CRG Clinical Services Ltd

Jigsaw House Cheshire

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this service at this inspection.

- Equipment checks were not always fully completed effectively as we found a number of out of date items.
- There was a lack of complete recording of patient early warning scores on patient records we reviewed.
- Not all aspects of the patient records were being audited to provide effective monitoring of all aspects of patient outcomes.
- The organisation did not always have clear governance structures in place to ensure oversight of services. We found that when audits had been completed there was no evidence of any action plans to improve standards of care when required. We also found that there were no actions or follow up to actions recorded following meetings where standards of care were discussed and improvements were required.
- Whilst the service had a clinical strategy in place, at the time of the inspection there was no evidence of an action plan to support the implementation of the strategy or any evidence of monitoring the strategy on a regular basis.
- There was a lack of assurance that performance was being monitored effectively as there was no service specific contract in place between the service and their commissioners to clearly outline performance measures for the service provided.

However,

- All staff were up to date with face-to-face mandatory training in key topics to ensure they could provide safe care to patients.
- The service controlled infection risk well. Documentation was in place for assurance about completion of cleaning and infection prevention and control of vehicles. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, and premises visibly clean.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. They managed medicines well. Safety incidents were managed well and learned lessons from them.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to continually improving services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Emergency and urgent care	Inspected but not rated	We did not rate this service at this inspection. • Equipment/consumable checks were not always fully completed effectively as we found a number of out of date items. • There was a lack of complete recording of patient early warning scores on a number of patient records we reviewed. • Not all aspects of the patient records were being audited to provide effective monitoring of all aspects of patient outcomes. • The organisation did not always have clear governance structures in place to ensure oversight of services. We found that when audits had been completed there was no evidence of any action plans to improve standards of care when required. We also found that there were no actions or follow up to actions recorded following meetings where standards of care were discussed and improvements were required. • Whilst the service had a clinical strategy in place, at the time of the inspection there was no evidence of an action plan to support the implementation of the strategy or any evidence of monitoring the strategy on a regular basis. • There was a lack of assurance that performance was being monitored effectively as there was no service specific contract in place between the service and their commissioners to clearly outline performance measures for the service provided. However, • All staff were up to date with face-to-face mandatory training in key topics to ensure they could provide safe care to patients. • The service controlled infection risk well. Documentation was in place for assurance about completion of cleaning and infection prevention and control of vehicles. Staff used

Summary of findings

equipment and control measures to protect patients, themselves and others from infection. They kept equipment, and premises visibly clean.

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. They managed medicines well. Safety incidents were managed well and learned lessons from them.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to continually improving services.

Summary of findings

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Summary of this inspection

Background to Jigsaw House Cheshire

Jigsaw House and Lincolnshire Resource Base is operated by CRG Clinical Services Ltd and Jigsaw Medical. Jigsaw Medical is an independent provider of ambulance Services with a head office in Chester and satellite bases in Lincolnshire, Buckinghamshire and Basingstoke. They provide emergency and urgent care and patient transport services. They provide services for the communities in Lincolnshire, Essex and Cambridgeshire, Buckinghamshire, Oxfordshire, Berkshire and Hampshire.

Jigsaw Medical has a registered manager who has been in post since 2018. The service was inspected in 2019 and the report was published on 19 July 2019. The service was not rated at the time of the inspection. The concerns at the 2019 inspection were management of controlled drugs, clinical waste and the safety of vehicles. A requirement notice was issued as a result of this inspection.

The regulated activities are:

- Transport services, triage and medical advice provided remotely
- Treatment of disease disorder and injury

The main service provided at the Lincolnshire Resource Base in Heckington is emergency and urgent care which was the focus of this inspection.

How we carried out this inspection

We carried out an unannounced focused inspection at the Heckington base and the head office in Chester after concerns following our monitoring of the provider.

We looked at two of the key questions: safe and well- led.

Whilst on site we reviewed vehicles, medicines, staff records including training and competencies, patient records and the environment of the base. Off-site we reviewed policies and procedures, audits and contract information. We looked at 46 patient records and we observed two vehicles used for urgent and emergency care purposes. One of these vehicles was off the road (VOR) at the time of the inspection.

At the base we spoke with two technicians, the base operations manager, the area clinical lead and the senior paramedic trainer.

At head office we interviewed the registered manager, the chief executive officer, the senior paramedic trainer and the head of compliance and governance.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is: because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This action related to emergency and urgent care services.

- The service must ensure they have oversight of all services provided. (Regulation 17(2)(a)).
- The service must ensure that processes such as audits are assessed, and improvements required clearly actioned (Regulation 17(2)(a))
- The service must ensure that staff complete all patient records fully . (Regulation 17(2)(c)).

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that all equipment on ambulances is checked and in date for use.
- The service should consider that there are workable plans in place for the implementation of their strategy
- The service should consider that clear agreements are in place which outline key performance indicators to monitor standards of care.
- The service should ensure that audits are completed within the parameters set.
- The service should ensure that there is evidence of a review of external policy documents that staff are required to follow.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Emergency and urgent care

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Emergency and urgent care safe?

Inspected but not rated

We did not rate this service at this inspection

The service provided mandatory training in key skills to all staff and everyone was up to date with the required level of training.

- We were shown mandatory training rates by the provider. They were at 100% for e-learning. Rates for face- to- face learning were at 16%. There were government restrictions put in place during the pandemic on some face to face training. We were told that face- to- face training for staff at Heckington had been arranged.
- Face- to- face training included safeguarding level three for adults and for children and young people, moving and handling and life support skills (basic life support and immediate life support skills).
- The compliance and governance team had oversight of mandatory training rates on an electronic system which alerted the team when staff's training was due for renewal. Staff were contacted the month before their training dates expired so that they could complete their training.
- The mandatory training included 20 different modules, dependant on job role and included Mental Capacity Act (MCA) training and training for Deprivation of Liberty Safeguards (DoLs).

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it

- The provider had three policies that related to safeguarding of adults and children and young people. There was a safeguarding guidance policy, a safeguarding operating procedure and a safeguarding strategy and corporate statement. The provider told us that they were reviewing them at the time of the inspection. None of the policies mentioned how the provider would complete statutory notifications to the Care Quality Commission.
- All staff in the organisation were trained to level three for safeguarding of adults and children and young people. There were new staff in post in three localities across the country who were area clinical leads; they were to be trained to level four in safeguarding for adults and children and young people. This met the standards in national guidance.
- Clinical staff also followed the safeguarding polices of the trust they were contracted to work for and completed any safeguarding referral paperwork, which was submitted to the appropriate trust. We saw that patient records included safeguarding details and evidence of completed safeguarding referrals.

The service controlled infection risk well. Documentation was in place for assurance about completion of cleaning and infection prevention and control of vehicles. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment, and premises visibly clean.

- There was a pre/post shift vehicle check book. We saw that a vehicle was used Monday, Thursday and Friday, a pre-shift check was completed on all three days but the post shift clean down was only documented on the Thursday, so we were not assured that the vehicle had been cleaned at the end of the shift. Following the inspection, the inspection team were provided with additional information giving assurance about vehicle cleaning between shifts.

Emergency and urgent care

- We viewed two vehicles during the inspection, one of which was off the road. They were visibly clean and tidy. PPE was available and plentiful on the base for restocking of vehicles. There were handwashing facilities on the base for the use of staff.
- We were told that the vehicles were deep cleaned every month by an outside contractor.
- There was an infection control policy which was called "Standard precautions formally IPC" which had a review date of August 2022. There was also a "COVID-19 update from December 2020 which gave information on issues such as personal protective equipment (PPE), social distancing guidance and hand hygiene.
- There was an infection prevention control (IPC) champion who had been in post for six weeks at the time of the inspection. They told us that their role was to audit IPC including hand hygiene and uniform compliance for bare below the elbow.
- There were weekly (IPC) audits. Examples of audits that we viewed showed that while issues were recorded follow up actions were not documented so we could not be assured that any actions were followed up by staff.
- The service provided audit information from March 2021 which showed 100% for hand hygiene, 95% with uniform compliance and 88% for base compliance at the Heckington base. There was an audit of 20 staff a month.

Whilst the design, maintenance and use of facilities, premises and vehicles were safe, equipment didn't always keep people safe.

- We checked consumables on two ambulances, one of which was off the road. We found that on one vehicle there were several out of date items including dressings, an oxygen face mask and a needle. One of the dressings had an expiry date of January 2020. We made the provider aware of this at the time of the inspection.
- There was a fleet manager for the provider who oversaw vehicle maintenance and vehicle checks. The fleet manager had records of insurance, MOT and servicing for all vehicles.
- The risk register indicated that seven vehicles registered in 2015 needed to be replaced. Sign off from the board was needed to commission the new vehicles. We were told that his would be implemented by January 2022.
- We were told that there were agreements in place for essential vehicle maintenance, tyre changes and recovery of emergency vehicles. Vehicles were given priority at local nearby garages. We observed that a vehicle was taken off the road for a service during the inspection at Heckington.
- We observed that the ambulance base at Heckington was clean and tidy. There was good security with close circuit television monitoring both inside and outside the base. Vehicles were kept inside the facility at night.
- There was a crew room with notice boards, information for crews, batteries for the radios and defibrillators were stored here. There was an information system so that staff could identify which vehicle and crew they were working with on a particular day. However, there were no changing, showering or secure locker facilities for staff on the base.

Staff did not always complete and update all risk assessments for each patient to remove or minimise risks. This meant staff may not identify and act upon patients at risk of deterioration.

- The patient record was a paper-based system supplied by the contracting trust. There was a section for the recording and calculation of early warning scores which would indicate if a patient's condition was deteriorating. The parameters for the scores was attached to the record book so that staff were aware of the appropriate parameters.
- However, we reviewed 46 patient records and could see that when observations were recorded the staff were not always completing the early warning score (EWS) totals. This means that staff may not be able to recognise a deteriorating patient during the time in their care.
- Staff worked to the paramedic pathfinder handbook, this stated that patients with a EWS score of greater than four must be taken to the urgent and emergency care department. The non-completion of the EWS totals meant that staff would not be aware of the EWS total.
- The provider was unaware of the non-completion of the EWS as they did not audit the EWS totals. They told us this was not a requirement from the contracting trust and was not included in their record audit.

- Staff had access to remote clinical support from the provider if they had any questions regarding clinical care or deteriorating patients. They were also able to contact the trusts clinical support network. We were told that resources could be made available for example, a consultant paramedic could be deployed from the contracting trust.
- There was an "application" that was downloaded onto phones from the Joint Royal Colleges Ambulance Liaison Committee which allowed individual ambulance services to combine the national guidelines with their regional information. This meant that ambulance crews had access to up to date clinical guidelines at all times.

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.

- We saw that recruitment systems were robust through the provider's safer recruitment policy. The head of compliance and governance described the application process including the requirement for disclosure and barring service. Two references were obtained which covered three years of employment, one of which was from their current or most recent employer or human resources department. The recruitment process included clinical competence-based questions for candidates. We were told about people who had been refused employment because of a reference discrepancy.
- The practice educator worked with all staff on the job to gain assurance about competencies as part of their induction. Newly qualified paramedics were mentored and supported by senior paramedics as part of their consolidation period before they were signed off. They had to spend 150 hours with a senior paramedic and were reviewed over 24 months before this sign off could take place. This included reflective practice. Certificates of competency were shared with trusts of contracted staff.
- Staff were provided with a local induction for the location at which they would be based and a trust induction for the contracting trust. Staff worked to the policies of the contracting trust which could be accessed online at Heckington.
- The provider had 287 staff registered and available to fill shifts. This was a mix of paramedics and technicians and emergency care assistants. Staff could move between bases to cover shifts as necessary but had to have completed the local trust induction for which they were working for.

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. However, where improvements in record keeping were needed we found no evidence of actions to improve standards.

- The patient record was paper based, and a copy of the record was kept by the patient after treatment. The patient record forms (PRF's) were returned to the base daily by the crews on shift and stored in a locked confidential box in the crew room until senior staff were able to remove them.
- Records we saw were clear and easy to read with appropriate amounts of information documented on the summary.
- We were told by the provider that they audited 10% of the records or ten records which ever was the greatest number for completeness. Information from the provider showed that the audit was taking place, but we were not shown any action plans when records did not meet the audit requirement.
- We were told that individual staff would be identified when any issues were found during the audit and that training would be put in place. However, we were not shown any evidence of this during the inspection.
- The numbers of records audited was very small compared to the numbers of records completed and did not always reflect the parameters explained by the provider. Therefore, this did not give a true picture of the completeness of the records.

The service used systems and processes to safely prescribe, administer, record and store medicines.

- There was a medicines management policy that was in date with a review date 1 December 2021.The policy contained information about controlled drugs. The provider had an in-date license for controlled drugs from the Home Office.

Emergency and urgent care

- Staff undertook training in the administration of medicines and completed appropriate competencies. This was managed by the practice educator for the service.
- We saw that medicine administration and medicine history was recorded on the patient record.
- We observed that there was safe storage of medicines at the location. Medicines were stored in a locked cupboard that was covered by close circuit television for security purposes. Stock and expiry checks were carried out to ensure continuity of supply.
- Medicines for use were stored securely in medicine bags which contained the appropriate medicines for the job role. Staff collected the bags at the beginning of the shift. There was a clear audit system for the use of medicines including which member of staff had used which bag. Records contained the reason for removal of a medicine from the bag including patient use, expiration, any refusal of a medicine by a patient.
- Medical gases were stored securely both in base and on the ambulance. We checked four cylinders on the vehicles and all were in date and had enough supply. On the base cylinders were secured in cages and empty ones were separated ready for collection.
- Controlled drugs were securely stored on vehicles and could only be accessed by a paramedic. There were monthly stock checks in place of controlled drugs on all vehicles.
- The provider followed guidance from the Joint Royal Colleges Ambulance Liaison Committee. (JRCALC) for the administration of medicines. Paramedics followed patient group directives from the trust that commissioned the service.
- We found that ambulance technicians were making the decision to treat patients with non-parenteral prescription only medicines. Whilst this practice is not supported by current legislation, an appropriate governance process was in place to assess and manage ongoing risk. Staff had undertaken appropriate training and were assessed as competent. This ensured people had timely access to safe treatment.
- We were told there were risk assessments in place for all grades of staff which indicated what medicines they can administer to patients. Following the inspection we were provided with the Jigsaw medicines route chart which showed the route of administration for all medicines and the grade of staff who could administer the medicines.

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

- The service had never had a never event. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.
- The service had an electronic incident reporting system. Staff we spoke with were aware of the incident reporting process and gave examples of how they had used it. Incidents were also reported to the contracting trust as appropriate.
- We saw from the minutes of clinical governance meetings that serious incidents were discussed as an agenda item. The head of compliance and governance told us that complaints and incidents were reviewed every week and a decision was made to see if any met the threshold for statutory notification to the Care Quality Commission. There were no records of these meetings but a spread sheet was produced as an outcome of the meeting.
- We saw that there was learning from incidents and complaints and an example was given where there was not the correct equipment on a vehicle for the treatment of a patient. This was followed up by the service and the appropriate equipment and training was provided.
- The provider told us that clinical updates were sent out to staff. They provided an example where amended guidelines from the Resuscitation Council had been sent out the week before the inspection.
- We saw evidence on site of compliments and positive feedback displayed on a notice board for staff to view and share positive care provided to improve patient safety.

Inspected but not rated

Emergency and urgent care

Are Emergency and urgent care well-led?

Inspected but not rated

We did not rate this service at this inspection

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for staff. They supported staff to develop their skills and take on more senior roles.

- The chief executive officer of the provider was a paramedic by background and other senior managers were from a clinical background. They understood the pressures of the service.
- Staff we spoke with told us that they felt supported by managers. Examples were given by staff where this support had been given.
- There was a lead for education and development of clinical staff. They had oversight of the training and development needs of all the clinical staff. They were involved in a robust recruitment process including a knowledge-based assessment. Following recruitment, they signed off appropriate competencies for newly qualified staff when training and assessment had been completed. They could recommend additional applicable training to meet any requirements.
- There were reviews and appraisals in place for all clinical staff.
- The provider had an apprenticeship programme with approximately 30 emergency care assistants and six advanced ambulance practitioners enrolled on the training, which was taking place on the day on the inspection.

The service had a vision for what it wanted to achieve. Leaders and staff understood and knew how to apply them but did not always monitor progress of the strategy.

- The provider had a core values and mission statement for the organisation.
- There was a clinical improvement strategy dated 2020. The aim of this was to reduce numbers of clinical incidents, to provide a safer environment for crews and patients, to improve the standard of care, reduce complaints and identify learning from the outcomes of incidents and complaints to support ways to improve the quality of care. However, we did not see an action plan to support the implementation of this strategy or any monitoring of the strategy.

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided staff with opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- We were told that all staff including those from black and ethnic minority backgrounds were risk assessed at the beginning of the pandemic and adjustments made to working practices as necessary.
- All staff we spoke with felt supported and valued in their work. We were given examples of the care staff provided which was positive.
- We were given examples where staff had provided excellent care and followed up vulnerable patient's needs. This was documented on the patient records and safeguarding referrals to the local authority and recognised by managers.
- There was continued professional development offered to all staff and we were given examples of staff development plans.
- We were told that staff were offered clinical development as part of their career development. The service could access information about staff qualifications from other training providers to support career development.

- There was a customer services, complaints and feedback policy with a review date of 2023. We saw examples of complaints raised by patients and the providers response to these complaints and any action taken.

Leaders did not always operate effective governance processes, throughout the service and with partner organisations.

- There were clinical governance meetings that were held every three months. There was a standardised agenda for the meetings. We were told that there was a presentation at each meeting to review oversight and themes and trends of patient safety and quality. We saw a presentation from the meetings in December 2020 and March 2021 which included mandatory training figures, shift fill rates, information about vehicles, and the new operations and clinical structures for the organisation. There were audit outcomes for patient records, infection prevention and control and medicines management. Complaints and serious incidents also reviewed.
- From the meeting minutes we saw that there were actions put in place following the presentation to address issues found from audits or performance information to improve outcomes. Following the inspection the provider told us that they intended to put a tracker in place to monitor actions and outcomes
- There were concerns that not all aspects of the patient records were being audited which meant there was a risk that not all patient outcomes were being monitored effectively
- We saw from the minutes of meetings that actions from the previous meetings were not always followed up and documented.
- The provider told us that there were monthly meetings with the contracting trust, but they didn't always receive a great deal of feedback from these meetings.
- We requested a copy of the contract between the contracting trust and CRG Clinical Services. We were provided with a specification of requirement for the service that was sent out to all providers who wished to tender for the service. We were not provided with any evidence that a service specific contract was in place to monitor performance which outlined key performance indicators for the service provided. The provider had not developed their own performance indicators. This meant there was a lack of assurance that all patient outcomes would be monitored effectively.
- There was an organisational structure which had recently changed. Three area clinical leads had been appointed in the week of the inspection. They were to have clinical oversight of services and responsibility for the auditing and performance of services. They would work alongside the clinical mentors who were currently in post.
- The provider told us that they reviewed both internal and external policy documents. We reviewed three sets of minutes of meetings and there was only evidence of a review of internal policies. We were told that staff worked to the policies of the recruiting trust so we could not be assured that the provider had oversight of the policies of the trusts that staff were contracted to.
- The service kept information about document checks. A driver disclosure form was completed every year and a license summary check completed every six months. They also reviewed Disclosure and Barring Service (DBS) checks every year. There was a mandatory requirement for staff to update these. The compliance team initiated these checks every year or checked if the staff member was on the update service. Some DBS checks had footnotes, and any disclosures were risk assessed by the service.

Leaders and teams used systems to identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- There was an organisational risk register which was reviewed as part of the clinical governance meetings. The top five risks were discussed at each meeting. Senior managers were able to articulate these risks and the mitigating actions.
- We saw that issues raised on the risk register had been addressed by the provider. One of these risks had been about replacement of emergency vehicles and this process was underway with a date of January 2022 for this to be completed.
- The risk register was submitted to the contacting trust as part of the contracting information specification.
- There was a business continuity policy for the provider which was in date.

Inspected but not rated

Emergency and urgent care

- There had been an analysis of the provider using SWOT methodology (strengths, weaknesses, opportunities and threats) to support future development of the organisation.

Leaders and staff actively collaborated with partner organisations to help improve services for patients. It was unclear how the service was engaging with patients.

- There were regular meetings every two weeks with the contracting trust where staff could discuss clinical cases and live case studies. Staff were given protected time for these sessions which were attended by senior managers and clinical staff.
- The service had an online patient experience form which was actively used by service users.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

- We saw that there was support for education and training and development for all clinical staff from the practice educator and that staff actively engaged with training to improve services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The organisation did not always have clear governance structures in place to ensure oversight of services.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Where audits had been completed there was no evidence of any action plans being introduced to improve standards of care when required.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There was incomplete recording of patient early warning scores in patient records.**