure machines. There was a checklist filed in a central folder for recording tasks that were completed, however, this was not consistently fully completed. Staff did not appear to have a process for checking what had been cleaned. Some items of clinical equipment were rusty and therefore unable to be cleaned effectively. We raised these issues at the time of our inspection.
- We saw nurses and other clinical staff wore clean uniforms and adhered to bare below the elbows to allow for effective hand washing. They wore personal protective equipment such as gloves and aprons when attending to patient's personal care. The trust required the compliance of effective handwashing to be audited internally every month by the service; the results when audited showed that for the past twelve months the OCE staff were between 70% and 90% compliant. However, in October, November 2016, June 2017 and August 2017 hand washing compliance was not audited. We are not aware of any actions to improve this compliance.

Safeguarding

- There was a new quality information board, this was a large white wallboard with patient's names and their pathways detailed on it, located in the ward office. Staff had been using this since the middle of October 2017, to make processes clearer to follow. For example, the dates when a Deprivation of Liberty safeguard (DoLs) application was made and when it ran out were displayed. Previously, staff had not understood the process of monitoring DoLs. There had been no local system and staff were unclear about the current position of applications they had submitted or expiry dates where applications and been granted. The new board enabled staff to check and monitor progress; we found an improved understanding of the process by staff.
- OCE staff made a DoLs application for those patients who had been assessed by the multidisciplinary team (MDT) as requiring electronic tagging or who needed a pen removable lap strap for their safety whilst using their wheelchair. There had been positive efforts to organise the supporting paperwork within the patient's records for staff to access, check and review progress.
- On the latest inspection in November 2017, we found documented mental capacity assessments, which informed staff when patients had no capacity and needed referral for DoLs. The trust policy stated that patients who lacked capacity must be assessed using the Mental Capacity Act and Deprivation of Liberty Policy and the results clearly and accurately documented in the patient's healthcare records. We found a marked improvement from the last inspection in August, and were assured that the OCE unit was now following trust policy.
- On this inspection, we saw that each patient had an assessment in place for the use of bedside rails, which were completed on the patient's initial admission to the ward.
- Since we last visited the trust the lead nurse for safeguarding had completed multi- professional educational updates in the Mental Capacity Act; most staff were now able to describe and understand the processes more confidently. We saw staff were all up to date with their adult safeguarding training and child safeguarding level one and two, this training was part of the trust's mandatory training.
- There was a new trust plan for the practice educators to be trained in capacity assessment; however, the practice educator post was vacant in the OCE unit. We have been informed that one of the ward sisters will assume the components of this role when the newly appointed sister starts in the unit.

Are medical care services well-led?

- A philosophy and vision paper was produced in November 2017, but we could not identify who was engaged in the process or who wrote it. There were no shared values or strategy displayed within the unit.

- We were not assured there was suffiecnt management oversite.
- The rating of risks did not appear to be consistent and some were rated lower than the impact would indicate, for example the nurse staffing vacancies, which had led to bed closures.
- We were not assured that risks were escalated upwards appropriately for the senior teams to consider.
- We were not assured that the monitoring of the service was effective, as the team had not recognised the risks we identified.
- There was no local mechanism for patient and relative feedback as there was a slow turnover for the friends and family test.
- We were not assured that the staff understood the requirements of the Duty of Candour.
- Managers had not created opportunities for a multidisciplinary team event for the last two years.

However:

- Staff were complimentary of the unit's local leadership and the wider multidisciplinary team in the unit.
- There was a process for feedback on incidents, actions, and learning.
- The leadership was involved in various research projects for improving patient outcomes.

Leadership

- The Oxford Centre for Enablement (OCE) was part of the Acute Medicine and Rehabilitation Directorate (AMR) in the Medicine Rehabilitation Cardiac Division (MRC).The senior management team in MRC, which consisted of a divisional director, divisional medical director, general manager, and divisional nurse and head of governance, they all had responsibility for the AMR team of clinical director and matron.
- A clinical medical lead and operational services manager led the OCE unit. Their portfolio of services was diverse and complex. It consisted of the ward, day hospital and administration team, medical staff, the Oxfordshire Wheelchair Service, Specialist Disability Service, Rehabilitation Engineering Department and the transport team. In addition, they were supported by speech and language therapy, occupational therapy, physiotherapy which were all part of the therapies department in AMR and psychology who were part of psychological medicine within the corporate division.
- Staff we spoke with described feeling well supported by their local line managers who were visible and approachable because they were located on site. Most staff spoke of an understanding of the difficulties in being away from main site and the accessibility of the trust senior leaders.
- The previous CQC inspection in August 2017 had raised safety concerns that meant senior staff from the trust had recently visited the site which most of the staff we spoke with had welcomed.
- The local nursing leadership team had various vacancies when we inspected, there was on going recruitment, but this left the unit struggling, for example, with education and development.

Learning , continuous improvement and Innovation

- The unit's clinical lead was involved in a number of research projects. For example, research into neuroplasticity in the upper limb amputee and research into the role of sleep in promoting motor recovery after stroke. There had been a number of papers written in conjunction with the brain team at the trust and University College, London.
- The unit was involved in some innovative developments, for example, it had developed a spasticity clinic that enabled ultrasound guided injections by physiotherapists during the past year. There were also innovative upper limb treatments in development for patients with neurological damage.
- Staff we spoke with told us of the recent installation of patient information boards in each room, these displayed details of their assigned team and the patients' exercises. The aim of the boards was to provide a reminder to the patient and information to their relatives.
- The trust had a quality improvement team that gave support to innovative projects; we did not see any direct links into this by staff at the OCE.
- We saw that because of the RIDDOR, the unit team had made changes and were still involved in the completion of many of these. For example, although the contractor had started the work on the door locks

it had yet to be completed. The contractors had to return to repair the leaks in the conservatory roof. Some improvements were complete such as the patient quality board, although its' use still had to be embedded in practice and sustained.

- The latest staff survey results (2016) were based upon a response rate of 29.1% for OCE staff, the rest of the trusts response rate was 37.5%. At that time there were 110 staff based in the OCE, which meant that 32 responded. The results showed that staff felt the same as the rest of the trust for 78 out of 88 questions. The other ten questions had significantly better responses than the rest of the trust. They were for example, opportunities to show initiative in their role and their appraisal left them feeling valued, were both 26% above the rest of the trust. Two other responses were 24% above the rest of the trust; being satisfied with the support from their line manager and not working additional paid hours over contacted hours. There were no average responses worse than the rest of the trust.
- The Oxford University Hospitals NHS Foundation Trust, latest friends and family test had an overall response rate of 22%, with 96% of responses positive. There were no responses from the OCE specifically, staff we spoke with said this was because most patients had a long length of stay and the turnover therefore was slow. The latest responses for OCE related to July 2017 when there was a 15% response rate with 96% positive responses.
- Whilst there was a wealth of generic information available for patients and relatives, there was not a specific patient or relative support group advertised. We did not see any evidence of patient or relative feedback leading to changes in the OCE.
- The unit had participated in the trusts peer review scheme; the last visit was in June 2016. The visit was reported using the same domains used by CQC. However, the results due to the amount of time lapsed could not be used for this report. It was not known when the next visit was planned.

Managing Information

- The unit contributed data to the UK Rehabilitation Outcomes Collaborative (UKROC)
- The agreed outcomes from goal planning which took place two weeks after the patient was admitted was uploaded onto the OCE IT system. There were regular goal planning updates with the patient every six weeks, uploaded by the key worker. Staff we spoke with commented that there was potential duplication by entering into two systems, the electronic patient record, and the OCE system which staff felt was a time issue.

Managing risks, issues and performance

- There was reference within the minutes of the monthly unit meeting to an apparent perceived lack of help from the division or directorate to lessen any local risks in OCE. The minutes also noted comments from the meeting that local OCE risks were' not necessarily escalated' up to that level. This may mean that the MRC or AMR management teams were not aware of the local risks, which in turn may mean the trust management team were not sited on them either.
- Staff told us that as a result of raising a risk in the past, a solution had been found and the risk was removed from the register, this risk related to the space for the storage of wheelchairs.
- The CQC team reviewed the latest local risk register, there were twelve local risks detailed, and rated according to likelihood and consequence. There were no red risks or risks rated as fifteen or above. The highest risk (rated at twelve or amber-high) was one related to non-payment of patient transport by the clinical commissioning group. The nursing staff vacancies, which were significant enough to reduce the number of patients admitted, was rated as six and yellow- moderate risk. Other staff vacancies including consultants and psychologists were rated as nine, amber- high.
- CQC did not feel assured that the risk rating scores were reflective of the actual level of risk and the impact it was having. Due to the risk ratings having a low score, risks affecting patient care and outcomes were not being escalated to senior trust teams in a timely way.
- Following the previous inspection in August 2017, senior staff immediately undertook a full environmental risk assessment of the OCE ground floor, ward, and day hospital. The highest risks

identified were the risks of patients wandering, and the risks of physical or psychological assaults towards staff. Both risks were rated and actions identified to reduce the risks. The initial risk assessment was reviewed in a series of senior reviews to ensure the ratings were assessed correctly and actions were being followed up.

- The operational manager produced a monthly performance report; this covered the patient waiting lists, the performance of OCE against the contract with NHS England and any operational issues affecting OCEs performance.

Governance

- The OCE held a large regular unit meeting; the leads or representatives of all the different professional groups working within the unit attended this. The chair was the clinical lead, the clinical governance and risk practitioner also attended. We saw that there were approximately eighteen potential attendees; however usually there were about seven apologies.
- We reviewed the minutes of the past three meetings. The agenda included management, finance, and clinical governance. Each of the different professional groups also reported on their issues such as recruitment, operational issues, and their progress. We saw how some issues were raised, discussed and the outcome then escalated for inclusion on the OCE local risk register, for example the age of the lease car fleet and its' need for replacement.
- The clinical governance and risk practitioner routinely informed the meeting about clinical governance. This report included updates on the local risk register, numbers of reported incidents and progress of any serious incident investigations. Two items named the 'AMR quality report' and 'CQC health assure' were standing agenda items but not reported on in the last three sets of minutes we reviewed.
- Local Incidents that could be classified as serious incidents were presented by the local leaders and reviewed at a weekly 72-hour review meeting, which was chaired by the associate medical director. This meant that there was senior trust oversight of potential serious incidences and their investigations.
- The different teams within the OCE held regular individual team meetings. For example, the ward sister held staff meetings to feed back the outcomes of the recent RIDDOR incident. Some staff we spoke with told us that ward meetings needed to be re-established again. Other teams we spoke with described both regular team communications and attendance at the main unit meeting for feedback. For example, the occupational therapists had team meetings and were represented at the main unit meeting.
- The meetings and reviews held by the senior team, did not assure us that effective monitoring of the service had taken place. There had been no previous recognition of the safety and risk issues within the service, which we recognised and highlighted.
- The students' educational area displayed a large amount of information, much of which appeared to be out of date and a few years old. This might make students feel unsupported and less inclined to apply for posts after qualification.
- When we inspected in August 2017, CQC was not assured that staff understood fully their responsibilities under the Duty of Candour requirements. There was no record of conversations between the organisation and families when a serious incident had occurred. The Duty of Candour was not one of the mandatory training topics for staff and there had been no updates from the trust regarding local staff training of this topic. The Duty of Candour and its requirements remains a challenge for the unit, as staff struggle with the terminology and its formal requirements, although staff we spoke with, were aware of the need to for openness and transparency when things went wrong.

Culture

- The staff we spoke with described the unit as a 'nice place' to work, they felt there was good support and opportunities for them to develop. They also felt that there was a good team in the unit.
- Most staff we spoke with had received an annual appraisal; they were utilised to plan any required or requested development and training. Junior staff told us that they were able to request specific training for consideration by the senior team, which was usually supported.

- We observed good interdisciplinary interaction at the daily board review, there was respectful challenge by members of different professional teams. The overall aim was obviously to act in the patients best interests throughout and to engage with each other to achieve this.
- We observed a good working relationship amongst staff members working with patients; they were keen to assist each other and responded well to requests. Staff spoke about patients and relatives politely, respectfully and with obvious affection, as the team knew some of them very well.

Vision and strategy

- When we inspected in November 2017, staff we spoke with were not aware of an overarching vision and strategy, there was not an existing one displayed in the unit. Since our inspection we have received a 'philosophy and vision' paper, dated 16 November 2017. It was not clear which staff had been engaged in writing it, who the author was or how it linked to the trust's strategy. There no evidence of any monitoring of progress against the vision, as it was so recent.
- The paper explained that there was a specific and unique goal focus within the unit; how the staff set and agreed goals with the patients rather than using their diagnosis as a focus. There was an informative description of the holistic service provided using the interdisciplinary team and the ability to provide a one site service to the patient. What was not clear was if there were any identified values, which had helped to shape the vision and strategy. We did not see any shared unit values displayed in the unit.
- Staff we spoke with described how, due to the interdisciplinary nature of the team, they really valued any shared team development or engagement time. Staff we spoke with told us that there had been no multidisciplinary team away day since 2015, which had made it difficult to ensure that they had agreed and were all working towards the same goal and objectives.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Ensure that all staff are able to describe and apply their responsibilities in relation to the Duty of Candour.
- Review the standard of record keeping ensuring each patient has a multi-disciplinary contemporaneous plan and record of care, which reflects their individual needs taking into account the assessment of safety risks associated with delivering the required level of care.
- Continue to monitor and review the staffing levels on the inpatients ward to ensure they are at the required level with the correct skill mix to meet the assessed needs of the patients.
- Ensure planned work to improve the safety of the ward and the unit in general is completed or escalated as not completed in the agreed time scales.
- Review staff education on the sepsis pathway and ensure that staff have received the required training on the use of the new electronic observation and escalation system.
- Review the content of staff mandatory training ensuring it reflects the needs of the unit using feedback from training needs analysis, local and national developments.
- Take action to improve the compliance with completion of mandatory training.
- Reviews the uses of the risk register ensuring staff understand the scoring system so that risks are recognised and escalated in a timely way.
- Review the monitoring of the quality of the service to ensure it is effective.
- Ensure that the new system to monitor application for Deprivation of Liberty Safeguards is understood by staff. Including the need for staff to understand they should track both the application, and the expiry dates, of any such applications to ensure they do not unlawfully deprive patients of their liberty.
- Ensure the new process for mental capacity assessments is embedded with completed and documented assessments for all patients considered not to have capacity. Where a patient lacks capacity, consideration must be given to what would be in the patient's best interest and if they are to be deprived of their liberty, safeguards required by legislation must be put in place.
- Ensure regular reviews of all plans of care and immediate reviews when there is a change to the patients' needs to ensure they remain current and relevant to the needs of the individual patient.
- Take action to ensure the conservatory is always a safe area for patients to use.
- Ensure all staff are aware of the importance of closing and securing all doors assessed as needing to be shut for patient safety reasons.
- Ensure the unit is secure and safe out of hours and a local fire risk assessment is carried out to reflect the changes in door security.
- Monitor and sustain the clear guidance as to when patients have the tagging system applied for their own safety.
- Monitor staff compliance with the use of the new guidance and criteria that must to be followed when considering placing patients under one to one supervision.
- Review the effectiveness of the service monitoring and reporting arrangements to ensure risks are identified and mitigated.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

Outstanding practice and areas for improvement

- Review the process that the senior teams are expected to follow when they are considering local risks to ensure ownership and oversite of risks is achieved.
- Review the ward's cleaning schedule including the monitoring of cleaning to ensure it is fit for purpose .
- Ensure that clinical cleaning is taking place and monitored.
- Review the use of the pre-printed care plans ensuring they are current and monitor how staff evaluation them and the evidence evaluation has occurred.

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
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Staff were not familiar with the full requirements of the Duty of Candour.** **Regulation 20 3 (e)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Staff did not receive training in some key areas.** **Medical staff had low compliance in mandatory training.** **Staff had not had training on the electronic observation and escalation tool.** **Regulation 12 2 (c)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Work had not been completed to prevent patients being placed at risk by the unsecure entry and exit points, which would enable some patients to leave the ward unsupervised.** **Regulation 15 1 (b) (c) (d)**

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was not always sufficient staff with the right mix of skills and knowledge to meet the needs of the patients. Regulation 18 (1) (2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Records were found to be difficult to integrate; each patient did not have a contemporaneous record of care. The scoring of service risks on the risk register were not accurate, which meant that appropriate escalation of risks did not take place. The monitoring of the quality of the service was not effective, there was lack of recognition and subsequent lessening of service risks. Regulation 17 (1) (2) (a) (2) (c)