Renovo South Newton Limited

South Newton Hospital

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We inspected rehabilitation services at South Newton Hospital to respond to ongoing risks we were aware of in the service and because the location had not had a comprehensive inspection since the service was registered in January 2020.

We carried out this short notice announced comprehensive inspection of the five key questions on 5 and 13 January 2022.

We rated the service as inadequate because:

- The service did not meet legal requirements relating to safe care and treatment, infection control, safeguarding and good governance.
- Patients and staff were at increased risk of exposure to harm due to ineffective processes and procedures to assess the risk of preventing, detecting and controlling the spread of COVID-19. Leaders did not regularly update infection control policies and procedures or regularly complete infection control audits.
- The service did not always use systems and processes to safely administer and record the use of medicines.
- Leaders did not always recognise safeguarding concerns and respond effectively or ensure staff were trained to the appropriate level.
- The service did not operate effective governance systems to improve the quality of services. Staff did not always keep accurate records of patients' care and treatment. Records were not clear, up-to-date or easily available to all staff providing care.
- Incidents were not always effectively investigated to reduce the risk of potential harm from similar or repeated incidents. Not all staff were able to describe what lessons were learnt from the incidents they reported. They were not always aware of any changes to practice to prevent incidents from happening again.
- Patients, those close to them and their representatives are not actively engaged with or involved in decision making to shape services and culture.

However,

- Staff were committed to supporting the individual needs of patients and patients were positive about the care they received.
- The service was organised to meet the individual needs and preferences of patients.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Inadequate 	We rated the service as inadequate. We had not previously rated the service. See the overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to South Newton Hospital

South Newton Hospital is an independent specialist service for the assessment, treatment and rehabilitation of adults with neurological conditions including acquired brain injury and progressive neurological disorders. The service is six miles from Salisbury in Wiltshire and is commissioned to provide NHS-funded services for patients from across the South East and South West of England.

Renovo South Newton Limited own and operate South Newton Hospital.

The service is registered to care for a maximum of 17 patients and is registered for the following regulated activity:

- Treatment of disease, disorder or injury.

The service did not have a manager registered with CQC at the time of inspection as the director of operations had recently had their application refused.

We inspected but did not rate the service during a focused inspection of the safe key question in October 2021. At the last inspection we issued one requirement notice in relation to the need for the service to inform CQC of notifiable incidents in a timely way. We continued to have concerns about the governance in the service.

The service currently has the following conditions on its registration:

- The registered provider must not accommodate patients overnight anywhere within the location other than Wylye ward or Avon ward.
- In order to ensure patient safety, the registered provider must ensure there is an effective traffic management procedure in place within the location that supports the following:
  - pedestrian only access to areas marked as 'Time Limited Vehicle Access' on the registered providers South Newton Hospital Site Plan between 8am and 7.30pm except for vehicles with a staff escort.

At the time of this inspection the service had seven patients on Wylye ward and no patients on Avon ward. An eighth patient was in another hospital for treatment. They were previously cared for on Avon ward and were expected to be discharged back to the service.

How we carried out this inspection

We inspected this service using out comprehensive inspection methodology. We carried out the inspection on 5 and 13 January 2022 on site and reviewed patient records remotely on 10 January 2022.

During the inspection we spoke with:

- 14 members of staff including, but not limited to, the chief executive, head of operations, safety and quality lead and ward manager.
- ten staff as part of a staff focus group.
- three patients.

We reviewed:

Summary of this inspection

- eight patient records
- documents, policies and patient records as necessary.
- individual patient rooms, communal areas and the ward environment.

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

Areas for improvement

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

Action the service MUST take to improve:

- The provider must ensure systems and compliance with mandatory training are operated effectively 17 (1)
- The provider must ensure governance and risk management processes are fully embedded and sustainable. Regulation 17(1)
- The provider must make sure all staff understand and report incidents correctly, investigations are robust, and learning is shared. Regulation 17(1)
- The provider must maintain securely an accurate, complete and contemporaneous record of each patient of the care and treatment provided. Regulation 17(1)
- The provider must ensure patient records are audited for quality and completeness. 17 (1)
- The provider must ensure systems to ensure NEWS scores are audited effectively 17 (1)
- The provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services and data on patient outcomes) 17 (2) a
- The provider must ensure processes for assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated are effective to protect patients and staff. 12 (h)
- The provider must respond to mental health risks in a timely way to ensure patient safety 12 (b)
- Systems and processes must be established and operated effectively to prevent abuse of service users including ensuring staff recognise and respond effectively. 13 (2)
- The provider must ensure compliance with the Controlled Drugs (Supervision of Management and Use) Regulations 2013

Action the service SHOULD take to improve:

- Regularity of completion of environmental audits.
- Regularity of completion of malnutrition universal screening assessment tool (MUST) audits.
- Staff did not keep records of patch rotations or body placement for patients prescribed medicinal patches.
- Monitoring clinical policies to ensure care is delivered in line with current national guidance.
- Records to demonstrate patients are offered activities such as going outside to the garden, even if they choose to decline.
- The hospital should keep a full audit trail for medicines held in stock. Records for waste medicines should be completed appropriately.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Medical care (Including older people's care)

Safe	Inadequate
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Medical care (Including older people's care) safe?

Inadequate

We rated safe as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff. However, leaders did not monitor compliance effectively to ensure all staff completed it.

The mandatory training was comprehensive and met the needs of patients and staff. Staff received and kept up to date with their mandatory training. Mandatory training was delivered in 47 modules which included, but was not limited to, infection control, moving and handling, medication administration, basic life support, and topics to health and safety. Data showed compliance with mandatory training for all staff was over 95% for 31 modules, between 90 – 95% for nine modules and below 90% for seven modules. The three modules with the lowest level of compliance were fire evacuation training (47%) moving and handling (75%) and safety intervention training (79%). The data we were provided with did not include a target compliance with mandatory training although this was included on the quality assurance dashboard.

The service did not monitor mandatory training compliance effectively. Data on the Renovo care group quality assurance dashboard for the service did not match up with the data the service provided us with for mandatory training. The quality dashboard was last updated in August 2021 when overall compliance was 73%.

Medical staff received and kept up to date with mandatory training. The service employed an external agency to oversee records of doctors' training.

Clinical staff completed training on recognising and responding to patients with mental health needs and neurological disorders. Staff mandatory training included modules in acquired brain injury, mental health, communication and positive behaviour support.

The ward manager monitored mandatory training and reminded staff when they needed to update their training.

Safeguarding

Leaders did not always recognise safeguarding concerns and respond effectively. However, staff we spoke with understood how to protect patients from abuse.

Inadequate

Medical care (Including older people's care)

The service did not always recognise safeguarding concerns effectively. For example, one patient complaint we reviewed contained safeguarding concerns as a member of staff had removed a whistle out of reach from a patient who used this as their primary mode of calling for help. While this incident was investigated internally, there was no evidence of a safeguarding referral being made.

Leaders did not ensure staff received safeguarding training in line with the provider policy and national guidance in the intercollegiate document. We were told on inspection the mandatory safeguarding training data provided was for level 1 training only. The provider safeguarding policy stated level 2 safeguarding adults training was provided to 'all staff who have regular contact with patients, their families or carers'. However, the service did not provide any data for level 2 training of staff.

Data showed training for the safeguarding and protection of the combined adult's level 1 and level 2 training mandatory training module was 98%. Data provided showed 88% of qualified nurses have undertaken Level 3 training which included both e-learning and face to face sessions and also covered the content of the level 1 and 2 sessions.

Staff we spoke with knew how to identify adults and children at risk of significant harm and knew how to make a referral and who to inform if they had concerns. The service displayed information including contact details for the local authority safeguarding team to staff.

Audit data showed between February and December 2021 the service audited safeguarding records once in May 2021.

Cleanliness, infection control and hygiene

Patients and staff were at increased risk of exposure to harm due to ineffective processes and procedures to assess the risk of, preventing, detecting and controlling the spread of COVID-19. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Leaders did not regularly update infection control policies and procedures or regularly complete infection control audits.

The service was not doing all that was reasonably practicable to mitigate risks associated with COVID-19 at the time of inspection. We raised concerns with the provider following the inspection and the provider took action to review and enhance the level of PPE used by staff. However, we still had concerns about the effectiveness of the patient testing regime and the provider's governance in relation to infection prevention and control.

At the time of inspection, staff did not use enhanced PPE (FFP3 masks, gloves and fluid-resistant gowns) routinely used for patients undergoing aerosol generating procedures (AGPs) such as cough assist and tracheostomy procedures. While staff had access to enhanced PPE the provider had interpreted national guidance and advised staff this was not needed. However, the provider was unable to show us their rationale or risk assessment to support their decision-making.

Patients were at increased risk of exposure to harm due an ineffective patient testing regime for COVID-19. The provider's COVID -19 risk assessment stated, "all patients tested monthly with a lateral flow test as part of normal surveillance." There was no evidence the provider's risk assessment or rationale for testing monthly rather than more regularly or using lateral flow tests or consideration of use of polymerase chain reaction (PCR) tests.

The service had not considered the additional challenges in detecting COVID-19 symptoms such as loss of taste and sense of smell in the patients you care for who have neuro-disabilities, acquired-brain injuries and disorders of consciousness nor how to mitigate these. When we raised concerns following the inspection the provider told us that patients' temperatures were monitored daily. However, this response did not fully address our concerns as people can have COVID-19 and show no symptoms.

Inadequate

Medical care (Including older people's care)

The service had not updated infection prevention and control and COVID-19 policies in line with national guidance throughout the pandemic. The risk guidance was not clear enough to ensure staff were informed on how to best manage infection risks. We reviewed the COVID-19 business continuity plan, version 6 last updated January 2022. The South Newton Hospital COVID -19 risk assessment dated 2022-01 stated "UK Government guidance is being followed" but did not state explicitly how to provide up to date guidance to staff. The link to Government guidance was a generic public-facing landing page not the link to specific IPC guidance for healthcare settings.

Staff tested for COVID-19 three times a week and/or each shift using lateral flow tests. However, the service was not able to give us data on how this was monitored and if PCR testing had been considered.

The head of operations told us they were working towards the COVID-19 compulsory vaccination requirements. However, the provider did not monitor data on the percentages of staff who had received their first, second and third (booster) doses of the COVID-19 vaccine in their governance reports.

Leaders did not always regularly complete infection control audits. While between February 2021 and December 2021, sharps handling and disposal audits were completed every month and hand hygiene audits were completed every month except March 2021. In the same period the waste handling audit was not completed at all and the mattress audit was completed in four months out of 11 months.

Ward areas appeared clean and had suitable furnishings which also appeared clean and well-maintained. All areas were visibly clean and corridors free from clutter.

Staff wore surgical masks at all times, and we saw staff changing aprons and washing their hands when moving between patients during the ward round.

Most cleaning records were up-to-date and showed all areas were cleaned regularly. However, cleaning records were just ticked rather than signed so there was not an effective audit trail of which staff were carrying out the cleaning.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw staff used 'I am clean' stickers to show equipment was clean and ready for use. Staff completed mandatory training modules in infection prevention and control, legionella and Control of Substances Hazardous to Health (COSHH) and training compliance for these three modules was above 97%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, leaders did not always complete regular audits of the environment.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. Medicines for medical emergencies were readily available when needed, were fitted with tamper evidence seals and were fit for use. Regular checks of emergency medicines and equipment were carried out by staff.

Staff had access to two types of ligature cutter, and these were stored in the nurse's office.

Inadequate

Medical care (Including older people's care)

The service had suitable facilities to meet the needs of patients' families. All patient rooms were single rooms with en-suite bathroom facilities. All rooms were fitted with ceiling track hoist equipment to support patients with reduced mobility.

The service had enough suitable equipment to help them to safely care for patients. We reviewed safety testing for a sample of equipment and found it was all in date for testing. However, equipment was not always stored effectively so it was ready for use. We saw portable suction machines in the storeroom that were not plugged in.

Staff disposed of clinical waste safely. The estates manager was responsible for ensuring clinical waste was securely stored until it was collected. However, domestic bins were used in clinical areas which presented a fire risk. We raised this with the ward manager during the inspection and they told us the bins would be replaced.

Leaders did not always complete regular audits of the ward environment and public areas. Data showed audits of the environment were not completed January to April 2021 and September to December 2021. When staff completed monthly audits between May 2021 and August 2021, performance with environment audits was consistently above 94%.

Assessing and responding to patient risk

Staff used a nationally recognised tool to identify deteriorating patients but did not always monitor and escalate them appropriately. Staff did not always recognise and respond to mental health risks effectively

Staff used a nationally recognised tool to identify deteriorating patients but did not always monitor and escalate them appropriately. Staff used the national early warning score (NEWS) to monitor and identify deteriorating patients. NEWS scores were calculated and escalated appropriately. Staff recorded patient's NEWS scores on a whiteboard in the nursing office with reasons for raised NEWS scores every day, so staff had an overview of patients. However, records showed staff did not always record action taken when patients had a raised NEWS score

Staff told us of challenges with accurate and timely scoring of NEWS scores due to data syncing and Wi-Fi signal issues. The head of of quality and governance told us they checked accuracy of NEWS completion every day. However, audit data showed between January and December 2021, NEWS records had been formally audited once in November 2021. Audit data recorded the audit was 'completed' with no reference to the score or action taken following the audit.

The electronic records system did not include baseline observations and parameters for patients. There was a risk staff, especially those less familiar with patients, would not be able to compare NEWS scores with patient's baselines. The resident medical officer told us all patients have established parameters and nursing staff know what is normal for that patient and when to escalate deterioration.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The electronic records system was set up to alert staff to review care plans every 28 days. Leaders completed an admission assessment audit every month in the past year except January and December 2021.

Staff knew about and dealt with any specific risk issues. For example, all eight records we reviewed included risk assessments for pressure damage. We saw body maps were used to track changes in patients skin condition. However, the service did not have a consistent approach to falls management. For example, we reviewed records for patients who could not move independently had crash mats beside their beds but a rationale for this was not recorded.

The service had access to a neuropsychologist on site twice a week to support patient's mental health and wellbeing.

Inadequate

Medical care (Including older people's care)

Staff did not always complete, or update, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We raised concerns about the welfare of a patient following review of patient records. The service did not respond in a timely way to mental health risks and review mental health risk assessments to mitigate risks to patient safety.

Staff shared key information to keep patients safe when handing over their care to others. The service had recently improved the structure of daily safety huddles

The hospital's admission criteria for the acute and extended rehabilitation pathway excluded patients with 'challenging behaviour and/or forensic problems' but this was not clearly defined in terms of how the service would assess if they could meet the patient's needs.

We reviewed the admission assessments for three patients and found the rehabilitation complexity scale extended (RCS-E) was used to assess the level of medical, nursing, and therapy input required. However, the summary section with the length of stay, service level required and data to enter in the UKROC database was not completed in two of the three admission records.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, use of agency staff was high.

The service had enough nursing and support staff to keep patients safe. The service employed 15 nurses, including two ward leaders, 14 rehabilitation and senior rehabilitation assistants, three physiotherapists, one occupational therapist, one speech and language therapist and eight administrative staff. The service also employed other rehabilitation staff such as dietitians on a sessional basis.

The service employed two responsible medical officers who worked one week on, and one week off.

The service always had a consultant on call during evenings and weekends. There was additional consultant doctor cover 24 hours a day provided by three specialist consultant doctors.

Leaders accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service did not provide data on vacancy and turnover rates. The service monitored the headcount, number of new starters and number of staff leaving every month.

The service had variable sickness rates. Between January and December 2021 staff sickness rates varied between 2% and 14%. The sickness rate was above 10% in June, October and December 2021. The data did not include a target for staff sickness.

The service had high rates of bank and agency staff used on the wards. Between January and July 2021 agency staff usage ranged between 0 and 9.5% with no agency staff used in four out of six months. Agency staff usage increased in the second half of 2021 with agency staff usage ranging between 20% and 40% between August and December 2021. The data did not include a target for agency staff usage. Leaders told us they mitigated the risk of high agency staff usage by requesting staff familiar with the service.

The risk register included an operational risk relating to maintaining patient safety while there are vacancies that was first recorded in August 2021. The staffing risk was mitigated by ongoing recruitment for rehabilitation assistants, using agency staff who are familiar with the service and limiting the numbers of patients admitted until staffing increases.

The service had vacancies for rehabilitation assistants and a vacancy for an occupational therapist at the time of inspection. The service had no nursing vacancies at the time of inspection.

Care at the service was consultant-led and patients admitted to the hospital were under the care of a neuro rehabilitation consultant. A neuro rehabilitation consultant was available on site every day and a neuropsychology consultant was available two days a week.

Records

Staff did not always keep accurate records of patients' care and treatment. Records were not clear, up-to-date or easily available to all staff providing care.

The service introduced a new medical records system in November 2021. The electronic records system was not fully embedded in the service at the time of inspection. Staff told us about problems with the new electronic records system not synchronizing in a timely way, so the devices did not always show the up to date contemporaneous records. The ward manager and clinical services manager were organising further support for staff to more effectively use the electronic records system. The service was competing an implementation survey to gather feedback from staff about the roll out of the electronic records system.

Patient notes varied in quality and completeness. We reviewed eight records (all the patients currently in the service) and found inaccuracies in relation to recording of patient's weights and food intake. We also found examples where other patients were referred to in patient's notes. Care plans were not always regularly reviewed. For example, one patient had two risk assessments that were a week overdue and three care plans that were overdue for review.

Patient records were not always fully accessible to staff. Patient's rehabilitation goals and multidisciplinary team meeting discussions were recorded on a paper records uploaded to an online system separate from the patient electronic records system. Medical staff completed paper records that were then scanned and uploaded into the electronic system.

The service did not audit the quality of patient records effectively. While we found concerns with the quality of patient records, the provider had not identified any issues through their audits. The electronic system allowed leaders to audit the 16 mandatory care plans that needed to be completed for each patient. The system alerted staff to care plans that had not been completed or were due for review. A simple audit of the completion of electronic records carried out in December 2021 showed overall compliance for completion of the 16 care plans was 95% (106/112). All the 106 care plans were in date, and 93 need to be reviewed and updated w/c 13th December.

The head of quality and governance completed a detailed clinical audit of documentation on 7 January 2022. This audit reviewed a random sample of 30 consultant ward round documentation records to check compliance with GMC standards. The audit showed records did not always include a date, time and signature and RMOs were not always using their stamp to record their name and GMC number. The quality and safety lead shared the results of the audit with consultants and RMOs and reminded RMOs to use their stamps at each ward round.

Records included care plans relating to communication, continence, daily life, emotional support, medication, mental capacity, mobility and nutrition. The only paper records related to do not attempt cardiopulmonary resuscitation orders, deprivation of liberty safeguards, inventories of patient belongings and clinical test results.

Inadequate

Medical care (Including older people's care)

Records were stored securely on the electronic system. The head of quality and governance told us if there were problems with the electronic system staff could use paper as a back-up.

Medicines

Although the service had systems and processes in place to administer and record medicines use, the staff did not appropriately manage medicines held in stock and record keeping of waste medicines. Controlled drug governance was not effective.

Staff followed systems and processes to prescribe and administer medicines safely. The Resident Medical Officer (RMO) was responsible for prescribing medicines. The RMO prescribed medicines on the medicine administration record charts (MAR). Staff responsible for administering medicines recorded administration of medicines on MAR charts. We reviewed MAR charts for five patients and found there were no gaps in in the administration records.

The hospital employed a pharmacist for eight hours a month to provide advice and carry out medicines related audits. The pharmacist from the pharmacy that supplied and dispensed medicines was also available to provide advice regarding medicines if needed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The RMO reviewed medicines prescribed to patients every week. Patients had medicine care plans to help staff provide appropriate care. We saw care plans had information on how to monitor and manage side effects of high-risk medicines such as anti-coagulants or monitor and manage people who experienced seizures.

Staff didn't always complete medicine records accurately or kept them up to date. Records of waste medicines were not completed appropriately. Waste medicines were returned to the supplying pharmacy for disposal. However, the staff did not always record the date or sign the waste medicine records. Also, the pharmacy responsible for collection and disposal of waste medicines did not record the date of collection or sign the records when they had collected medicines for disposal from the hospital.

Staff didn't always store and managed all medicines and prescribing documents safely. The hospital held some medicines in stock. However, the audit trail of medicines held in stock and used was not effective. This included one medicine which is subject to high levels of regulation and can be misused.

Waste medicines were returned to the supplying pharmacy for disposal. However, there was no dedicated waste medicine storage container. Also, the staff did not always complete waste medicine records appropriately.

On the ward, medicines were stored in dedicated secure storage areas within their recommended temperature range with access restricted to authorised staff.

Staff learned from safety alerts and incidents to improve practice. There was a process in place to receive and act on medicine alerts and a process in place to report medicines related incidents. Medicine incidents and outcome of audits were discussed at the monthly clinical governance meetings.

There was an audit schedule in place for medicines. The staff carried out medicines management audits which included secure storage, controlled drugs and record keeping of administered medicines. However, the staff did not audit medicines held as stock at the hospital.

Inadequate

Medical care (Including older people's care)

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Patients at the hospital were not being administered medicines covertly. Covert medication is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example in food or in a drink. The medicine administration records we reviewed provided assurance that medicines were not being used to control people's behaviour.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Leaders investigated incidents and shared lessons learned with the whole team and the wider service.

Leaders investigations of incidents were not always comprehensive and lacked detail. We reviewed six completed investigations. These showed that the root causes of these incidents were not identified or explored, and recommendations were not made to mitigate the risk of similar incidents occurring.

Leaders were responsible for investigating incidents and had received training. However, the head of quality and governance, who had recently joined the service at the time of inspection had recognised there was a need to improve incident management.

All staff knew what incidents to report and how to report them. Staff received training on incidents as part of their induction and further training was completed when the hospital changed their incident reporting system in October 2020. The head of quality and safety was working to improve staff understanding of incident reporting and ensure neutral language was used when incidents were reported.

Staff raised concerns and reported incidents through an online system. Some staff told us they did not receive feedback. Leaders did not effectively share learning from incidents and there was no evidence of sharing of learning from a number of the incidents we reviewed. The provider produced a safety performance report (in relation to incidents reported on the electronic system). The report showed between February and December 2021, there were a total of 218 incidents. Of these incidents, 40 related to behaviour of patients, 38 related to a clinical event/deterioration and 33 were patient falls. There was no mention of lessons learnt or actions taken to prevent, manage or mitigate incidents.

The 'reporting of management and incidents including serious incidents and never events policy' dated October 2020 contained incorrect information in respect of learning from incidents. The policy stated that wider learning is shared with staff via a variety of different methods, including 'learning from incidents' meetings, but there were no incident meetings held, and staff we spoke with confirmed this. We were told the monthly governance meeting covered incidents, we reviewed the most recent minutes for this meeting, for the reporting period of October to November 2021 the report recorded that in respect of incidents, 11 incidents had been open for more than 45 days, the oldest incident is dated 15/2/2021 and was related to 'SNH inability', no further rationale was provided in respect of actions, and ownership of next steps to manage and mitigate and ensure patient safety. The policy also states that all serious incident will be shared with the group Chief Operating Officer (GCOO), for onward dissemination to the Renovo Care Board for their oversight of such incidents on a monthly basis. The policy states the GCOO is the providers executive lead for quality and safety and is responsible and accountable for ensuring there is a reporting structure in place via the integrated governance committee. There was no integrated governance committee and there is no group chief operating officer for organisation and there has not been for a number of months.

Staff understood the importance of reporting both incidents and near misses and were aware of the incident reporting process. Staff reported they felt confident in using the incident reporting system.

Inadequate

Medical care (Including older people's care)

Are Medical care (Including older people's care) effective?

Requires Improvement

We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, leaders did not have effective audit processes to check to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We reviewed the care pathway for the acute and extended rehabilitation pathways and found the pathway stated all patient's rehabilitation goals would be agreed within 14 days of admission, in line with British Society of Rehabilitation Medicine (BRSM) standards.

Policies we reviewed included references to relevant national guidelines. For example, the rapid tranquilisation policy referred to national institute for health and care excellence (NICE) guidelines NG10 and NG11 in relation to violence and aggression and challenging behaviour.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The hospital did not have effective processes to monitor compliance with national guidance. The site quality and governance exception report had identified a need for a database to demonstrate care was delivered in line with The National Institute for Clinical Excellence (NICE) Guidance and Quality Standards. The NICE guidance being referred to by the hospital had not been reviewed for relevance/baseline assessment. The provider did not have a record of the NICE guidelines where a decision had been taken not to implement the guidance noting why. There was no information within this report as to when these areas would be addressed or who by

Nutrition and hydration

Records showed staff did not always give patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary but did not record or monitor these effectively.

Staff did not always fully and accurately complete patients' fluid and nutrition charts. Records were not accurate enough to demonstrate if patients had enough to eat and drink, especially for those with specialist nutrition and hydration needs.

The clinical services manager and ward manager acknowledged the electronic records system did not support staff to record fluid intake and output accurately. The ward manager had arranged further training sessions for staff on the electronic records system. We saw staff were reminded to record all fluids offered to patients even if they were refused during the safety huddle we observed.

We reviewed records for three patients with percutaneous endoscopic gastronomy (PEG) (a feeding tube to allow nutrition, fluids and medications to be directly put into the patient's stomach) showed records were not always accurate to confirm feeds had been given as prescribed. We reviewed inaccuracies in records with the ward manager and clinical services manager and they were able to confirm feeds were given as prescribed, but the records were inconsistent.

Enteral feeding plans were all on different forms so there was a risk staff would not be familiar with the paperwork which could increase the likelihood of errors. After the first day of inspection we raised concerns that the enteral feeding plans were recorded on different forms for each patient. The service updated the feeding plans for each patient and decided to use the form the dietitian was most familiar with.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed eight records and found MUST assessments were completed for all patients. However, audit records showed the service did not audit MUST risk assessments.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. The service employed a speech and language therapist full time and the had a service level agreement to employ a dietitian to visit the service once a week and up to three days a week if needed.

Staff completed fluid and nutrition training as part of mandatory training and compliance was 98%.

The hospital had an onsite kitchen and the chef made all meals for patients including those with modified diets, such as pureed food.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff recorded when 'as required' medicines were prescribed and given for pain relief.

Patient's we spoke with were positive about the way their pain was managed.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment but did not use the findings to make improvements to the service to ensure good outcomes for patients.

While the service participated in relevant national clinical audits the data was not benchmarked to ensure outcomes were positive, consistent and met expectations, such as national standards. The service provided data on patient outcomes in line with the UK Rehabilitation Outcomes Collaborative Data (UKROC) showed for four patients admitted onto the acute rehabilitation pathway and subsequently discharged during 2021 the average length of stay was 83 days, ranging between 19 and 204 days. However, we did not receive evidence to demonstrate the service formally submitted the required data to the (UKROC) programme to benchmark patient outcomes.

The service used recognised assessment tools to assess patients' level of care needs. For example, staff used function independence measures and functional assessment measures to measure the level of disability in patients with brain-injuries and monitor progress.

Inadequate

Medical care (Including older people's care)

Leaders and staff did not always use the results of audits to improve patients' outcomes. For example, we reviewed Brain Injury Awareness questionnaire data provided by the service. These questionnaires were completed by patients to demonstrate their progress in understanding their condition and how the brain and memory work. While the service reported on this data and outcomes, include the impact of the brain injury awareness course on mood there was no analysis or action to improve outcomes noted in the audit.

While the service did not use national audit data to improve outcomes, locally, teams monitored patient outcomes by using a goal setting approach. The service monitored patient's personalised rehabilitation goals through interdisciplinary department meetings (IDT) attended by therapy, nursing and medical staff. The purpose of this meeting was to ensure care continued to be appropriate to people's needs.

The newly appointed head of quality and governance was reviewing the audit programme at the time of inspection to ensure it was relevant and focused on improving outcomes for patients.

Competent staff

The service made sure staff were competent for their roles. Leaders appraised staff's work performance but processes to monitor compliance with yearly appraisals were ineffective.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Leaders gave all new staff a full induction tailored to their role before they started work. We spoke with one new member of staff who was positive about their experience of induction and the welcome they had received. New staff received a book of information about the patients to support them getting to know their needs and preferences.

Nursing staff completed competencies in relation to specific aspects of care. For example, tracheostomy care, percutaneous endoscopic gastronomy (PEG) feeding and catheter care.

Leaders supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Data the provider submitted showed at the time of inspection 90% of staff had received a yearly appraisal. At the time of inspection, the provider learning development manager was working to improve the appraisal process and align it to the new provider values.

However, the service did not monitor appraisal compliance effectively. Data on the Renovo care group quality assurance dashboard for the service did not match up with the data the service provided us with for appraisal rates. The quality dashboard was last updated in August 2021 when overall compliance was 30%.

Leaders identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The director of operations told us staff could apply to the learning and development committee for funding for further training. For example, an occupational therapist assistant was funded through an apprenticeship. The provider had a learning and development manager who visited the site once a month to support staff.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Inadequate

Medical care (Including older people's care)

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. On admission referrals were agreed through a multidisciplinary assessment with input from the director of operations, medical, nursing, therapy and neuropsychology staff.

Multidisciplinary meetings every week and were attended by physiotherapy, occupational therapy, speech and language therapy, nursing, medical. We reviewed the minutes of two of the meetings and found updates were given from all disciplines. However, there was not always detailed input from psychology staff. Meetings were focused on patient goals and the therapies and interventions needed to support patient goals.

Staff worked across health care disciplines and with other agencies when required to care for patients. Care was delivered by a multidisciplinary team. For example, staff worked with carers from a patient's home care agency who continued to support the patient in hospital for psychological support. Patients could be referred to the community mental health team for ongoing support.

Patients had their care pathway reviewed by relevant consultants. The service employed neurorehabilitation specialist consultants who reviewed patient's care regularly.

The service liaised with social workers to arrange services for patients when they were discharged. However, multidisciplinary team meeting records showed social workers did not always attend meetings to support discharge planning. The clinical services manager was working with commissioners to improve input from social workers.

Seven-day services

Key services were available seven days a week to support timely patient care.

The service provided care 24 hours a day, 365 days a year. A resident medical officer was available 24 hours a day seven days a week on site. Consultants led daily ward rounds during the week and were available to advise staff 24/7 through an on-call rota covered by four consultants.

A dietitian was available on site one day a week and could attend up to three days a week as needed.

Physiotherapy and occupational therapy were available Monday to Friday.

The neuropsychologist was available on site two days a week.

A pharmacist was available onsite once a month and provided remote support by telephone during working hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Inadequate

Medical care (Including older people's care)

We reviewed ten mental capacity assessments for different decisions for three patients and found the quality of documentation was variable. From electronic records reviewed it was unclear when the mental capacity act assessments were actually completed as most were dated 15/12/2021 when staff transferred from paper to an electronic records system.

Leaders acknowledged the quality of mental capacity assessment records varied in quality and were working to improve this. The service had sent a survey out to all staff to measure knowledge and confidence levels with the mental capacity act. The head of quality and governance planned to arrange targeted training sessions following the survey.

Leaders monitored the use of Deprivation of Liberty Safeguards (DoLs) and made sure staff knew how to complete them. We reviewed the DoLs database (as updated 10January 2022) and found the service had a system to monitor expiry dates effectively. Leaders completed an MCA and DOLs audit, but this was not completed regularly. Audit data showed these audits were completed twice in the past year in April and July 2021.

Are Medical care (Including older people's care) caring?

Good

We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff interacting with patients in a warm and friendly way.

Patients said staff treated them well and with kindness. For example, patients told us “I feel that everything is done for patients, not for the convenience of staff.” We observed positive interactions between staff and patients and saw people looked happy to see staff when they approached.

Staff followed policy to keep patient care and treatment confidential. Throughout the inspection we saw staff respecting patient’s privacy and knocking before entering patients’ rooms.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal and cultural needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patient’s had access to sessions with a neuropsychologist on a regular basis. Patients we spoke with were positive about the emotional and psychological support they received.

Inadequate

Medical care (Including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients had access to a courses and psychological support to help them come to terms with their condition.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff we spoke with had a good understanding of the patient's preferences and communication needs. All records we reviewed had a detailed 'this is me' page that included input from the service user or family in relation to care planning and what was important to them in their rehabilitation.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service collected feedback through online surveys sent to patient's families. We reviewed the hospital's compliments report and saw 34 compliments had been received between February and September 2021. If the compliments included feedback on areas for improvement, the service identified these. For example, improving menu choices and ensuring therapy sessions started on time.

Staff supported patients to make informed decisions about their care. Patient's rehabilitation goals were focused on what mattered most to them. For example, going to watch a family member play sport. Staff also supported patients to make advanced decisions. Care plans we reviewed contained information on patient's advanced decisions about their care.

Patients gave positive feedback about the service. Patient's told us their preferences were met, for example in relation to when they chose to have a shower. Staff we spoke with were aware of patient's preferences. For example, their favourite TV shows or music.

Are Medical care (Including older people's care) responsive?

Requires Improvement

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Leaders worked with commissioners to organise services to meet the needs of the local population. The service admitted patients from across the South West and South East of England. The hospital mainly treated NHS patients, but patients could fund their treatment privately also. At the time of inspection two patients were on an acute rehabilitation pathway.

The other six patients were longer-term patients on a slow-stream rehabilitation pathway or complex disability management care pathway. The clinical services manager told us the longer-term patients were patients who had enduring neuro-disabilities and commissioners had decided they had reached their rehabilitative potential so needed ongoing care.

The director of operations told us they had positive relationships with local commissioners. The risk register included a risk in relation to having enough patient referrals to ensure the viability of the service. This risk was mitigated by working to improve relationships with commissioners across the South East and South West and building a relationship with the local NHS trust.

Facilities and premises were appropriate for the services being delivered. All rooms were single rooms with bathrooms attached so patients did not share sleeping accommodation or toilet facilities with members of the opposite sex in line with NHS guidance.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, the service ensured patients could access support from the community mental health teams or multiple sclerosis specialist nurses as needed.

While the service had some facilities to support patients in therapeutic activities, staff did not regularly support patients to use them. Patient's had access to a small garden outside the hospital. The garden was not adapted to be accessible or engaging for people using wheelchairs or people with cognitive impairments. Activity records showed in December 2021 staff supported patients to go outside on two out of 31 days of the month.

The service had a hydrotherapy pool staff could support patients to use. Activity records showed the pool had been used once in the month of December 2021. We discussed the use of the hydrotherapy pool with the clinical services manager and they told us only one patient was suitable for hydrotherapy and they had not been physically well enough to engage with sessions recently.

The service had two gyms for physiotherapy and a room for speech and language therapy.

The service had a kitchen for patients to use as part of occupational therapy.

The service had a café space where patients could meet with visitors.

The service had a multifaith room patient could be supported to access.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients had access to various therapies including physiotherapy, occupational therapy and music therapy, hydrotherapy.

Staff made sure patients living with mental health problems and learning disabilities received the necessary care to meet all their needs. The service employed two learning disability nurses and a consultant neuropsychologist was available on site two days a week.

Inadequate

Medical care (Including older people's care)

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment All staff completed mandatory training in communication skills. Data showed 93% of staff had completed this training. The clinical services manager told us they supported staff by modelling effective communication methods with patients with complex communication needs.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service had admission criteria to ensure only those patients who could be cared for on the wards were accepted. New referrals were discussed at the admissions committee to identify the suitability of the patient based on the information received. Once approved the hospital worked in partnership with the commissioners to transfer the patient and meet their needs throughout their stay at the hospital. On admission staff carried out nursing, therapy and psychological assessments for all patients.

The service reviewed patients within 48 hours of admission to ensure all initial assessments were completed and the referral was suitable. For patients on the acute rehabilitation pathway, staff reviewed patients at two weeks for goal setting, at six weeks for a mid-point review and ten weeks for discharge planning.

The hospital worked with commissioners and other agencies to facilitate safe admissions and discharges. Typically for rehabilitation, patients stayed with the hospital for 12 weeks. Patients had a mid-point review to assess whether the hospital was on target to deliver the rehabilitation goals and prepare the patient for discharge and communicated this to other agencies to allow for continuity of care.

Leaders and staff worked to make sure patients did not stay longer than they needed to. However, data showed length of stay for patients on the acute rehabilitation pathway was highly variable. While the ideal pathway was 12 weeks (84 days) the average length of stay was 83, ranging between 19 and 204 day.

Leaders and staff worked to make sure that they started discharge planning as early as possible. Leaders told us discharge planning started at admission for patients on the acute rehabilitation pathway.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. However, concerns and complaints were not always treated seriously enough, or learning identified and shared effectively.

Patients, relatives and carers knew how to complain or raise concerns. The head of governance and safety told us there was an email address that was advertised around the hospital where patient families could send their feedback to the service.

The service clearly displayed information about how to raise a concern in patient areas.

Inadequate

Medical care (Including older people's care)

While leaders investigated complaints, it was not clear themes were identified and appropriate action taken. The service reported they had three formal complaints and one informal complaint in the past year. While all three complaints related to the behaviour of staff there was no joined up action to improve the culture of care in the service. Leaders took action to improve individual staff behaviours through increased supervision and asking staff to complete reflections but there was no evidence of wider learning for all staff in the service.

Leaders shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with told us if a complaint related to their practice this would be discussed with their manager during supervision.

Are Medical care (Including older people's care) well-led?

Inadequate

We rated well-led as inadequate.

Leadership

Leaders did not always show they had the skills and abilities to run the service. While they understood some of the issues the service faced, leaders did not always take ownership of these and make improvements. However, leaders were visible and approachable in the service for patients and staff.

There was a clear management structure with lines of responsibility and accountability.

The Board had responsibility of overseeing the business. There were various committees which

which made up the board which included South Newton Clinical Governance Meeting, Clinical

Governance & Risk Management Committee and the Medical Advisory Committee (MAC).

The organisation was led by the Renovo Care Group Board chief executive officer (CEO). The leadership team included a director of operations, a chief finance officer, a director of clinical development, and a human resources manager.

There was no CQC registered manager in post at the time of inspection. At the time of inspection CQC had recently rejected the director of operation's application to be the registered manager. The director of operations was supported by a quality and governance lead, who had been recently appointed. Supporting the leadership team there was clinical services manager, a ward manager and an estates manager.

There were a number of changes to the leadership team during the inspection period. It was during our inspection senior leadership changes were announced, the leadership team at the hospital were not aware of the changes and were only given a weeks' notice of these. The chief executive officer retired, and a new CEO started in post.

The Board was made up of a chairperson, two non-executive directors and members of the South Newton leadership team. We were informed during our inspection that the chair of the board had retired, giving a weeks' notice and a new chair appointed. The exiting chair had told us that they had not been able to provide a board handover to the incoming chair.

Inadequate

Medical care (Including older people's care)

Staff we spoke with were very positive about the leadership and told us that leaders were approachable and visible. Staff said they felt supported. During the inspection, we observed positive interaction between staff and leaders. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

The leadership team did not have full oversight of all the issues relating to quality and safety in the service. They did not always prioritise them appropriately and take timely action to resolve them. We were told by the exiting chief executive he had prepared for the new chief executive a formal handover for all four of the provider CQC registered locations he was accountable for. These included another hospital and two care homes. We reviewed this handover and found it lacked key information relating to governance, risk, audit and organisational priorities. There was no mention on the needs of patients or what mattered to them.

It should be noted the handover report, when referring to previous CQC registration and inspection processes stated, 'It became clear that leadership and quality (at South Newton) needed to be improved'. The exiting CEO had recognised quality auditing process needed attention and had recently recruited two new leads, for the whole organisation, for quality and safety. The handover report recorded that the leadership team had improved the Clinical Governance and Risk committee which meets monthly, however there was no further information as to what this meant and the report for the new CEO had not been included.

We raised serious safety and governance concerns with the exiting CEO and the Director of Operations on day one of our inspection, these were in relation to stock held medicines, the management of waste medicines and some staff not having confidence in the new electronic patient record system, both leaders were unaware of these issues. When we returned to the hospital a week later, no action had been taken in respect or the issues we had raised, we raised these again with the new CEO (who had been in post 5 days), he immediately arranged for the safe disposal of a stock held medicine which was used to treat anxiety disorders and had not been prescribed for any individual patient at the hospital.

Vision and Strategy

The vision for the organisation was in development. It was not clear what the service wanted to achieve there was no strategy to turn it into action. The vision and strategy had not been developed with people who use the service or relevant stakeholders.

The organisation was going through a process of updating the vision, values and strategy. Leaders we spoke with were not able to tell us how the vision, values and strategy been developed. We were told there had been some discussion with a local NHS trust spinal rehabilitation service in relation to the moving of patients from one location to another, however, there was no formal process or evidence of this. The provider was not using a structured approach to update the strategy in collaboration with people who use services, and those who matter to them, or other external partners, such as commissioners, these key stakeholders had not been included in the development of the vision, values and strategy for the organisation.

A first draft of the organisations vision and values had been shared with staff and their feedback was being considered. One of the core values proposed states that the organisation 'puts the needs of patients at the heart of the work.' However, patients and their relatives or carers had not been asked about their views on the vision, values or the strategy for the organisation. We were told there would be separate consultations with patients, but no work had started on this, and senior leaders we spoke with were unable to tell us how or when this would be undertaken.

Inadequate

Medical care (Including older people's care)

Not all staff we spoke with knew and understood the provider's vision and values and how they applied to the work of their team. Some staff told us that the service didn't work to a rehabilitation model and at times the service could be seen as a care home. Some staff told us that they felt admissions of patients were motivated by finance, bed occupancy and referrals and admissions were not always appropriate due to the acuity of patients' mental health needs.

The leadership team told us they had plans to develop the hospital but there was no evidence to demonstrate how the strategy was being delivered. Strategic objectives were not supported by measurable outcomes, which were cascaded throughout the organisation. Leaders did not fully understand the challenges and did not have an action plan to achieve the strategy, which included effects of the pandemic and local health economy factors.

Structures to support the delivery of the hospital's aims and objectives were not effective, and this was evidenced by the lack of discussion at board and governance meetings. Minutes from the clinical governance and risk management meetings referred to a quality strategy. However, there was no recorded discussion on the strategy in the minutes for these or on any of the last three board meetings.

The formal handover from the exiting CEO to the new CEO focused more on sharing diary commitments than ensuring the vision, values and strategy for the organisation were known and it made insignificant reference to risk factors impacting on the service provision, or the quality, safety and sustainability of services for patients.

Culture

The service was updating the organisations vision and values at the time of inspection. This process involved had conversations with staff, however, not with patients or any external stakeholders.

Staff told us they felt respected, supported and valued. Staff were focused on the needs of patients receiving care. The service had a culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with were positive about working at South Newton Hospital commenting that it was a "lovely" place to work with "friendly" staff. The human resources lead commented they had received positive feedback from staff who recently joined the service.

Most staff told us they felt well supported by their manager. Staff meetings were held regularly to engage with them and seek their views.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. There was a Freedom to Speak up Guardian (FTSU) on the board but there were no FTSU champions in the hospital and the board papers did not include regular updates on concerns raised to the FTSU guardian. The director of operations told us while there were no FTSU champions but there was a 'speaking up' policy and staff could go to the human resources lead if they had concerns.

The provider did not have a fully developed approach to staff wellbeing. While there had been an increase in behaviours that challenge during summer 2021 there was no evidence of increased support for staff in managing the physical and emotional impact of this.

The service did not have effective mechanisms to enable and encourage open communication with people who use the service and those that mattered to them. South Newton Hospital cares for people with complex communication

challenges. However, there was minimal accessible, tailored and inclusive ways of communicating with people how to feedback about the service such as patient surveys, easy read leaflets. Information for people using the service, including their own care plans did not have information available in formats which met their communication needs in line with the Accessible Information Standard.

Governance

Leaders did not operate effective governance processes to continually improve the quality of the service.

The arrangements for governance and performance were fully clear and do not always operate effectively.

The service had the following clinical governance meetings:

- South Newton Clinical Governance Meeting
- Clinical Governance & Risk Management Committee
- Medical Advisory Committee (MAC)
- All staff meetings every other week

The board met every two months and we reviewed the minutes of the most recent meetings held in July, September and November 2021. We saw that information from the clinical governance meetings were shared with the board and that it had been noted for the November meeting that that information from recent CQC findings were 'clear evidence that there had been internal failures in the quality and assurance procedure and reporting, with the outcome of the board being presented with poor information'. As a result of this the provider had arranged for a review of the Governance and Audit framework and in November 2021 had recruited a new lead for governance and quality.

We spoke with the new head of quality and governance who had identified areas for development and improvement. They had recognised that the Quality Assurance dashboard was more of an overview of data rather that evidence of quality. We reviewed the dashboard that was in use at the time of the inspection and found that it provided quantitive data. There were headings such as safe and responsive care and whilst areas such as pressure areas care, falls and infections were covered there was no information about COVID-19 assurances. The dashboard had no qualative information to demonstrate safe patient outcomes, timeliness or effectiveness of patient care and treatment, there was no indication of patient experience or satisfaction. The dashboard had not been reviewed to ensure it was contained accurate and relevant information it had no information recorded for October, November or December 2021.

To provide assurance of quality for the board there was a site quality and governance exception report, this was presented to the clinical governance site committee (which is a subcommittee of the board) every other month. For the most recent report, for the reporting period of October to November 2021 the provider had identified that the clinical audit programme was an 'area for improvement'. The report identified ten areas of non-compliance, beneath these the detail described for some areas what action had been undertaken to comply, however, there remained a further ten areas where it had not been recorded what action had been taken, by whom to rectify areas of shortfall. The report stated these areas would be reviewed and will be updated for 2022, however, there was no information as to when these areas would be addressed or who by.

The site quality and governance exception report, which is used as board assurance of quality and safety recorded, 11 incidents had been open for more than 45 days. The oldest incident was dated 15/2/2021 and was related to 'SNH inability', no further rationale was provided in respect of actions or ownership of next steps to manage, learn from incidents and ensure patient safety.

Inadequate

Medical care (Including older people's care)

During this inspection concerns around safety, including infection control and medicines, and concerns around the governance of stock held and waste medicines management had not been identified or addressed, meaning the leaders did not have clear oversight of the issues affecting patients

The service did not have a system in place to regularly audit the delivery of individualised care including ensuring appropriate documentation was in place, nor were there any measures of the quality of information to inform and guide staff practice. We reviewed the providers care plan audit, dated December 2021, this stated that overall compliance for completion of 16 Care Plans was 95%, the provider had recognised and recorded on the audit that 'A separate and more detailed in-depth audit is required to ascertain the quality of the Completed Care Plans'. No further information as to who and when this would take place, or the detail of the required audit had been recorded.

An effective audit process was not in place to demonstrate that the services provided effective and safe, we found that leaders did not always complete regular audits of the ward environment and public areas. Data showed audits of the environment were not completed January to April 2021 and September to December 2021

We found that there were a number of policies and procedures to govern and guide staff practice that contained inaccurate and incorrect information or had not been updated in line with government guidance or the providers own policy. For example, the 'reporting of management and incidents including serious incidents and never events policy', dated October 2020 contained incorrect information in respect of learning from incidents. The policy stated that wider learning is shared with staff through a variety of different methods, including 'learning from incidents' meetings, but there were no incident meetings held. The policy also stated that all serious incidents would be shared with the group Chief Operating Officer (GCOO), for onward dissemination to the Renovo Care Board for their oversight of such incidents on a monthly basis. The policy states that the GCOO is the providers executive lead for quality and safety and is responsible and accountable for ensuring there is a reporting structure in place via the integrated governance committee. Board does not meet on a monthly basis, there was no integrated governance committee and there is no group chief operating officer for organisation and there has not been for a number of months. We also found that leaders did not regularly update infection control policies and procedures in line with government guidance or regularly complete infection control audits.

There were no staff working under practising privileges at the time of inspection. A practising privilege is a type of subcontracting arrangement a form of 'licence' agreed between individual medical professionals and a private healthcare provider.

Management of risk, issues and performance

Leaders and teams did not manage performance effectively. They did not always identify and escalate relevant risks and issues and did not implement effective actions to reduce their impact.

Staff had access to the risk register through an electronic incident reporting system and were able to effectively record risks on the system and were able to raise concerns as needed. However, leaders did not always effectively identify and manage risks in the service. We were told the director of operations was responsible for reviewing and monitoring the risk register and we saw this was mentioned at monthly governance meetings.

We reviewed the South Newton Hospital risk register and found the service had recorded seven active risks. The head of governance and quality told us all risks with a score of 16 were added to the register. The risk register included identification of risks, such as infection prevention and control, the safe management of COVID-19, specifically about staff

recruitment and retention, not patients. The risk register recorded an organisational lead for each risk, and risks were reviewed monthly at the clinical governance and risk management meetings. We saw from our review of the electronic risk register that each risk recorded mitigating actions. However, the register did not identify who had ownership of these underpinning actions and did demonstrate the oversight and management to reduce the associated risks.

Leaders did not always rate the severity of risks accurately or review the risk register regularly. For example, there was a risk relating to the management of COVID-19 risk on the risk register, with nine underpinning actions. However, the 'current' risk rating was 'medium' despite the when Omicron variant being the most prevalent at the time the risk was recorded. The risk register was not reviewed in November or December 2021.

Leaders did not always identify and escalate relevant risks and issues and did not implement effective actions to reduce their impact, for example in relation to concerns identified during the inspection such as the unsafe management of stock held medicines and the lack of joined up, clear and accurate patient records, patients and staff were at increased risk of exposure to harm due to ineffective processes and procedures to assess the risk of, preventing, detecting and controlling the spread of COVID-19.

We also found that policies to direct and inform staff practice had not been reviewed to ensure they contained accurate information; this had not been identified as an area of concern on the hospitals risk register.

The hospital's quality dashboard was ineffective and not reflective of performance. The last time leaders reviewed the dashboard was in September 2021. Issues noted during our previous inspection and actions to address these were documented completed, but our findings did not verify what was reported as part of the routine audits. When we spoke with the new quality and governance lead, they told us that they were aware the data on the dashboard was not an accurate record and had been reviewing a number of areas relating to risk and governance in order to identify areas of development.

The hospital's audit programme was ineffective. Leaders told us they had a clinical documentation audit tool however The audit showed records did not always include a date, time and signature and RMOs were not always using their stamp to record their name and GMC number. The quality and safety lead shared the results of the audit with consultants and RMOs and reminded RMOs to use their stamps at each ward round.

There were plans in place for emergencies and other unexpected or expected events.

Information Management

We were not assured that the service collected reliable data and analysed it. Data was not always in easily accessible formats due to the use of multiple systems.

There was a commitment to improve existing platforms and develop new ones to support efficient governance and delivery of patient care in particular the introduction of an electronic patient record system.

Staff had access to the equipment and information technology they needed to do their work. The electronic patient record system was password protected and set up to help protect the confidentiality of patient records.

The provider had introduced a new patient electronic recording system in November 2021; however, staff told us they could not always find the data they needed in easily accessible formats. Patient records were recorded and stored in a number of areas making it difficult for staff to document all aspects of care and for others to follow the patient journey.

Some staff told us there were some issues with recording information using new electronic system. The system did not always update or synchronise in a timely manner. It was also reported to us that the system does not flag concerns from patient observations (e.g. high blood pressure). We were told no paper records being used alongside new computerised system, however in reality this was not the case. We saw that patient pathways in respect of their rehabilitation and information relating to admission to the service were held in either a paper-based record or a different electronic system.

Data collected by the hospital was not always reliable enough to monitor performance, identify areas of concern and monitor improvements. Leaders mainly used information for assurance and rarely for improvement. We saw several examples of data not reflecting performance as detailed within this report. For example, the November 2021 care plan audit, the Renovo care group quality assurance dashboard and the location quality and governance exception report.

The service did not monitor mandatory training compliance or staff appraisal effectively. Data on the Renovo care group quality assurance dashboard for the service did not match up with the data the service provided us with for mandatory training or for appraisal rates, please see the competent staff section of this report for further detail.

Engagement

Leaders and staff engaged with staff and some local stakeholders to plan and manage services. However, people who use services, those close to them and their representatives are not actively engaged with or involved in decision making to shape services and culture.

People who use services, those close to them and their representatives were not actively engaged with or involved in decision making to shape services and culture. The service was updating the organisations vision and values at the time of inspection, this process involved had conversations with staff, however, not with patients, those who were important to them or any external stakeholders.

There are patients with prolonged disorders of consciousness (PDOC) and there were minimal efforts to ensure people were able to make their views and wishes known. There were no individualised methods of communicating with people in respect of obtaining information about their choices and decisions about their day to day life.

There was minimal accessible, tailored and inclusive ways of communicating with people how to feedback about the service such as patient surveys, easy read leaflets. Information for people using the service, including their own care plans did not have information available in formats which met their communication needs in line with the Accessible Information Standard

Those people who use services were not asked for their views or experiences, these were not gathered and acted on to shape and improve the services and culture. The service did not have effective mechanisms to enable and encourage open communication with people who use the service and those that mattered to them. The provider showed us they were in the process of developing some documents for people with communication challenges in easy read format, but these were not in place and no timeframe for when these would ready to use was shared with us.

There are some developing relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population

Staff meetings were held regularly to engage with them and seek their views.

The service had an employee of the month scheme to recognise staff achievements.

Inadequate

Medical care (Including older people's care)

Learning, continuous improvement and innovation

Leaders did not have a good understanding of quality improvement methods or demonstrate the skills to use them.

There was no structure or governance in relation to quality improvement

The organisation did not always react sufficiently to risks identified through internal processes and at times has relied on external parties to identify key risks before they start to be addressed.

Documentation we reviewed during our inspection evidenced that leaders had reflected on inspections of other services owned by the provider and considered how findings could be used to make improvements.

Before our inspection the hospital had commissioned an independent review of the quality and safety of their service. The commissioned company undertook a two day simulated a CQC inspection of the location in November 2021 and overall judged the location as requires improvement. The judgements were based on a number of areas assessed which covered operational management of the services and nursing care. The model used did not account for the complex acuity of patients and did not mention specialist neuro rehabilitation or the assessment, treatment and rehabilitation of adults with neurological injury and condition.

During the inspection innovative practice was shared with us and observed in practice. Staff shared with us a positive example of how for one particular person flavours were important to them and although the person was 'nil by mouth' the staff were trying 'flavour bubbles' and in response were receiving positive responses. Giving the person a cup to smell and being very clear when supporting that person, we observed good, individualised person centred support.

The provider was looking into research opportunities with Bournemouth University, we were told by leaders that they were looking to work collaboratively with the university and a number of clinical and health psychology master's students, looking at nature-based therapies for neuro rehabilitation. This collaboration was in the early days of development, staff we spoke with were committed to developing this area to improve outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure systems and compliance with mandatory training are operated effectively 17 (1) • The provider must ensure governance and risk management processes are fully embedded and sustainable. Regulation 17(1) • The provider must make sure all staff understand and report incidents correctly, investigations are robust, and learning is shared. Regulation 17(1) • The provider must maintain securely an accurate, complete and contemporaneous record of each patient of the care and treatment provided. Regulation 17(1) • The provider must ensure patient records are audited for quality and completeness. 17 (1) • The provider must ensure systems to ensure NEWS scores are audited effectively 17 (1) • The provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services and data on patient outcomes) 17 (2) a

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider must ensure processes for assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated are effective to protect patients and staff. 12 (h) • The provider must respond to mental health risks in a timely way to ensure patient safety 12 (b)

This section is primarily information for the provider

Requirement notices

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 must be established and operated effectively to prevent abuse of service users including ensuring staff recognise and respond effectively. 13 (2)