St Cyril's Rehabilitation Unit

Quality Report

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Date of inspection visit: 01 - 02 March 2017
Date of publication: 21/09/2017

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive?	Inadequate
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

St Cyril's Rehabilitation Unit is operated by St George Care UK Limited

We inspected this service using our comprehensive inspection methodology. We carried out the announced inspection on 1 and 2 of March 2017 and an unannounced visit to the hospital on 13 March 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was Community Inpatient Services.

We rated this hospital as inadequate overall because:

- Safety was not a sufficient priority. Standard operating procedures and processes designed to keep people safe were not always followed.
- Action was not always taken when areas of serious concern were identified and as a result poor and unsafe practice was allowed to continue.
- Staff did not always recognise, assess and mitigate risks to patients' safety. This included poor compliance with the completion of important risk assessments and failure to escalate when patients' conditions deteriorated.
- Medicines (with the exception of controlled drugs) were not managed safely and where improvements were identified in audits; these had not been addressed and no action had been taken.
- There was no credible local vision or strategy for the service and there was a lack of robust governance and risk management systems.Where local governance and risk management systems were in place these were not used effectively to ensure the safety of patients and the quality of care delivered.
- The prevention of abuse and improper treatment was not effectively managed. Staff training was not at sufficient levels to make sure that staff recognised and addressed safeguarding concerns appropriately. In some cases, safeguarding incidents had gone unrecognised and we saw other examples where they had been recognised but not addressed appropriately.
- There were no arrangements to set appropriate rehabilitation goals that all staff worked towards and no arrangements to make sure that the achievement of specific goals were monitored.
- The principles of the Mental Capacity Act 2005 were not adhered to; with decisions made without consulting patients, their relatives or undertaking best interests meeting.
- Mental capacity assessments were generic and did not meet the required two stage test which establishes whether the person can make a specific decision at a given point in time.
- Patient care and treatment was not person centred and care records did not reflect individual choices, personal preferences or cultural needs. Arrangements for social events to meet individual needs and reasonable adjustments to routines were not in place.
- Dignity was not always maintained and personal clothing was not managed to make sure that each person received clothing that was theirs only.

Summary of findings

- Records were poorly maintained and lacked key information, including, goals and the monitoring of goals in order to make sure that patients' received the correct care and rehabilitation.
- The hospital did not have adequate systems and processes in place to check the skills and competencies of the staff, in order to make sure that staff only undertook tasks for which they were competent.
- Staff training was not monitored in order to make sure that have received up to date training relevant to their job role.
- Staff, patients and the public were not sufficiently engaged in order to assist in giving their views and improving the quality of the service.

However,

- Staff treated patients with kindness and provided care to patients while maintaining their privacy, dignity and confidentiality.
- There were multidisciplinary meetings between consultants, registered nursing staff and allied health professionals.
- Controlled drugs were stored and managed appropriately.
- Staff were aware of how to use the incident reporting system.
- Infection rates were low. Clinical areas and waiting areas were visibly clean and staff followed "bare below the elbow" guidance.
- Staff had a good knowledge of the complaints process so could direct patients if they had a complaint about the service.

Due to the concerns and issues found on inspection we have taken enforcement action. The following regulations were breached; 9 Person-Centred Care, 11 Need for Consent, 12 Safe Care and Treatment, 13 Safeguarding service users from abuse and improper treatment and the hospital was given a compliance date and we will follow this up to check compliance with the regulations.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	**Inadequate** 	We rated this hospital as inadequate overall because: • Safety was not a sufficient priority. Standard operating procedures and processes designed to keep people safe were not always followed. • Action was not always taken when areas of serious concern were identified and as a result poor and unsafe practice was allowed to continue. • Staff did not always recognise, assess and mitigate risks to patients' safety. This included poor compliance with the completion of important risk assessments and failure to escalate when patients' conditions deteriorated. • Medicines (with the exception of controlled drugs) were not managed safely and where improvements were identified in audits; these had not been addressed and no action had been taken. • There was no credible local vision or strategy for the service and there was a lack of robust governance and risk management systems.Where local governance and risk management systems were in place these were not used effectively to ensure the safety of patients and the quality of care delivered. • The prevention of abuse and improper treatment was not effectively managed. Staff training was not at sufficient levels to make sure that staff recognised and addressed safeguarding concerns appropriately. In some cases, safeguarding incidents had gone unrecognised and we saw other examples where they had been recognised but not addressed appropriately. • There were no arrangements to set appropriate rehabilitation goals that all staff worked towards and no arrangements to make sure that the achievement of specific goals were monitored. • The principles of the Mental Capacity Act 2005 were not adhered to; with decisions made without consulting patients, their relatives or undertaking best interests meeting.

Summary of findings

- Mental capacity assessments were generic and did not meet the required two stage test which establishes whether the person can make a specific decision at a given point in time.
- Patient care and treatment was not person centred and care records did not reflect individual choices, personal preferences or cultural needs. Arrangements for social events to meet individual needs and reasonable adjustments to routines were not in place.
- Dignity was not always maintained and personal clothing was not managed to make sure that each person received clothing that was theirs only.
- Records were poorly maintained and lacked key information, including, goals and the monitoring of goals in order to make sure that patients' received the correct care and rehabilitation.
- The hospital did not have adequate systems and processes in place to check the skills and competencies of the staff, in order to make sure that staff only undertook tasks for which they were competent.
- Staff training was not monitored in order to make sure that have received up to date training relevant to their job role.
- Staff, patients and the public were not sufficiently engaged in order to assist in giving their views and improving the quality of the service.

However,

- Staff treated patients with kindness and provided care to patients while maintaining their privacy, dignity and confidentiality.
- There were multidisciplinary meetings between consultants, registered nursing staff and allied health professionals.
- Controlled drugs were stored and managed appropriately.
- Staff were aware of how to use the incident reporting system.
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- Staff had a good knowledge of the complaints process so could direct patients if they had a complaint about the service.

Summary of findings

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Inadequate

St Cyril's Rehabilitation Unit

Services we looked at
Community health inpatient services

Summary of this inspection

Background to St Cyril's Rehabilitation Unit

St Cyril's Rehabilitation Unit is a single storey purpose built facility which provides a wide range of accommodation to meet the needs of patients. Facilities include; quiet lounges. Television rooms as well as dining areas, a therapy suite, a gym and a purpose built hydrotherapy pool.

All patients' bedrooms are single with en-suite bathrooms offering privacy. All bedrooms are fitted with electronic ceiling hoists and a nurse call bell system.

The unit comprises of four patient bedroom wings, a therapy wing and an administration wing. The therapy wing includes a gym, occupational therapy, and speech and language therapy.

St Cyril's has a total of 26 beds, two of which are one-bedroom bungalows designed to help patients transition to a higher level of independence prior to discharge. The primary function of the service is to provide a facility for those who have complex needs as a result of neurological impairment or physical disability. There are seven beds in use to meet the needs of patients with challenging behaviour as a result of neuro-disability. These patients may or may not be detained under the Mental Health Act (1983, amended 2007).

The service has four separate care/bedroom areas and central communal facilities.

- The Cheshire Suite supports patients with complex physical needs, including those with low awareness or with continuing care needs.
- The Grosvenor Suite provides active short to medium rehabilitation with physiotherapy, occupational therapy and speech and language therapy (SALT) available as required.
- The Westminster Suite offers specialist care to individuals who present with challenging behaviours as a result of neurological impairment.
- The Dee unit adjacent to the Westminster suite is intended for patents that are progressing along their rehabilitation programme and supports patients with a higher level of independence.

The hospital does not have a registered manager. An Interim Hospital Manager has been in post since July 2016. The nominated individual is Mr Naser Fouad, Chief Executive.

We carried out an announced inspection of St Cyril's rehabilitation Unit on 1 and 2 March 2017. We carried out the unannounced inspection on 13 March 2017.

Our inspection team

The inspection team was led by a CQC lead inspector,three CQC inspectors, an inspection manager and specialist advisors with expertise in rehabilitation, a specialist advisor with expertise in safeguarding, a specialist advisor with expertise in governance and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Why we carried out this inspection

We undertook this inspection as part of our comprehensive programme of independent healthcare inspections.

Summary of this inspection

How we carried out this inspection

We carried out an announced inspection on 01 and 02 March 2017 followed by an unannounced inspection on 13 March 2017.

During the inspection we interviewed the Interim Hospital Manager (also a safeguarding lead), the Controlled Drugs Accountable Officer (CDAO), the Clinical Lead Nurse (also a safeguarding lead) and the Director of Governance and Risk. We spoke with 25 staff members including; registered nurses, therapy staff, health care assistants known as Rehabilitation Co-therapists (RCT), reception staff, medical staff, domestic service staff, catering staff and senior managers. We observed care and treatment, spoke with seven patients and eight relatives visiting patients. We reviewed 14 sets of patient records and 16 staff files.

We also undertook three periods of observation using Short Observational Framework for Inspection (SOFI). This is a formal method we use to understand the quality of the experiences of people who use services who are unable to provide feedback due to cognitive or communication impairments. Our observations ranged from 40 minutes to an hour.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times and the most recent inspection took place in November 2015, which found that the hospital needed to improve the safety of the care and treatment it provided.

The CDAO for controlled drugs (CDs) was the Interim Hospital Manager.

There were no incidences of hospital acquired methicillin-resistant Staphylococcus aureus (MRSA), methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or e-coli between July 2015 and June 2016.

The hospital had received five complaints made to CQC between January 2016 and January 2017.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate, because:

- Standard operating procedures and processes designed to keep people safe were not followed. Senior staff members were aware of some of these issues but had not taken steps to mitigate the risks posed to patients.
- There were no arrangements in place for the hospital to monitor its own safety performance. Safety alert information was not made available to staff in order to maintain the safety of patients.
- Incidents and safeguarding issues were not recognised correctly, reported or addressed in order to maintain patients' safety.
- Staff members were undertaking tasks for which they had not received the correct training. This meant that these tasks were not always carried out safely.
- The use of restraint was not explored or monitored; the recognition of what constituted restraint was inconsistent.
- The arrangements for the promotion of effective infection control were unclear and were not always followed fully in order to make sure that risks relating to the spread of infection were reduced.
- Records were inaccurate, out of date or unclear. Records were managed using several different systems that staff did not always access in order to plan and deliver safe care and treatment.
- Risks were not always recognised, assessed or mitigation plans put into place.
- Changes in a patients' condition or escalating needs were not always recognised or appropriately responded to.
- There were no arrangements to recognise and manage the development of sepsis .

However,

- Staff members were aware of how to use the hospital's electronic incident reporting system and had received training in its use during their induction.
- Staff members were aware of how to verbally raise safeguarding concerns should they identify one.
- Medicines were safely and correctly stored. Controlled drugs were observed to be correctly recorded and managed.

Summary of this inspection

- Cleanliness and hygiene arrangements were in place. There had been no incidents of hospital acquired infection. Hand wash sinks and hand gel dispensers were available throughout the hospital. Staff members were observed to use personal protective equipment.

Are services effective?

Inadequate

We rated effective as inadequate, because:

- Staff members were not aware of their responsibilities in relation to the Mental Capacity Act (MCA) 2005 although they had received training in this subject. As a result, patients and families were not appropriately consulted with to give their views before care and treatment was delivered.
- Consent was not always obtained in a manner that maintained patients' legal rights in relation to the obtaining of an informed consent.
- In some cases the arrangements to administer medicines covertly were not sufficient to make sure that a patients' right to refuse medicines was appropriately protected.
- Pain relief was not routinely monitored or managed sufficiently; particularly for patients less able to vocalise their need for pain relief.
- Systems to ensure that staff members were competent to care for patients effectively were not in place.
- Staff did not receive on-going clinical supervision in order for them to review and increase their individual practice.
- Competency assessments for staff were not consistently in place or monitored to make sure that staff only undertook activities that they were competent to undertake.
- Overall, care records were not specific to individual patients' choices and were not person centred in their approach. As result they did not identify patients' preferences for food and drink.
- We saw that some nutritional assessments were not calculated correctly. As such, the calculations to determine the risk to patients of malnutrition could not be relied on.
- Records of food and drink were incomplete and not monitored to make sure that patients received a good nutritional intake.
- Outcomes for patients were not measurable or measured. Individual goals were not set for patients or monitored other than the therapy goals which were not included in an overall treatment plan that staff were working towards.

Summary of this inspection

- Monitoring of goals for discharge planning were not in place. There was no monitoring of Multi- Disciplinary Team (MDT) meetings to make sure that all discussed plans and goals were reflected within the care planned and delivered.
- Communication systems were not effective with vital information missed at handovers between shifts and meeting records were not always available to inform staff of ongoing concerns or actions.
- The recording and monitoring of behavioural and emotional needs of patients was insufficient to identify triggers and assist in creating plans to support patients in managing their own emotions.
- In the reporting period 2015-2016 93% staff received an annual appraisal.

However,

- There were multidisciplinary meetings between consultants, registered nursing staff and allied health professionals.
- Policies in place were based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines. An example of this was the services clinical policies and procedures.
- Care records we reviewed cited some national rehabilitation guidelines which were located in care records developed by the therapy teams.
- Protocols were in place for food and drink, and the administration of medicines for patients with nil by mouth needs. These were followed accurately by staff.
- Catering staff were knowledgeable about the special diets needed by specific patients and had created a separate menu for one person to meet their needs.
- The use of food thickeners when used to thicken fluids was managed correctly and recorded accurately in order to maintain the safety of patients. However we did observe that thickener was not stored safely.
- There was an induction programme for all staff with external and internal training provided that was specific to the hospital.
- Staff told us they received annual appraisals and that they found these of use.

Are services caring?

We rated caring as inadequate, because:

Inadequate

Summary of this inspection

- Patients were not always involved in decisions about their care and treatment. Some patients' families spoken with told us they were not given adequate information regarding the treatment and support in place for their relatives.
- Interactions between staff and patients less able to communicate were minimal. Interactions observed were conversations about tasks to be undertaken and not conversational in nature.
- There were not sufficient plans and considerations in place to allow effective communication with patients, who were less able to vocalise or for whom English was not their primary language.
- We found items of shared clothing, such as socks and individual clothing was not always tagged appropriately to ensure patients wore their own clothes.
- Staff informed us that they found the care records, "too big and repetitive" to use and did not think that the format would assist patients or their families in understanding patients care. Most patients families told us that they had not always been involved in formulating their relatives' treatment or any goals and most were unaware of the contents of care records.
- Patients expressed views were not determined nor taken into account when considering activities and there were limited social opportunities for most patients outside the hospital.

However;

- When staff spoke to patients this was with respect. All the people we spoke with were positive about the way they had been treated by staff.
- Personal care was delivered in a manner that maintained patients' dignity, doors were closed when personal care was provided.
- Staff told us they had sufficient time to spend with patients when they needed support.
- Staff members were keen to develop additional skills such as counselling qualifications to support patients emotionally.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- The providers' statement of purpose which outlined how it would deliver services was not being followed in areas such as information to patients and relatives and allocation of a key worker. As such patients did not always receive care and treatment that responded to their individual needs and preferences.

Summary of this inspection

- There was limited access available to other specialised nursing services, such as a tissue viability nurse (TVN). We saw an incident where a referral to a TVN was not made despite this being an identified need.
- Equality and diversity needs were not identified, planned for or appropriately met in the delivery of care and treatment. This was despite staff having received training in this area.
- There was a corporate "Supporting patients with Learning Disabilities and Autistic Spectrum Conditions" however there was no dementia strategy that would support staff to deliver care and treatment to patients with this specific need.
- There were no arrangements in place to monitor patients' rehabilitation progress and influence changes in their treatment and support.
- Most staff members spoken with were unable to describe improvements made following complaints. The majority of staff were unaware how complaints were addressed.

However,

- Facilities to assist patients' physical rehabilitation were available, including; a gym, therapy rooms and a hydrotherapy pool. Patients' told us they found these facilities of particular benefit to their rehabilitation.
- Printed leaflets about the service were readily available in the hospital.
- The hospital had facilities to access interpreters if required.
- The hospital had a complaints policy and responded appropriately in the complaints records we reviewed.

Are services well-led?

Inadequate

We rated well-led as inadequate, because:

- Governance and risk management systems were not used effectively to ensure the safety of patients and the quality of care delivered.
- Staff, including senior managers, did not recognise, assess and mitigate risks appropriately.
- Action was not always taken when areas of serious concern were identified and as a result poor and unsafe practice was allowed to continue.
- The senior managers at the hospital did not effectively manage or lead.
- Staff and service users were not engaged sufficiently.
- We did not identify any areas where the hospital had tried to develop or adopt innovative ways of working.

However,

Summary of this inspection

- The corporate management team were responsive when we raised concerns with them.
- Some staff told us that they got on well with managers and could approach them.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Inadequate

Community health inpatient services

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Are community health inpatient services safe?

Inadequate

We rated safe as inadequate.

Safety performance

- We looked at how the service monitored its own safety performance. We saw that there were no arrangements in place within the hospital to monitor its own safety performance.
- We were told by the management team that alerts regarding safety were made available to the staff and stored in the clinic room. We checked in the clinic room on several occasions where we were unable to locate safety alerts. We asked the management team to locate the safety alerts from the clinic room or from anywhere else they might be available. They were unable to provide any safety alerts. Most staff spoken with confirmed that they were not made aware of safety alerts
- We observed that a food thickener (which had been the subject of a safety alert in the last year and should not be left out) was found in areas accessible by patients. Staff members we spoke with (with the exception of the catering staff) were not aware of safety needs regarding food thickener.

Incidents reporting, learning and improvement

- Staff told us that they had access to the hospitals electronic incident reporting system. 23 out of 25 staff were able to tell us how they would report an incident using this system. Staff members spoken with were clear about when to report incidents and what actions they should take. There were induction records available that showed that staff received training on how to use the incident reporting system as part of their induction to the hospital.
- We saw incidents that occurred at the time of the inspection; such as, medicines not signed for, changes in a patient's condition, National Early Warning System (NEWS) scores which were not reported as an incident. As such incidents were not consistently recognised or reported in order for investigations to take place and learning to be shared.
- We spoke with senior management who told us that they did not review all incidents. We saw that there were limited records to demonstrate that appropriate actions had been taken in response to incidents.
- Staff told us they rarely received feedback relating to incidents they raised. Minutes of meetings did demonstrate that incidents were discussed but there was limited evidence to show that learning from incidents was explored or changes to practice had been implemented.

Safeguarding

- The hospital followed a provider wide safeguarding policy. This policy set out how issues of a safeguarding nature should be identified and acted on. This policy was comprehensive and contained clear instructions for staff to follow. We found that staff were consistently not following this policy and the steps set out in it.

- The safeguarding policy in place stipulated that referrals of safeguarding issues should be made to local authority and the police within 24 hours of identification.
- We found that in two cases there had been issues in the reporting and investigations of incidents of a safeguarding nature. In one case the hospital lead nurse had been made aware of an incident when it occurred but did not report the incident until three days later using the hospital reporting system. This was not in line with the internal reporting system and policy which specified that an incident must be reported within 24 hours of the occurrence. In a second case we found that a service user had been exposed to significant risk of harm. However when we reviewed the investigation report relating to this incident we found that this case was not referred as a safeguarding alert. There were also no documented actions taken as a result of this investigation to safeguard other service users.
- Most staff members we spoke with were aware of how to identify issues of potential abuse, neglect and access support. However, they were unaware of any formal reporting system in place, stating that they would verbally report concerns to their line manager.
- There was also a standard pro forma for staff to make referrals through these channels within the provider policy.
- This form was not used in the hospital and the leads for safeguarding in the hospital were unaware of its existence.
- The Interim Hospital Manager informed us that they did not feel confident in judging whether an issue required a safeguarding referral to the Local Authority. As a result, they advised that they did not make any formal referrals to the local authority and police even when there was an allegation of abuse. The Interim Hospital Manager would telephone the local authority and request advice and permission before completing a referral. This action was not in line with the hospital's own policy and could potentially result in a delay before appropriate action was taken. During a handover on 2 March 2017 we observed that four out of six patients in one clinical area had been given doses of 'as required' (PRN) medication with sedative effects. The handover report stated that the sedative had been given to the patients to settle them overnight. The Clinical Lead Nurse told us that the use of sedation to settle patients without an assessed mental health need was not an area that was monitored. The Clinical Nurse Lead also confirmed that usage of sedatives had not been considered as a possible form of restraint.
- We observed an incident where physical restraint was used, staff members were observed to be physically holding the patient still. The staff member undertaking this practice told us that they had not seen the patients' plan of care and had not had training in how to undertake restraint practices. Additionally, other patients' care records contained reference to, "passive restraint", with no explanation as to what form this should take. In discussion with staff they stated that they did receive training in how to appropriately restrain a patient in episodes of aggressive behaviour. Neither of these examples were related to maintaining the safety of staff or other patients. Staff also informed us that they did not undertake restraint, were not aware of any incidents and had not recorded any restraint that was not related directly to aggressive behaviour. As such, incidents of possible restraint were not being recognised, recorded or monitored to determine if restraint was an appropriate response in order to safeguard patients.
- Documentation reviewed recorded that training rates for mandatory training in safeguarding adults were 100%, which met the hospital target of 100% and indicated that all staff had received training in safeguarding adults. However we found that this training did not meet the minimum required standard. An example of this was that the adult safeguarding training which was provided by the corporate learning and development team contained terms which were used prior to the introduction of the Care Act (2014) and did not list all types of possible abuse.
- At the time of our inspection there were no patients under the age of 18 receiving care and treatment. However the hospitals statement of purpose set out that the hospital could provide care and treatment to patients under the age of 18 in exceptional circumstance. However at the time of the inspection the staff were not appropriately trained in

safeguarding children which would be required should an individual under 18 years be admitted. The provider also had no plan in place to ensure this requirement was met in the eventuality of such an admission.

- The hospitals policy regarding safeguarding training recorded that clinical staff were required to undertake level one training for safeguarding children and level two training for safeguarding vulnerable adults.
- The intercollegiate document titled, 'Safeguarding children and young people: roles and competencies' (2014) sets out the levels of competencies and training for staff working with children and young people. This document states that all staff that assess, plan, intervene and evaluate care with children and their parents should undertake training at level three.
- Information provided by the hospital showed that 96% of frontline staff had completed in-house level one safeguarding children training. However, no staff members within the organisation had completed training above level one. Senior managers were trained to level one in safeguarding children and had insufficient training to provide appropriate guidance and support to staff.
- There was no named nurse or doctor for safeguarding children. As a result there was no advice, guidance and support to staff to make sure that they would be able to seek advice when needed, nor any arrangements to make sure that safeguarding concerns were effectively investigated and acted on.
- The service was not meeting this national guidance as they had provided care and treatment for a child in the twelve months prior to our inspection. Additionally a risk assessment in relation this decision had not been undertaken at the time of the inspection. Senior managers were unable to give a rationale as to why the decision to provide care and treatment to a child had been undertaken. When we highlighted this to the provider they undertook a risk assessment immediately.
- The intercollegiate document also stipulates that level four training should be undertaken by all specialist staff members that are named leads for safeguarding children. No staff members had undertaken this level of training at the time of the inspection, including the two designated safeguarding leads.
- The hospital lead for safeguarding was the Interim Hospital Manager and the Clinical Lead Nurse; neither had received any training in safeguarding in the 12 months prior to the inspection. In addition, the training they had received prior to this was not at the advanced level needed for staff making decisions, investigating potential safeguarding concerns or advising staff appropriately.

Medicines

- In one of the two medicine storage areas we found eight bottles of liquid medicine that had been opened without recording the opening date. It is important that liquid medicines have the date they were opened clearly documented. This is to ensure they can be discarded within the timeframes recommended by the manufacturer and patients do not receive medicine that has been open for longer than the recommended time frames.
- The hospital commissioned their pharmacy provision from a community pharmacy. A separate pharmacy team carried out a quarterly audit of medicines. We reviewed three audits and saw that there was no actions recorded to address the findings and identified issues for areas such as missing signatures, no instructions for PRN medicines and dating medicines in use these identified areas for improvement persisted across the audits.
- A pharmacist reviewed all medical prescriptions to identify and minimise prescribing errors. We spoke with two pharmacists who showed us the records they kept when they reconciled medicines and audits. These identified a number of issues that had not been addressed. For example, one patient record showed that of their stock of medicine 41 paracetamol were available that could not be accounted for. The amount received and the amount of signatures recording that paracetamol was given showed that there should have been 41 less tablets available than there actually was. Meaning that staff had signed for 41 paracetamol that had not been given to the patient. We looked at other pharmacy records and found that other medicines

showed similar discrepancies. We spoke with a member of the management team who informed us that they were aware of these discrepancies but did not raise them as an incident and took no action to investigate these anomalies.

- When we spoke with staff they informed us that records regarding PRN medicines did not provide sufficient detail for them to make evidence based decisions to give a PRN medicine. For example, the prescriber cards recorded the use of medicines PRN as, "for pain" or "for agitation". A review of care records showed that there was no further exploration of this instruction available. As such, staff did not have the information they needed to determine when a patient required a PRN medication. This was particularly relevant for patients unable to vocalise if they needed pain relief.
- We saw that one patient had received a patch medicine a day early on two occasions in the month prior to the inspection. We were informed that there was a reason for this and it was to meet the needs of the patient. When we reviewed the patient's completed records for these dates we were unable to find any recorded explanation for applying the patch 24 hours early. Additionally, their treatment plans did not include any information as to when it was acceptable for the patch to be replaced early. A family member informed us they had frequently observed that the patch had become dislodged from the patient which meant they would not be receiving the dose of medicine they needed.
- The system for prescribing medicines was at risk of prescribing errors. This was because the initial prescription was made as a private prescription to the pharmacy. A second prescription was then recorded on the prescriber cards which staff used to administer medicines. We spoke with staff and the management team to identify what checks were made in order to make sure that the prescription cards and private prescriptions did not have transcription errors in place. We were told that there were no checks and if errors had occurred they would be unaware of these errors.
- In reviewing prescription cards we identified that the discontinued dates of medicines had not always been recorded and there were missing signatures where staff had failed to sign to say whether the medicine had been given or not.
- The prescription cards we reviewed included over ten entries in the month prior to the inspection where medicine had not been given to patients because either the person was asleep or refused. We saw that this medicine dose was then omitted and there was no record of an attempt to return to the patient with the medicine.We spoke with two staff about how they dealt with medicines when the dose was omitted as either refused or the patient was asleep they confirmed that no action was taken to make sure that the patient received the medicine.
- We observed that controlled drugs were correctly stored, recorded and managed in line with legislation. Records for controlled drugs were accurate and checks indicated that there were no items unaccounted for.
- We reviewed fridge temperature records, which showed that records were up to date and staff recorded the temperature range as well as current temperature. Staff told us how they would raise concerns if the temperature was found to be outside of the maximum or minimum range.
- We observed that the doors to both medicine storage areas were kept locked and both areas were visibly clean and tidy.
- Records reviewed indicated that returned medication was correctly logged and controlled drugs were denatured (destroyed) in accordance with legislation and the hospital's policy and procedure.

Environment and equipment

- The service used a range of equipment for each patient.We reviewed the moving and handling assessments related to patients and the specific equipment used by them.The moving and handling assessments failed to mention the specific equipment in place for each patient or demonstrate risk assessment.This was particularly relevant to the use of lap belts for patients in wheelchairs or shower chairs.

- Emergency resuscitation equipment was in place in the main lounge. A review of the records indicated that the equipment was checked weekly. We spoke with staff about how they accessed this equipment in an emergency. Staff members were able to give us clear information as to where the equipment was located and the actions they would take to maintain patient safety. We observed that there were signs throughout the hospital indicating where this equipment could be located highlighting this to staff and visitors.
- We saw that equipment used was visibly clean; maintenance records were available for a range of equipment such as specialist wheelchairs, hoists and overhead tracking. The maintenance records indicated that checks to maintain the safety of equipment were undertaken yearly and any malfunction addressed. During our inspection we saw checks of equipment being undertaken as an external maintenance team were on site to check and repair equipment.
- Records we reviewed indicated that electrical safety testing was up to date for all equipment we looked at.

Quality of Records

- Treatment plans were paper based and we saw that they were securely stored in the nursing offices. The care records were organised with risk assessments, daily notes and treatment plans in place. However, the files were large, often containing information that was out of date and no longer current. As a result staff said that they were unable to locate information easily and did not believe that the format was suitable for patients and their relatives. Each treatment plan contained separate sheets of paper but we saw that only the front sheet had the name of the patient available. This meant there was a risk that the separate sheets of the treatment records could not be associated to the correct patient if they were separated
- We reviewed 14 sets of patient treatment records and in all 14 records we found at least one section had not been completed. This included; risk assessments, social histories, patients and relative's inclusion or personal preferences. Without up to date records, staff will be unable to deliver consistent care to patients that meets their individual needs.
- Separate to the paper records the therapy team kept electronic records. These records were not utilised as part of the treatment planning by nursing staff or the Rehabilitation Co-Therapists (RCT's) in order to make sure that this information was shared across the care team.
- RCT staff kept a further set of records; these were records of observations, food and drink charts, behavioural charts and turning charts as examples. In reviewing these records, we identified discrepancies and incomplete or inaccurate records. None of these records were regularly checked or reviewed by the registered nursing staff or management to check for accuracy or use the information to update treatment plans.

Cleanliness, infection control and hygiene

- We observed two staff handovers and heard that two patients required certain measures in place to reduce the risk of spreading infections to other patients and staff. We checked records and saw that the rationale for this was not recorded and there was no clear description as to how staff members were to manage and reduce any risks. In discussion with staff, they were unable to explain the steps they took when barrier nursing the two patients. This meant that staff did not have the information they needed to make sure they reduced the risk of the spread of infection and meet the needs of the two patients
- We spoke with staff regarding their understanding of how to prevent the spread of infection and the results of infection control audits. Staff were unaware of who the infection control lead was or the results of any of the audits. As such, staff members were unaware of any potential issues for infection control, how to monitor these and who to raise concerns with if necessary.
- We spoke with the Interim Hospital Manager and were informed that the infection control lead was the Clinical Lead Nurse.
- We were provided with results for hand hygiene and environmental audits. The results of these showed 100% compliance with the required measures. The audits were undertaken on a quarterly basis.

- All areas of the hospital observed were visibly clean and tidy.
- There had been no cases of methicillin-resistant staphylococcus aureus (MRSA) bacteraemia infections, methicillin-sensitive staphylococcus aureus (MSSA) bacteraemia infections or clostridium difficile (C.diff) infections at the hospital between January 2016 and January 2017.
- We observed there were hand wash sinks and hand gel dispensers available throughout the hospital. All soap dispensers that were in communal areas contained liquid soap reducing the risk of cross contamination amongst staff, patients and visitors.
- Staff members were observed using personal protective equipment (PPE), such as gloves and aprons and changing this equipment between each patient. We saw staff washing their hands using the appropriate techniques and all staff followed 'bare below the elbow' guidance.
- The hospital had a contract with an external company for the removal of clinical waste. We saw that there were arrangements in place to make sure that clinical waste and contaminated items were dealt with correctly. Pedal bins were available in all bathrooms, the kitchen and clinical area which meant that staff would not contaminate the bin each time they used it. Sharps boxes were available for the safe and hygienic disposal of used medicine ampoules and needles.

Mandatory training

- At the time of the inspection, the Interim Hospital Manager was unable to give us an accurate understanding of compliance with mandatory training. This meant the hospital was unable to monitor if the staff they employed had the correct training they needed to safely care for patients.
- We were informed that mandatory training was two-step training with training at induction undertaken at the providers Head Office and local mandatory training renewed as needed. We were given a list of training and informed that everything on the list was considered mandatory by the service.
- Following the inspection, the senior management team provided us with updated figures relating to training rates. This showed that uptake levels of mandatory training were significantly below the hospital target of 100% in key subject areas.
- Records showed that 40% of staff had received training in moving and handling. This meant that over half the staff had not received training in moving and handling. We saw over the three days of inspection that all staff undertook moving and handing activities. This meant that there may have been staff undertaking moving and handling of patients or equipment that did not have up to date training, placing patients and themselves at risk of harm.
- Records showed that basic life support (BLS) training had been undertaken by 67% of staff. The records forimmediate life support (ILS) resuscitation training of staff were held corporately and therefore unavailable at the inspection despite asking several times. However the records were shared with CQC following the inspection which demonstrated almost full compliance.
- Local knowledge of training compliance rates should be available locally but local senior managers did not appear to be being monitored ILS training rates effectively.

Assessing and responding to patient risk

- The hospital used a national early warning score (NEWS) system to monitor patients' clinical condition and identify any deterioration so that appropriate action could be taken. The NEWS system was designed to assign a score to each clinical observation to indicate potential deterioration in patients' condition and prompt clinical action. The associated outline of clinical response to NEWS scores document provided stipulated set actions to be taken when patients overall score reached a specified level.
- We were provided with a copy of the tool and escalation process for the use of NEWS. The Clinical Lead Nurse advised us that the NEWS scoring tool and escalation process was in use and located on a shared computer drive.
- We saw that staff members were not following the providers' internal operating procedure for escalating

patients with deteriorating conditions. For example, we reviewed the records for five service users which showed that between 19 February 2017 and 2 March 2017 there were 69 occasions when patients NEWS scores were between one and four, which indicated that monitoring four to six hourly was required, but this was not undertaken on any of the 69 occasions. On 11 occasions, NEWS scores were between five and seven, which meant that hourly monitoring was required, along with a need to urgently inform the medical team for urgent assessment, but this was not undertaken on any of the 11 occasions. On five occasions, NEWS scores were recorded as over seven which meant patients should be continuously monitored and staff should immediately inform the medical team for a potential transfer of clinical area outside of the hospital but this did not happen on any of the five occasions. Additionally we identified from care records that on three occasions NEWS scores exceeded eight and appropriate action was not undertaken.

- As result of staff not taking the prescribed action when risks were identified, patients were placed at significant risk of harm. We addressed this immediately with the senior management team and received assurances that this matter would be addressed urgently. When we returned for the unannounced inspection we saw that the provider had made arrangements for NEWS scores to be monitored and escalated when required. We saw that one person who's NEWS scores had reached over seven had been assessed by a doctor and transferred temporarily to another service to receive appropriate care and treatment in line with the NEWS escalation protocol.
- Concerns regarding the monitoring of patients' conditions had been identified at a previous inspection on 23 November 2015. Following this inspection the provider developed an action plan to address this. The action plan was submitted and monitored by CQC and other external partners but at the time of the inspection it was unclear whether these actions had been taken to address these concerns as the issues from the last inspection were still prevalent at this inspection.
- We observed two clinical handovers as part of the inspection. During one of the handovers we were informed that a patient had undergone a tracheostomy change at 7am in the morning. Following this their condition had changed. This complication was not communicated on the written handover sheet or verbally. Therefore the nurses caring for this patient after the shift change were unaware of the complication and did not have the information they required to care for the patient safely. Following the inspection we received information from the provider stating that tracheostomy changes would now only take place at times when more registered nursing staff were available and a doctor was on site in order to maintain the safety of the patient and take swift action should complications occur.
- Another handover highlighted that a patient had red skin. We reviewed the patients' records which stated that there were broken areas of skin but there was no specific treatment planned. In discussion with staff it was identified that the patient did have a pressure ulcer. There was no information in their care records to guide staff as to the action to take to prevent any further deterioration. Additionally, the patients' risk assessment regarding the development of pressure ulcers had not been updated to reflect the increased risk to them. The handover we observed was insufficient to provide staff with the correct information they needed to address risks to patients in their care.
- We reviewed the arrangements in place for staff to recognise and act on the key signs of SEPSIS and what they would do if a patient was suspected of developing sepsis .SEPSIS is a rare but serious complication of an infection that can lead to shock, multiple organ failure and death if not addressed rapidly.
- There had been training on SEPSIS and posters were in the service. However, there was no policy or procedure relating to the management of sepsis and the provider had no system to assure that staff were identifying or acting upon triggers for sepsis .
- Additionally records and notes taken at the time of the inspection showed that there were instances of potential SEPSIS that had gone unrecognised.

- We looked at 14 patients' records to determine how general risks were managed and what action was taken to maintain the safety of patients. We saw that that risk assessments designed to keep patients safe were not always completed or were inaccurate. In one example, we saw that the risk assessment had identified a patient at high risk of falls and required repeating in seven days. The record reflected that the required repeat did not occur and there was no record that measures described in a treatment plan had put in place to reduce the risk of falls. We observed during the inspection that the patient had significant fresh facial bruising, which we were informed by nursing staff as resulting from a fall. The failure to assess risks and take appropriate action had placed patients at significant risk of harm..
- Staff were not trained appropriately to respond to key risks including complications during procedures. Training records also showed that 19.8% of staff had received tracheostomy care training and 19.8% of staff had received training in care and management of percutaneous endoscopic gastrostomy (PEG) equipment. We saw records that showed that staff who did not have up to date training in PEG management were undertaking this activity.
- Of the 18 registered nursing staff, 13 did not have up to date tracheostomy training. Records we reviewed confirmed that registered nurses had undertaken tracheostomy changes without the relevant up to date training for this. Duty rotas showed that there was not always a registered nurse on duty who had training in tracheostomy care to supervise or lead tracheostomy changes and maintain the safety of patients. We raised this with the management team who immediately ensured that there was a member of staff competent to deal with this care need on duty at all times. Following our inspection we received information from the provider stating that they intended to train more registered nurses in tracheostomy care; in particular changing tracheostomies.

Staffing levels and caseloads

- We asked the Interim Hospital Manager for the arrangements in place to determine staffing levels and deployment required to safely care for patients. They were unable to provide us with this information. As such the hospital was unable to determine if correct number of staff were available to meet patient needs or ensure that staff members with the correct skills were appropriately deployed.
- Rotas available within the hospital did not accurately record the staff on duty each day to support patients. Senior managers were unable to explain how they ensured that the correct staff members with the correct roles were available to meet patients' needs safely. As a result there were no monitoring arrangements in place to make sure that the hospital operated at the correct numbers of staff to maintain the safety of patients at all times.
- The majority of staff spoken with told us they felt that there were sufficient staff members available. We observed that medicine arrangements were long with medicines starting at 8am in some instances and not being completed until 1pm. During the unannounced inspection we observed that two nurses were unable to have a break until late afternoon as they were giving medicines until 3.30pm. We also saw that a member of staff was being inducted to the service that day and correctly required assistance to ensure their practice was supported. The impact of the support had not been taken into account on the workload of staff for that day.
- The service utilised the services of on agency and bank staff on 416 occasions between September 2016 and December 2016. We observed a handover where an agency member of staff conducted the handover. This handover did not convey all the information which the team coming on to shift required.
- There were several associated staff including physiotherapists, Speech and Language team (SALT), occupational therapists and an activities co-ordinator in place to provide care and support to patients.
- There was a lead medical doctor for the unit who was available via a call system seven days a week. The doctor was also on site three days a week to review patients. There was an additional doctor who attended two days a week. The interim hospital manager told us that they were looking at recruiting a full time doctor but at the time of the inspection no arrangements had been made

Major incident awareness and training

Inadequate

Community health inpatient services

- Staff we spoke with were unable to say what they would do in the event of a major incident and told us that they did not receive training in this subject.
- On the day of our inspection the fire alarm sounded and staff met at the evacuation point. Other staff stayed with patients in order to maintain their safety.Staff spoken with and the lack of available records confirmed that evacuation training and planning was not ongoing.
- Fire awareness training was part of induction training but this did not cover the specific arrangements needed in the event that the building needed to be evacuated.
- We were given copies of individual personal emergency evacuation plans (PEEPS) for each of the patients. Most staff we spoke with were unaware of these or their contents. The PEEPS had not been updated to reflect any changes since they were implemented at the admission of the patient. As such staff did not have easy access to the information they would need in the event of an evacuation.

Are community health inpatient services effective?

(for example, treatment is effective)

Inadequate

We rated effective as inadequate.

Evidence-based care and treatment

- Policies we reviewed were based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines.We requested information as to how the hospital audited in terms of local and national practice within rehabilitation services.This information was not available. We were informed by senior management that this did not take place as there was no local services on which to determine a comparison.
- Care records reviewed cited some national guidelines this was noted in care records developed by the therapy teams. Overall, care records were generically written, not geared to meet patients specific needs. As such the evidence needed in care records to inform staff practice was often not available. Examples including a lack of recorded information to inform staff with regards to the administration of 'as required' PRN medicines, how to manage falls and the management of diabetes.
- The hospital provided a list of audits prior to the inspection.These included audits on records, handwashing, prescription cards, infection control and mental capacity as examples. Clinical audits included, pressure ulcer care, tracheostomy, dysphagia hazards and catheter care.
- Audit information was inconsistent, some audits listed the measures to be reviewed others did not. An example was the tracheostomy management audit was undertaken in July 2016, this audit reviewed a number of areas in relation to tracheostomy care the overall score was 99%, however there was no measures in this audit as such there was no indication of how the scores had been determined in order that evidence based care and treatment could be put into place.
- A catheter management audit was undertaken in June 2016, this audit reviewed a number of measures such as documentation around interventions and clinical aspects, such as positioning of the drainage bag. The results of this audit varied across the measures with 5 out of 16 standards scoring zero percent compliance. This included documentation on how often the bag should be emptied and how frequently the catheter should be changed. The hospitals own audit indicated that patients' catheter care was not sufficient to ensure that they received effective care and treatment.
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  The hospital had Abbey Pain Scales records available. The Abbey Pain Scale is an instrument designed to assist in the assessment of pain in patients who are unable to clearly articulate their needs. When we reviewed these for four patients we saw that despite receiving PRN pain relief these were not used, none of the four patients were able to vocalise feelings of pain. There were no arrangements in place to personalise these to demonstrate what an individuals' non-verbal indicators would look like to staff. Three staff spoken with said that they did not use this tool as it required completion for every dose of pain relief and was

therefore too onerous to complete. They were unable to explain how they would determine non-verbal indicators of pain as this was not recorded in patients' care records. As a result, consistent practice was not in place as staff relied on their individual memory and experience with specific patients.

- Treatment plans and prescriber cards for the administration of pain relief medicines, did not record that once a pain relief was administered that staff monitored the effectiveness of the pain relief and reported this information to the prescriber. As such the hospital had no means to make sure that where pain relief was given that it made sure that this meet the patients' needs and alleviated their pain.
- Patients able to vocalise pain were satisfied that they received pain relief when they requested it.

Nutrition and hydration

- There were no records of patients' specific likes and dislikes in relation to food. Staff informed us that they knew what patients less able to express a preference liked to eat and matched the menu choices to this. They did not have any information available other than their memory on which to base these choices or to meet their specific dietary needs.
- The service did not have a dietitian on site but could access this service, if required through their GP.We saw examples within patient records where dietitian advice had been sought and implemented. We asked if the menus available for patients had been assessed for their nutritional content but were told they had not.
- MUST score was available in all care records reviewed. The MUST is a validated nutritional screening tool with five steps, designed to identify adults at risk of malnutrition. The tool allows patients to be categorised as being at low, medium or high risk of malnutrition and enables care plans to be developed.
- We saw that the MUST score was not completed for two records of the ten MUST scores reviewed and was incorrectly calculated for a third which meant the level of risk of poor nutrition had not been identified for three patients. We discussed this with a member of the management team who confirmed that the MUST score was not correct and the risk of poor nutrition had not been correctly recognised for three patients.
- We saw that the MUST score required the weight of a patient (or an estimation of their weight using mid-upper arm circumference (MUAC) and a height (or an estimation using an alternative measurement (ulna, knee height or demispan) could be used). We saw three of ten MUST records reviewed stated unable to weigh with no MUAC in place or an estimation of height. As such, the calculations to determine the risk to patients of poor nutrient could not be relied on as staff did not utilise the tool effectively.
- For patients calculated as at risk of poor nutrition, staff recorded their food and drink. We looked at these records and saw that they were not always completed correctly. For example, staff often recorded the meal presented without a determination of how large this meal was, then recorded that half or all had been eaten. Without knowing what the size was originally it was not possible to accurately confirm what the amount eaten represented in nutritional terms.
- A previous action plan which was in place as a result of an adverse incident had stated that all daily records such as fluid and food charts would be checked daily. We saw that at the time of this inspection, none of the records were reviewed by registered nursing staff in order to determine that they were accurate or identify any concerns. Staff we spoke with confirmed that the records were not checked daily for this information.
- There were eleven patients who had percutaneous endoscopic gastrostomy (PEG) arrangements in place whereby food and drink was directly supplied via a tube to the patients' stomach. This is commonly undertaken due to a reduction in the patients' ability to swallow safely. Records showed and conversation with staff highlighted that protocols were in place for food and drink and the administration of medicines for patients with this need. Records reflected the type of enteral nutrition to be used and timing of this. All patients with this type of feeding automatically score at risk of developing nutritional needs under the MUST score in place in the hospital and this was reflected within patient records.
- We spoke with catering staff regarding the arrangements of food to patients. Catering staff were knowledgeable about the different types of food needed by patients such as soft, thickened or diabetic.

We were told of one example where the chef had spent time with a family member and developed a separate menu for a patient to meet their individual needs.

- For some patients, the use of a thickening agent was prescribed for diet and fluids in order to prevent swallowing issues. These arrangements were reviewed by the SALT team staff in order to ensure that the correct instructions were available for staff to follow. Records indicated that the correct amounts of thickener was being used and recorded accurately in order to maintain the safety of patients.

Patient outcomes

- Outcomes for patients were not measured. This was because treatment goals were not routinely reviewed in order to make sure they remained relevant. Although the therapy team did have separate rehabilitation goals, these were contained on a computer system and were not incorporated into the general day to day care undertaken by the Rehabilitation Co-Therapists (RCT's) or registered nursing staff. Treatment plans were in place but the treatment goals outlined were not reviewed as described in the treatment plan in order to determine that they remained suitable, took into account individual progress and were renegotiated as needed. Families informed us that they were not aware of goals that had been sent and care records were not in formats easily accessible by all patients.
- The hospital made no comparisons of their performance against others management informed us that they did not do this as they felt there were no similar services to compare against. As such there were no benchmarking arrangements in place by which the service could assess their performance in relation to national patient outcomes.
- We asked management how they monitored patient outcomes they informed us that there was no formal systems in place.
- We did see that there was a plan to discharge two patients into the community. However, there were three patients who had lived in the hospital for over three years with no plans for discharge and no monitoring of rehabilitation targets to determine if the hospital environment remained suitable to meet their needs.

Competent staff

- Staff told us they received annual appraisals. Information from the provider showed that in the reporting period 2015 to 2016 93% of staff received an annual appraisal. The hospital target was 100%, which was not achieved. The management team were unable to provide an explanation of what monitoring arrangements to make sure that staff received their annual appraisals were in place.
- We requested information from the hospital that showed how they determined that staff were competent to undertake their job role. We were presented with a large pile of booklets and informed that staff completed the booklets and returned them to the hospital. A number of these booklets were not checked or signed by a reviewer to confirm that staff had accurately completed the booklets and where therefore competent to undertake the specific tasks.
- We were further informed that not all the staff competency booklets had been returned. We requested confirmation as to the arrangements to determine the competency of staff. We were informed that this information was not available on three separate occasions during the inspection, the information was not been provided following the inspection.
- There were a number of tasks being undertaken by staff despite the lack of assurance to the management team that the staff members were competent to do so. An example of this was that staff were undertaking care of tracheostomies and undertaking clinical observations with no records or assessments of their competency to do so.
- Qualified staff told us there were no formal systems for clinical supervision and they did not feel well supported to develop their clinical skills and knowledge. Managers we spoke to confirmed that there were no clinical supervision arrangements in

place. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work.

- Newly appointed staff underwent a generic induction programme which was delivered at the providers head office. A more specific induction was undertaken at St Cyril's Rehabilitation Unit in order to provide staff with skills to meet the needs of patients in the hospital.
- The hospital had a process to review staff records yearly to ensure registered nursing staff had a current professional registration. Copies of these reviews were available on individual files and assisted in making sure that registered nurse were fit to practice as nurses.
- There were two doctors who worked in the hospital on a rota basis. This varied from a minimum one hour Monday to Friday and attending the hospital on a weekend for several hours as needed. Additionally they provided 24 hour on call assistance for patients.

Multidisciplinary working and co-ordinated care pathways

- A multidisciplinary team of staff was available, consisting of nurses from different disciplines, consultants, health care assistants known as Rehabilitation Co-Therapists (RCT's), physiotherapists, occupational therapists, speech and language therapists (SALT) and an activities co-ordinator.
- We observed practice, reviewed records and discussed with staff, which confirmed that there was not a robust and effective multidisciplinary team (MDT) in place. MDT minutes were available within the hospitals computer system. However, the minutes of these meetings and the therapist team planning was not utilised to provide rehabilitative goals that was available to guide staff to deliver consistent care that met patients' needs and promoted their independence.
- There was no monitoring of MDT meetings to make sure that all discussed plans and goals were reflected within the care planned and provided.
- There was limited involvement of patients and their families in both the care planning arrangements and care planning meetings. Two families informed us they were not aware of when the meetings were held or what the outcomes were.
- There was a meeting held daily with the registered nursing staff on duty and the Clinical Lead Nurse. This was undertaken in order to monitor specific needs of patients, co-ordinate the care daily and review ongoing actions. We were informed that this should be undertaken every day with a copy of the minutes available to share knowledge of patients and monitor the care they received. It was also to highlight any learning and actions that needed to be taken.The minutes were located in the staff room anonymised to maintain patient confidentiality. However, we saw that in the last three months there were gaps on at least four occasions of up to 10 days where no minutes were available.We requested the copies that were not included from management and were informed that these meetings had not occurred. We also noted that these meetings did not take place when the Clinical Lead Nurse was not available. The purpose of the meeting in assisting staff to co-ordinate the care to patients and monitor progress of patients was not maintained when the meetings were not consistently held.
- We were informed by some staff and families that there had been concerns with regards to accessing GP service for patients.The majority of the patients do not live locally. Initially, there had been an arrangement with a local GP to provide services but this arrangement was no longer in place. As the hospital is community based with doctors available on site 5 days a week and on call at the weekend referrals to other services such as hospital appointments or other professional need to be communicated to the patients GP. Some services such as tissue viability required a GP involvement in order for the patient to receive this service. We spoke with a family member who stated that their relative had been without a GP for over 6 months and they had not been informed of this. We spoke with the management team who informed us that patients retained the services of their GP no matter what the distance was and we were assured verbally that all patients now had an allocated GP. We reviewed care records and could not locate the

contact details or arrangements in place for all patients' GPs. We asked for written confirmation as to the names and addresses of all GPs for patients' but this were not available.Staff we spoke with were unaware individual patients GPs stating they would contact the hospitals doctors for any medical interventions.

Referral, transfer, discharge and transition

- We looked at how patients were referred and transferred to other facilities or supported to return home. As targets and goals were not routinely set, there was no clearly outlined plan. Patients were discussed during multi-disciplinary team meetings. Records and conversations with a patient due for discharge confirmed that when it was determined that the patient was ready for transfer this was discussed with the patient and their families.
- We saw that arrangements for transition to other facilities or home were structured and included weekend leave and social worker assistance.
- There were some patients that had lived in the hospital for up to five years and there were no clear plans to work towards discharging them to an alternative setting or home. Defined goals that would assist identifying when patients were approach the need for discharge planning were not available. As a result patients' treatments plans did not reflect transition or discharge as an achievable possibility for all staff to work towards in collaboration with patients and their families.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Patients can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The Deprivation of Liberty Safeguarding (DoLS) orders that were in place demonstrated that these had been applied for to the local authority and the orders granted. Where conditions were in place for DoLS, these were monitored. Two patients had orders that stated they required social interactions as part of their orders and two books were maintained regarding their social interactions. However, these were both very brief and reflected limited social events or recorded that none had taken place. In addition, the information in the books was not utilised in the individuals care plans in order to make sure that all staff were aware of the requirements and how to meet them.
- Within the service were posters highlighting the availability of Independent Mental Capacity Advocates (IMCAs). We examined records and spoke to staff which confirmed there was no information available within the hospital that patients had accessed an IMCA should they require this service.
- Of the 14 records we examined, 13 held overarching capacity assessments for decisions such as, "consent to care and treatment" which did not meet the two stage test where consideration should be given to whether a patient, "can make this decision at this time". In two sets of patient records we noted that the patients' had been deemed as lacking capacity to make their own decisions about care and treatment despite staff and the records reporting that their capacity was variable.
- A relative reported to us that a patient had a Do Not Attempt Cardiopulmonary resuscitation (DNACPR) authority in place without consultation with them. They explained that when they challenged this, they had been informed it was a medical decision. There was no evidence in the patients' records that the family or a patients' representative had been consulted regarding their views before the decision had been made. There was also no evidence that the

patients' ability to make the decision or put forward their views with regards to the decision had been assessed. We raised this with the hospital management team who informed us that this would be addressed immediately.We were informed from the hospital management that following our inspection a capacity and best interests meeting that consulted with the family member was undertaken.

- In conversation with staff they had referenced that they made care decisions at relatives' requests. When we reviewed the information regarding the relative's legal authority to act on behalf of the patients in medical decisions, there were no records available that showed any family members had this authority. As such, the service was not acting within the boundaries of the MCA.
- We looked at records which indicated that a patient was receiving medication covertly (without their knowledge).The records showed that medical permission has been given to administer medicines covertly.However, there was nothing recorded to show that a capacity assessment or best interest discussion had taken place, what medicines were essential and could be given covertly or how the medicines were to be administered.Staff we spoke with were not aware of the need to undertake a capacity assessment or best interests meeting before giving medicines covertly stating they believed that the permission of a doctor was sufficient.As a result, we could not be assured that the patients' rights had been maintained or legally addressed.
- Contemporaneous notes reflect that a review of the file demonstrated no LPA at any level, no discussions with any family, No capacity assessment, No best interest discussion, No treatment planning arrangements, no determination of essential medicines and no pharmacy arrangements needed to maintain the patients' rights.
- Observations showed that staff did not always seek consent or inform patients of the actions they were taking such as, putting them to bed, taking them to a meal or moving them in their chair, prior to undertaking these interventions.
- Training records reflected that all staff had received training in their induction for the MCA. Additionally, the service had an up to date policy that reflected the provisions of the MCA.

Are community health inpatient services caring?

Inadequate

We rated caring as inadequate

Compassionate care

- We undertook three Short Observational Framework for Inspection (SOFI) observations which ranged from between 40 minutes to an hour. These are a formal method we use to understand the quality of the experiences of people who use services who are unable to provide feedback due to their cognitive or communication impairments. Whilst we observed that staff interactions were neutral and positive in nature, these were minimal. For example, we saw that three people remained in the same chairs in the same part of the building from 10 in the morning until 2.30pm. During this time we undertook a SOFI observation for an hour of all three people and saw that one patient received an interaction which lasted three minutes. No other direct interactions occurred in the hour. Staff did acknowledge patients as they walked through the room saying "hi" but did not stop to interact further.
- As part of the inspection, we saw that there was a large box in the laundry area that contained a variety of matched socks. None of these were identifiable as belonging to an individual patient. A member of the management team confirmed that the socks were used by patients. Additionally, we looked at variety of clothing for patients. Some were marked on the clothing tab with the patient's initials but some gave no indications as to who the owner of the clothing was. A member of the management team confirmed that other than initials in some clothes, there was no other method that ensured that patients did not wear each other's clothing, including potentially wearing another patient's intimate clothing. We asked the Interim Hospital Manager to address this immediately and we were informed that this would be undertaken.

- We spoke with four patients, who all gave us positive feedback about how staff treated and interacted with them. Relatives we spoke with told us that overall they found that staff as individuals were kind and caring but expressed some concerns about the consistency of a compassionate approach from all staff. In addition some relatives told us they felt that the approach of the management team was not supportive of them.
- We observed that the interactions between staff and patients, when they occurred, that staff spoke to patients with kindness.
- We observed that when personal care was delivered, doors were closed to protect privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients who were able to represent themselves and vocalise their views told us staff kept them informed about their care and treatment. They spoke positively about the information staff gave to them and their support. However, they told us that they had not been involved in formulating their treatment plan or any goals; they were unaware of the contents of their care records.
- Our observations demonstrated that staff did not consistently respect patients' rights to make choices about their care. We observed staff undertaking interventions such as moving people in wheelchairs without discussion or explanation. On the second day of our inspection we observed that 11 patients had been returned to bed by 6pm. We were informed by a senior RCT that as the majority of patients were at risk of developing pressure ulcers they were returned to their beds in the afternoon. Some family members informed us that they were aware that their family members spent up to 20 hours a day in bed. They told us that this was inappropriate and that more social interactions needed to be in place. We reviewed eleven care records for patients observed to go to bed by 6pm for a rationale for the time patients spent in bed none of the care records contained a rational for this action or a plan that outlined patients preferred evening routines and preferred bedtime information.
- We were informed that there were two patients where English was not a primary language and one patient with significant hearing impairment. Two of the three records showed that interpreter arrangements were not always in place. We were informed for one person and shown documentation that they had been offered interpretative services on two occasions but had refused as a result there were no arrangements in place that supported these patients to be involved and understand the care and support they were receiving. No further exploration of this need had been undertaken with the patient to determine if other forms of communication would be beneficial to them or what if any their reasons for refusing this support maybe.
- A review of eleven records for patients unable to vocalise showed that there was no information regarding alternative means of communication, such as non-verbal gestures or assistive technology. We observed that where people were unable to vocalise or had a cognitive impairment, there was no information in place as to how to communicate with them. Throughout our inspection we saw staff attempt communication by verbal means or written means. As a result, patients may not have been supported to receive information in formats that best suited their needs.
- Care records were not available in different formats such as picture records to assist patients. Staff informed us that they found the care records, "too big and repetitive" to use and did not think that the format would assist patients or their families in understanding patients' care and treatment plans.
- All the relatives we spoke with told us that they were not included in the planning of care and treatment, they were unaware of any goals set for their relatives and their views were not taken into account. As an example, some relatives told us that they anticipated that their relatives would be involved in social events outside the hospital. They told us that apart from external hospital appointments, their relatives had not left the hospital for months. We reviewed records related to activities and occupational therapy and saw that there were no social opportunities outside the hospital for most patients.

Emotional support

- We looked at how the hospital supported patients with their emotional needs, in particular those with a

mental health need. Care records reflected where patients required extra support but were not specific about how to assist patients in managing their emotional needs.

- Staff monitored the behaviour of patients through an antecedents, behaviour and consequences (ABC) monitoring process. These were completed by Rehabilitation Co-Therapists (RCT's) when emotional or behavioural support was needed or following an episode of aggressive behaviour. We reviewed twelve records for three patients and saw that there was minimal information available. For example, staff did not fully report the antecedents such as what the person was doing at the time, what staff or other patients were in the area, what they had presented like for the majority of the day, what was said (if anything) to the patient, if they had received visitors or been undertaking any specific activity. RCT staff explained that they did not fully record this information as there was limited space available on the form. RCT and nursing staff told us that these reports were not reviewed or the information used to add into patients' treatment plans. We saw ABC records with emotional and behavioural needs that had not been used to update the care and treatment of the patients in order to determine what the potential behavioural triggers were and to include this in treatment plans. As a result, vital information to assist staff in planning and delivering appropriate support was not available.
- Psychological support services attended the Hospital and planned interventions to assist patients as needed. Records did not demonstrate how and when the recommendations had been implemented or to what effect.Counselling services were not readily available to patients. We were told by management that referrals could be made as needed for both psychological and counselling services; however none of the records viewed showed that referrals had been made for this support
- Staff told us they had sufficient time to spend with patients when they needed physical support.

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

(for example, to feedback?)

Inadequate

We rated responsive as inadequate.

Service planning and delivery to meet people's needs.

- All the relatives we spoke with were unaware of the planning around the delivery of the service and had not been involved in any aspects of running the hospital. The hospital management told us that patient and relatives meetings were available but these were not well attended. There were no alternative arrangements to ensure that patients and their relatives who often lived a significant distance from the hospital could be effectively communicated with.The providers' arrangements as to how they would deliver services were not in place to assist patients and their relatives in influencing the care to be received or the service delivery.
- The service's statement of purpose (SOP) stated "On admission the patient will be orientated to the hospital and the care environment. A named therapist and key worker will be appointed prior to admission to undertake transitional work to ensure a planned and smooth admission. A copy of the Patient Handbook will be made available for patients and a Relatives and Carers Handbook for patients' families."None of the fourteen care records we examined identified a named key worker or therapist. In addition, relatives informed us that they were not aware of any key worker arrangements nor received a copy of the Patient Handbook. However, a written copy of the Patient Handbook was located in the main dining area. Some of the relatives we spoke with were aware that this information was accessible in the dining area. There were no different formats of this information available such as braille, large print or pictorial to assist patients and their relatives.
- The SOP reviewed also stated, "From their admission the patient will commence a comprehensive

assessment exploring holistic care needs". We looked at fourteen patient records which showed that patients received an initial assessment to determine if the hospital was suitable to meet their needs.

- We looked at treatment plans and saw that staff did not always review these within the timescales set in the documentation. Changes to treatment plans were rarely made in the records we reviewed. As such, it was not possible to determine what progress patients had made beyond their initial assessment on admission. Monitoring arrangements were not sufficient to assist staff in their delivery and planning of treatment to respond to patients changing needs.
- We were informed by relatives that the hospital did not have access to a Tissue Viability Nurse (TVN)to provide support to all patients with a wound and who need specialist wound care to recover . We spoke with management and staff who confirmed that a TVN was not employed within the hospital and to access this specialist they needed a referral via the patients' GP. We saw one patient who had developed a pressure ulcer, a review of their records showed that a specific treatment plan was not in place and a referral to a TVN had not been made.
- The general environment of the hospital was visibly clean; there were facilities such as a gym, therapy rooms and hydro therapy pool available to assist patients in their physical recovery. We spoke with two patients who told us they had found it particularly beneficial to access the gym easily.
- We looked at how the signage within the hospital assisted patients (particularly those living with a cognitive impairment or dementia) to navigate independently and saw that this was not always clear. For example, all the doors were the same colour and signs on the doors indicating the purpose of the room or the personal bedroom of patients were not suitable to meet the needs of someone living with dementia, patients who were visually impaired or those whose first language was not English. This is because there were limited pictorial indicators of areas such as bathrooms or therapy rooms.

Equality and diversity

- Information leaflets about the service were readily available in all the areas we visited. However, information leaflets in different languages or other formats, such as braille or pictorial if patients needed them were not readily available. The majority of staff members we spoke with were unaware of how to access information in different formats. None was available for patients in the hospital that were assessed as having a communication need such as impaired cognitive ability. There were patients' who needed information in different languages but staff told us that information in different languages had not been provided for the patients. This was supported by records we reviewed.
- We saw instances where translation services particularly for the hearing impaired had not been put into place. We were informed by staff and management that a patient would benefit from staff having a basic understanding of British Sign Language (BSL) as the patient used this language to communicate. We reviewed the care records for the patient and could not find reference to any arrangements for staff to communicate with them in any format such as pictures or quick reference BSL cards. We spoke with four staff who confirmed that they had not received the training in BSL but had been told they needed the training two months ago. There were no records that reflected that staff had received any training in BSL. In conversation with the hospital management team we were informed that they recognised that training in BSL would benefit patients and staff but had not yet put this training in place.
- In conversation with staff members they told us they were aware if patients had cultural needs but were not always clear as to how they would meet these. Information regarding equality and diversity specific to individual patients was not available within the fourteen care records, treatment plans or assessments we reviewed.
- We looked at how different cultural needs and diets could be catered for. The catering staff explained clearly how they would meet individual cultural needs and showed examples of when and how they would take this into account in providing food and drink
- Where patients did not have English as a primary language, translation services could be accessed either via a telephone call or in person dependent of

the patents preferences. We looked at the records of two patients who required translation services which showed that translation services had been utilised for one patient.

Meeting the needs of people in vulnerable circumstances

- There was minimal consideration to providing treatment and support specific to patients' individual needs, choices and preference. Care records we looked at were generic, vital information about the needs of individual patients' such as cultural, communication needs, social needs and personal preferences were not ascertained made available to staff or utilised as part of the planning and delivery of the care patients received.As a result the planning of patients' needs and delivery of care and treatment was not person centred.
- Staff members spoken with were aware of when they needed to make reasonable adjustments for patients living with a disability. However we observed, there were no specific arrangements to make adjustments or considerations for patients living with a learning disability or dementia such as adaptations to the environment, routines such as bedtime that met individual needs and social events outside the hospital.
- The staff members we spoke with were unaware if there was dementia or learning disability strategy in place and what form this would take. We were informed and records confirmed that there were patients living in hospital with a diagnosis of dementia. A review of patient records showed that their dementia diagnosis had been determined there were no assessments or plans in place. Overall, the care records we reviewed where geared to meeting physical needs and did not take into account patients other.
- Some relatives we spoke with informed us that their relatives had not been involved in any social activities external to the hospital. They thought that this needed to be increased. Where patients were able to vocalise or had greater independence skills social events did take place such as shopping trips and group activities.

Access to the right care at the right time

- There were no arrangements in place for the hospital to monitor that patients had met their initial admission criteria which outlines patient's suitability for rehabilitation or setting rehabilitation goals for patients both in the short and long term to increase their independence.
- Management informed us that access to GPs in order to have referrals for additional support such as Tissue Viability and Dietician had presented a barrier in the last few months. However, management felt that this was now resolved and all patents had access to a GP.
- We were informed that one patient had developed a pressure ulcer; however a review of their records showed that a referral to a tissue viability nurse had not been made.
- One relative informed us that they were concerned about the lack of access to tissue viability nurses in order to provide timely treatment. Management told us initially that there were plans for some staff to receive training in tissue viability in order to address this. However in further interviews they confirmed that no training had in fact been planned and staff had not yet been scheduled to attend.
- 14 records reviewed and observations showed that there was ready and prompt access within the hospital for Speech and Language therapy (SALT), physiotherapy and occupational therapy. Interventions from the SALT team working in the hospital were recorded in patents daily records outlining the activities undertaken.

Learning from complaints and concerns

- The service received five complaints in the period January 2016 to January 2017. Records indicated that all five complaints were fully upheld after internal investigations.
- Patients and relatives we spoke to told us they knew how to make a complaint. Leaflets were readily available around the hospital detailing how to make a complaint. Relatives' views as to how complaints were dealt with were mixed. Some felt that their concerns were responded to positively however two relatives told us that they though that the complaints were not actioned appropriately.

Inadequate

Community health inpatient services

- Staff were unable to describe improvements made following complaints. The majority of staff spoken with were unaware of what actions the service took when complaints were made or how the findings were used to improve the service.
- Staff were unable to describe improvements made following complaints. The majority of staff spoken with were unaware of when complaints were made or how these were addressed.
- The hospital had a complaints policy and aimed to acknowledge all complaints within seven days and to provide a full response within 30 working days.From information provided by the hospital, most complaints met these timescales.We reviewed three complaints and saw they were all acknowledged within the provider's timescale. The complaints were responded to quickly.

Are community health inpatient services well-led?

Inadequate

We rated well-led as inadequate.

Leadership / culture of service

- The corporate management team lacked oversight of the unit and had failed to recognise and pick up key issues despite regular attendance at the hospital.
- The overall lead for the hospital was the Interim Hospital Manager and the Clinical Lead Nurse. Some staff members we spoke with were confident that the leadership was bringing about necessary changes for example an increase in staffing numbers and an improvement in culture. However, some relatives we spoke with were not complimentary about the approach of the manager or their leadership ability.
- Both the interim manager and the Clinical Lead Nurse were designated as safeguarding leads. Neither of these members of staff had undertaken additional training to undertake this role. Both staff members told us that they did not feel confident in assessing safeguarding issues and making decisions. Despite this neither staff member had raised this as a concern with their line managers despite having regular one to one meetings.
- The Clinical Lead Nurse advised us that they had raised concerns regarding the low number of staff with competency in undertaking key clinical interventions with the interim manager. They advised that this had not been actioned and the issues persisted.
- The interim manager had failed to notify the CQC of any safeguarding notifications between July 2016 and January 2017. The corporate team were unaware that these notifications were not being made.
- Following the inspection the corporate team informed us that they had been aware of the majority of issues found during the inspection.These included the lack of safeguarding training on the part of the interim manager and lead nurse, persistent medication compliance issues, lack of checks on compliance with NEWS, staff competency assessment rates and poor compliance with audit actions and risk assessments. They were unable to provide any evidence of what action they had taken to address these concerns stating that they had accepted the reassurances of the acting manager there was no evidence that they had tested the validity of those reassurances despite requests to provide information regarding what arrangements were in place to address any failings identified.
- The management team were unaware of staff's basic competence and skill set. They were unable to provide us with information that showed that all staff had received training and that their competency had been determined before they were allowed to carry out the activities they were trained to do. Outcomes of training were not monitored to make sure that staff competency was maintained.

Vision and strategy

- The Interim Hospital Manager and lead nurse told us that they were not aware of any corporate strategy despite evidence being provided that they had attended an away day on this subject.
- There was no local strategy or vision for this hospital.

- All staff we spoke with were unaware of the corporate strategy and vision. They told us they were unaware of any local strategy within the service.
- There was a corporate strategy and vision. This strategy and vision set out the behaviours and values expected of staff working for the organisation. The vision was set out by the corporate provider St George Healthcare Group. This vision was that the group strives to provide high quality patient centred care, improving the quality of life for patients with brain injury. To support the people in their care to achieve their maximum potential, whether it is determined by them or for them, in an environment where Clinical Governance guides compliance and best practice to promote a culture of continuous learning, self and service development. The shortened vision was displayed on the services website and was “Ethical practice, transparency and accountability underpinning all we do".
- The provider also had a number of fundamental service values which were built upon the fact that the patient is the centre of all aspects relating to their care. These included recognising the central importance of communication in delivering forensic mental health services to service users and encouraging formal participation, consultation and involvement in all aspects of care delivery.

Governance, risk management and quality measurement

- There was a corporate risk management policy in place. This set out the responsibilities of managers and senior managers in relation to risk management. Risk management was not understood or practiced effectively within the service.Staff, including senior staff, were unaware of key risks identified as part of the inspection. In addition we saw that the corporate governance team had identified concerns relating to this hospital in the weeks prior to the inspection which persisted at the time of the inspection. There was no evidence that any action had been taken to address these issues. An example of this was issues with ensuring service users had access to interpreters and staff taking account of service users’ needs in relation to language barriers. This was highlighted in an email from the corporate team to the interim manager prior to the inspection but we did not see any actions or improvements during the inspection.
- There were limited systems in place to monitor safety goals for patients. When we asked the acting hospital manager how they measured safety and quality, they advised that a number of corporate audits were undertaken. When these audits were reviewed they were very broad and did not specifically consider or measure important aspects of care being provided at the unit. For example, there was a lack of monitoring of clinical observations and compliance with the triggers outlined in the Early Warning Score system, which is the system used by the provider to identify and respond to patients whose clinical condition may deteriorate.
- We found that there were limited assurance systems operated locally within the unit. An example of this was a lack of managerial oversight in relation to the daily medicines management audits. When we spoke with the Clinical Lead Nurse she advised that she ‘spot checked’ these audits but was unaware that they had not been completed for extended periods of up to two weeks. She was also unable to provide any evidence that she had undertaken any checks in relation to these audits. We also found no evidence that the registered manager had any oversight of this key audit.
- We found that important issues and risks identified on the local risk register had not been escalated to senior management corporately. An example of this was the very low rates of tracheostomy training. This was identified on the local risk register as a ‘significant’ risk but had not been escalated to the provider’s board or risk management committee. This was despite it being past its due date.
- As part of the inspection, we found key risks that were not identified and recorded appropriately. An example of this was the very low rate of percutaneous endoscopic gastrostomy (PEG) training compliance. This was acknowledged by both the interim manager and Clinical Lead Nurse as being a serious issue. However, it had not been risk assessed, placed on the local risk register or escalated outside of the unit’s immediate management team.

Inadequate

Community health inpatient services

- There were a large number of outstanding open actions on the unit's quality action plan with little progress information recorded and some actions did not have target completion dates. We found that some of the significant safety issues identified on this plan with open actions were still live issues during the inspection and little progress if any had been made to close them. For example, it was identified during a corporate visit that bottles of liquid medication did not have opened dates recorded. This action remained open on an action plan with no target completion date. The interim manager and the Clinical Lead Nurse were unable to provide any evidence that they had monitored compliance with this action. When we attended for the unannounced inspection we found multiple bottles or oral medication with no opened dates recorded.
- A total of six risks were identified on the register. Two of these risks did not have a deadline for action and completion. There was an action plan in place alongside the risk register but in reviewing the action plan we saw that actions had not been completed within the timescales specified. As a result, improvements that were identified as being needed were not undertaken in a timely way.
- There was a clear corporate governance structure in place. However, senior managers within the hospital were unable to tell us how they reviewed and brought together different areas of governance to inform risk management, such as internal incident review, accident monitoring, review of complaints data and review of incident data. As a result improvements were not always identified or action taken to increase the quality of the service provided.
- We reviewed minutes from the governance meeting which was held on a monthly basis. These minutes showed that key issues such as low compliance with medication management audits had not been highlighted or actioned.
- Clinical safety alerts were distributed by the Clinical Lead Nurse but there were no checking processes to ensure staff were aware of these alerts.

Public and staff engagement

- Some of the patients' relatives spoken with told us that their views were not sought on new developments and changes and they were not included in the decisions which affected their relatives whilst receiving care in the hospital. Some relatives told us that they were unhappy with a number of aspects in relation to the care and support of their relatives but these concerns had not been addressed or resolved.
- There were monthly staff meetings which staff told us were well attended and we confirmed this by reviewing minutes of these meetings. Notes from these meetings were available for staff to access on a shared computer drive.
- There was a service user consultation group which the Interim Hospital Manager told us was very poorly attended. The manager was unable to tell us what actions had been taken to improve engagement with this forum.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that they provide care and treatment that meets patients' needs, preferences and choices.
- The provider must ensure that all persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.
- The provider must ensure that there are safety systems in place to recognise and respond appropriately to the deteriorating patient.
- The provider must ensure that they provide care and treatment to patients, only with the informed consent of the relevant person.
- The provider must ensure that they provide care and treatment in a safe manner.
- The provider must protect patients from abuse and improper treatment with systems and processes which are sufficient to effectively prevent abuse, meet the needs of service users, investigate and prevent discrimination and inappropriate restraint.
- The provider must ensure that governance systems and processes are operated effectively to enable them to assess, monitor and improve the quality and safety of the services provided.
- The provider must ensure that there is adequate leadership and oversight of the location to ensure that they can recognise issues and improve the service as needed.

Action the provider SHOULD take to improve

- The provider should ensure that they update their policies and procedures in line with best practice guidance.
- The provider should make sure that staff are supported to appropriately access and be aware of the contents of all current policies and procedures.
- The provider should consider reviewing the environment to ensure it meets service user's individual needs.
- The provider should ensure that all staff are aware of health and safety alerts and that these are incorporated within the practice of the service.
- The provider should review how it meets its own statement of purpose in particular in relation to setting rehabilitation goals, monitoring of rehabilitation goals and communication rehabilitation goals across the entire staff team.
- The provider should review its arrangements for written care records in order that these can be easily accessible and understood by staff, patients and their relatives.
- The provider should consider how they provide information and communicate with patients and their relatives in order to include them in the planning and delivery of care and treatment.
- The provider should review its arrangements to include patients and their relatives in the running of the hospital.

This section is primarily information for the provider

Enforcement actions

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 9 HSCA (RA) Regulations 2014 Person-centred care Care provided to service users was not always person centred and did not take account of service users preferences and choices.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent was not always sought from service users in an appropriate manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users. Risks were not always assessed or mitigated.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes to protect service users from improper treatment were not effectively operated.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance systems and processes were not operated effectively and did not effectively monitor the quality and safety of the services provided.