St Cyril's Rehabilitation Unit

Quality Report

Countess of Chester Health Park
Liverpool Road
Chester
CH21 1HJ
Tel: 01244 635330
Website:

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

Overall summary

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

We undertook this unannounced focused inspection of St Cyril's Rehabilitation Unit in response to concerns that we identified during a previous inspection on 29 June 2017. As this was a focused inspection we did not rate the service.

We had also carried out an announced inspection of the service on the 1 and 2 of March 2017. Therefore the rating for the provider following a comprehensive inspection in March 2017 remains as inadequate.

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 found the following areas for improvement:

- The service had appointed a new hospital manager who was in post on the day of inspection. However, during the inspection period we were informed that the hospital manager had left which meant that the hospital continued to be without a registered manager.
- The hospital management team had monthly meetings with members of the executive team. However, it was unclear from minutes of these meetings what actions had been implemented to make improvements and who was responsible for these.
- The hospital had introduced a system for managing evidence of staff competencies. However, senior staff were not fully aware of these and struggled to provide assurance of the competencies of staff.
- There were a higher number of staff who had completed full competency checks for providing tracheostomy and PEG care since the last inspection, however, these numbers were still low. This meant that we were unsure if there were sufficient numbers of competent staff on shift at all times.
- We found that documentation regarding tracheostomy and PEG care was inconsistent.

Summary of findings

- Some improvements had been made with medicines management. However, there were occasions when this was still not carried out in line with hospital policy and required further improvement.

However,

- A new clinical services manager had recently started and a substantive consultant who specialised in neuro-rehabilitation had been appointed, although was yet to start.
- Members of the management team were able to identify the key risks that the hospital currently faced.
- Improvements had been made with the calculation and use of NEWS. Additionally, most patient records that we reviewed had evidence of appropriate escalation taking place when needed.
- Staff rotas indicated that between 1 July 2017 and the time of inspection there had been a senior band 6 nurse on all shifts apart from one to provide leadership.

Following the inspection, we told the provider that they must take some action to comply with the regulations and that they should make other improvements, even where a regulation had not been breached, to help the service improve.

Summary of findings

Contents

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 and 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 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.

Services provided at the hospital under service level agreement:

- Pharmacy
- Consultant cover
- Specialist nurses for example Tissue Viability Nurse.

The hospital does not currently have a registered manager. The nominated individual is the Chief Executive.

Our inspection team

The inspection team was led by Jacqueline Hornby, Inspection Manager, and comprised of two CQC inspectors.

Why we carried out this inspection

We undertook this unannounced focused inspection of St Cyril's Rehabilitation Unit in response to specific concerns that we had identified during a previous inspection on 29 June 2017 and raised with the provider.

Summary of this inspection

How we carried out this inspection

During the inspection we interviewed the deputy chief executive, the hospital manager and the clinical lead. We also spoke with ten staff members including; registered nurses, health care assistants, known as Rehabilitation Co-therapists (RCT), and reception staff.

We observed care and treatment as well as reviewing documentation which included policies, patient records, medicines charts and staffing rotas.

In addition, we also reviewed information we held about the location before and after the inspection.

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?

The safe domain was rated as inadequate at the previous full inspection. As this inspection was not rated the overall rating remains inadequate

- Some improvements had been made with medicines management. However, there were occasions when medicines were still not managed in line with hospital policy and required further improvement.
- There were a higher number of staff who had completed full competency checks for providing tracheostomy and PEG care since the last inspection, however, these numbers were still low. This meant that we were unsure if there were sufficient numbers of competent staff on shift at all times.
- We found that documentation regarding tracheostomy and PEG care was inconsistent.

However,

- Improvements had been made with the calculation and use of NEWS. Additionally, most patient records that we reviewed had evidence of appropriate escalation taking place when patients condition had deteriorated.
- Staff rotas indicated that between 1 July 2017 and the time of inspection there had been a senior band 6 nurse on all shifts apart from one to provide leadership.

Are services effective?

The effective domain was rated as inadequate at the previous full inspection. As this inspection was not rated or the effective domain inspected during this inspection, the overall rating remains inadequate.

Are services caring?

The caring domain was rated as inadequate at the previous full inspection. As this inspection was not rated or the caring domain inspected during this inspection, the overall rating remains inadequate.

Are services responsive?

The responsive domain was rated as inadequate at the previous full inspection. As this inspection was not rated or the responsive domain inspected during this inspection, the overall rating remains inadequate.

Summary of this inspection

Are services well-led?

The well led domain was rated as inadequate at the previous full inspection. As this inspection was not rated the overall rating remains inadequate

- The service had appointed a new hospital manager who was in post on the day of inspection. However, during the inspection period we were informed that the hospital manager had left which meant that the hospital continued to be without a registered manager.
- The hospital management team had monthly meetings with members of the executive team. However, it was unclear from minutes of these meetings what actions had been implemented to make improvements and who was responsible for these.
- The hospital had introduced a system for managing evidence of staff competencies. However, senior staff were not fully aware of these and struggled to provide assurance of the competencies of staff.

However,

- A new clinical services manager had recently started and a substantive consultant who specialised in neuro-rehabilitation had been appointed, although was yet to start.
- Members of the management team were able to identify the key risks that the hospital currently faced.

Community health inpatient services

Safe	
Well-led	

Are community health inpatient services safe?

Environment and Equipment

- Every patient who had a tracheostomy had equipment for use in the event of an emergency (a tracheostomy is a tube that is inserted into a patient's neck to enable them to breathe). We checked all emergency equipment, finding that the required equipment was available on most occasions. However, on one occasion the size of the tracheostomy tube required was incorrect. This meant that there was a risk that the equipment available would not be effective in the event of an emergency.

Medicines

- The hospital had a medicines management policy which was available to all staff. This included topics such as administration, storage and destruction of medicines. Staff who we spoke with knew about this and were able to find it if needed.
- Registered nurses were responsible for administering all medicines. We checked staff rotas from the 1 July 2017 to the time of inspection, finding that there had always been a qualified nurse on duty to undertake this role.
- The hospital had two clinical rooms that were used for storing all medicines. We observed that the doors to both medicine storage areas were kept locked and secure.
- The hospital commissioned their pharmacy provision from a hospital pharmacy. The pharmacy team carried out weekly and monthly audits of medicines management. We reviewed all of the audits that had been completed between 1 July 2017 and the time of inspection, finding that some improvements had been made since our last inspection.
- For example, we reviewed an audit that had been completed on the 24 August 2017 which showed that the hospital had achieved 100% compliance with all expected standards. This was in comparison to an audit that was completed in July 2017 which showed that improvements were needed in areas such as liquid medicines not having a date opened sticker (this was important as there was a risk that medicines would be out of date) and discontinued medicines still being in the cupboard (this was important as there was a risk that medicines would be given despite them being no longer prescribed).
- However, there were still areas of medicines management that required improvement. Staff were required to complete 'application of transdermal patch' forms when applying a new transdermal patch (transdermal patches are applied to the skin to deliver medicines to a patient). We found that between the 1 July 2017 and the time of inspection all three records that we reviewed in relation to these were incomplete. Examples included missing times and dates as well as charts not being completed when the patch had been changed. However, we reviewed prescription charts against this documentation, finding evidence that staff had administered transdermal patches within the correct time period on all but one occasion.
- We reviewed prescription charts for all patients between the 1 July 2017 and the time of inspection. We found that medicines had been administered and signed for appropriately on the majority of occasions. However, there had been six occasions during this period when signatures had been omitted. This meant that on these occasions it was unclear if medicines had been administered appropriately.
- In addition, on occasions when medicines had been discontinued, stop dates had not been clearly documented on prescription charts. This meant that there was a risk that medicines would still be given to patients despite them no longer being prescribed.
- Since our last inspection, staff had completed weekly medicine reconciliation audits for individual patients. These had been completed in addition to the external audits that were completed by a pharmacy technician. However, results of these indicated that the amount of medicines recorded had not always tallied with the amount of medicines present. On the majority of occasions this was for liquid medications, however, there were a small number of occasions when tablets

including diazepam had not been accounted for. Importantly, there was no evidence that these incidences had been reported as a clinical incident or had been investigated.

Mandatory Training

- We followed up concerns that we had about there being insufficient numbers of adequately trained staff to undertake tracheostomy and PEG care (a PEG is a tube that is inserted surgically into a patient's stomach and is used to administer food or medicines). This was because there was limited evidence on the last inspection, of staff competency in these areas, which meant that there was a risk of staff not being able to provide the correct care in the event of any complications or an emergency.
- Records indicated that compliance with full tracheostomy and PEG competencies had improved since the last inspection. This was mandatory for staff delivering this care. However, compliance with this was still low. Only 78% of registered nurses and 36% of RCTs had completed full competency checks for PEG care. In addition, only 26% of RCTs had completed full tracheostomy competencies.
- We reviewed rotas between 1 July 2017 and the time of inspection, finding that appropriate numbers of competent staff had been available on 100% of occasions during the day. However, this had only been achieved on 54% of occasions during the night, meaning that during these times there was an increased risk that staff would be unable to deal with complications or emergencies effectively.
- We raised our concerns about this with the hospital management team who were able to provide assurance that sufficient numbers of competent staff would be available going forward.
- We reviewed rotas between the time of inspection and the 7 September, finding that there were sufficient numbers of competent staff planned to cover all shifts.

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, for example blood pressure and temperature, to indicate potential deterioration in patients' condition and prompt clinical action. The associated outline of clinical response to NEWS document provided stipulated set actions to be taken when patients overall score reached a specified level.
- We found that some improvements had been made with the documentation and use of NEWS since our last inspection. We sampled a number of patient records, finding that the NEWS had been completed correctly on all but three occasions (out of 103 time periods checked). We also found that there was evidence of patients having been escalated to a nurse in charge when needed. This was in line with hospitals policy which stated that patients must be escalated to a nurse in charge if they had a NEWS of between one and four.
- Weekly audits were undertaken to measure compliance with the calculation and use of NEWS. We reviewed all audits that had been undertaken in August 2017. The results of these were mixed. For example, the average compliance rate with the correct calculation of NEWS was 100%. However, patients had only been escalated to nursing staff appropriately on an average of 70% of occasions.
- When sampling patient records, we found four examples of when patients had a NEWS of five or more. On three of these occasions there was evidence in their corresponding medical notes that they had been escalated for medical review appropriately.
- However, compliance with this had not been measured as part of the ongoing weekly audits, meaning that it was unclear if patients had been escalated for medical review on all occasions during the same period.
- All staff received training in the use of NEWS. However, training records indicated that only 61% of staff were up to date with this. Staff who we spoke with were able to describe how to use NEWS and when escalation was required.
- We also sampled patient records for tracheostomy and percutaneous endoscopic gastrostomy (PEG) care.
- We found that documentation for these was inconsistent. For example, the type of tracheostomy used was not always clearly documented and the reason for the use of suction was not always documented. However, we noted that the pressure of the tracheostomy cuff was always present, as was the colour of any secretions.
- In addition, records for PEG care did not include documentation of skin integrity or measurement of the length of the tube. This was important when

determining if the tube was in the correct place before administering either food or medication. Guidance from the National Institute for Clinical Excellence (NICE CG32) states that this should be done on a daily basis to check whether the tube is correctly located. We noted that this was not included in the enteral feeding policy that the hospital had.

- There was one patient who had a nasogastric (NG) tube present (a nasogastric tube is inserted through the nose and into the stomach). The hospital referred all patients requiring a NG tube to a local hospital so that it was inserted correctly. We sampled patient records which indicated that staff checked the placement of the NG tube before use. This was important as there is a high risk of aspiration associated with the use of NG tubes (aspiration is when food or medicines enter the lungs inappropriately).
- However, we noted that the length of the NG tube was not documented by staff on any occasions. This is an additional check that can be used to check the correct placement of the NG tube prior to use. This was not in line with NICE guidance (CG32).
- We reviewed incident reports between February 2017 and August 2017, finding that there had been no incidents reported regarding tracheostomy care or NG care. However, there had been three incidents reported about PEG care. All of these incidents were incidences of PEG tubes becoming dislodged. We saw evidence that appropriate action was taken at the time of the incident and that the nurses who had provided the care on these occasions had been signed off as being competent to do so.

Staffing levels and caseloads

- The service employed registered nurses, learning disability nurses as well as health care assistants who were known as rehabilitation co-therapists (RCTs).
- At the time of inspection the hospital employed six band 6 nurses and seven band 5 nurses. The registered nursing establishment had been set at three during the day and two at night. These numbers included a band 6 nurse 24 hours a day, seven days a week.
- On reviewing staff rotas between 1 July 2017 and the time of inspection, records indicated that there had been a senior band 6 nurse on every shift apart from one. This was an improvement since our last inspection, when we found that most night shifts only had a band 5 nurse present, which meant that there was no clinical supervision for staff during these times.

Are community health inpatient services well-led?

Leadership / culture of service

- The service had appointed a new hospital manager since the last inspection who had been in post for six weeks. However, the service did not have a registered manager with the care quality commission. We were informed that at the time of inspection an application for this had been made. All registered providers who carry out regulated activities must have a registered manager who is responsible for the service.
- However, during the inspection period we were informed by the executive team that the hospital manager had resigned. In order to mitigate any immediate risks, arrangements had been made for a member of the executive team to provide interim leadership. We were informed that the process of recruiting a new manager had started.
- A clinical services manager had been recruited and commenced in post since the last inspection. They were responsible for clinical leadership and supporting the hospital manager in the day to day running of the hospital.
- The medical cover arrangements were provided on a sessional basis by two consultants from local trusts which did not provide dedicated substantive medical oversight. However the service had recruited a full time substantive consultant who specialised in neuro-rehabilitation and senior staff told us they were due to start at the unit shortly after the inspection.
- The hospital employed a team of band 6 nurses who were available 24 hours a day, seven days a week. They were responsible for the day to day management and leadership of the care staff at the hospital whilst on shift. . The hospital also operated an on-call rota to support band 6 staff.

Governance, risk management and quality measurement

- There was a clear governance structure in place that facilitated monthly governance meetings between the

management team from the hospital and the executive team. We reviewed minutes of these meetings and found that there was a set agenda which included incidents, safeguarding and infection control.

- We noted from evidence that was provided during the inspection, there were no clear actions against issues that required improvement. Additionally, there was no record of who was responsible for areas as well as when actions were to be completed by. This meant that we were unsure of how improvements were being made when needed. However, the management team provided evidence following the inspection that actions for improvement had been documented and that there was a person responsible for completing these.
- The hospital had implemented further audits to the programme that was already in place. An example of this was the weekly medicines reconciliation audit that staff had completed on a weekly basis during the month of August 2017. This was implemented to make improvements to poor medicines management which had been identified in our previous inspection.
- The management team had introduced new competency assessments for staff to complete, particularly in providing tracheostomy and PEG care. However, we found that training records were difficult to find. This meant that it was unclear if sufficient numbers of competent staff had been deployed on all occasions.
- Members of the management team were able to identify the key risks that the hospital currently faced. We reviewed the hospital risk register, finding that this had been recently updated. Key risks included a lack of clinical leadership and low numbers of staff competent in tracheostomy care. We noted that all identified risks had controls in place as mitigation, there were actions for improvement and there were dates for each risk to be reviewed.
- The hospital contracted several external services such as pharmacy services under a service level agreement (SLA). However, the management team were not monitoring the quality that each service provided.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that there are always sufficient numbers of competent staff to deliver safe care and treatment to patients, particularly when providing PEG and tracheostomy care.
- The hospital must ensure that medicines are managed and documented in line with hospital policies.

Action the provider SHOULD take to improve

- The hospital should ensure ways in which to make sure the correct emergency equipment for patients with a tracheostomy is available at all times.
- The management team should consider ways in which to make sure that up to date competencies for all staff are readily available.
- The management team should consider ways in which to monitor compliance with NEWS, particularly for patients who have scored a NEWS of 5 or above.
- The management team should consider implementing clearer actions resulting from governance meetings, including whose responsibility these will be.
- The management team should consider ways in which to make sure that all policies reflect up to date national guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Medicines had not always been managed in line with hospital policies. This included incomplete documentation when transdermal patches had been applied. Additionally, there had been incidences when medicines had not tallied correctly. There was no evidence that these incidences had been investigated. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Sufficient numbers of competent staff had not always been available to deliver safe care and treatment, particularly when providing PEG and tracheostomy care. Regulation 18 (1) (2) (a)