SSAFA Care CiC CRT/AVS Service

Quality Report

Grace Dieu Ward
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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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an unannounced focused inspection of SSAFA Care Community Interest Company (CIC) on 3 October 2016. This inspection was carried out because we had received information which indicated potential

Summary of findings

concerns. This information was in relation to a seven day acute visiting service and clinical response team service which is provided from an office located in the Grace Dieu Ward, Loughborough Hospital, Hospital Way, Loughborough, Leicestershire, LE11 5JY. The information shared with CQC indicated potential concerns about the safe management, storage and security of medicines, including medicines stored in vehicles used by this service. Information also indicated potential concerns in relation to medical equipment used by this service and located in vehicles. Other information provided indicated potential concern in relation to information governance and security and the management of patient identifiable information and also regarding the suitability and qualifications of clinical staff employed by this service and of clinical staff provided through external agencies.

Our key findings across all the areas we inspected were as follows:

- The provider was not registered correctly with the CQC. The location where services operated from had not been registered appropriately with CQC. Their statement of purpose had not been updated to reflect these services being provided.
- Medicines were not stored or managed safely and appropriately. Medicines were permanently stored in vehicles overnight and were exposed to large variations in temperature which could alter the effectiveness of these medicines. Some medicines were found to be out of date. There was no stock control system in place for medicines transferred from the main stock to the vehicles. The medicines management policy was out of date and did not refer to this location.
- Patient group directives (PGD's) were in use however, not all staff working under these PGDs had signed them. There was no evidence of authorisation of these PGD's within the organisation for use by the organisation.
- Clinical items and equipment was not stored or maintained appropriately. For example, some items were permanently stored in vehicles overnight such as a defibrillator which had been exposed to large variations in temperatures. Some clinical items were out of date such as defibrillator pads.
- There was not an effective process in place in relation to infection control. Sharps bins were stored in vehicles overnight in the boot and on passenger seats. Some sharps bins were found to be more than three quarters full. The safe use of sharps policy dated 2014 had not been reviewed and was not relevant to this service/location. We observed that some clinical waste stored in vehicles was not in clinical waste bags.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. There was no process in place to ensure that staff provided by recruitment agencies were suitable to perform the duties expected of them or that appropriate inductions, security and identification checks were carried out before commencement of shifts. No driving licence checks were carried out for agency staff.
- There was not an effective system in place for the reporting and investigation of incidents or lessons learned as a result.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the provider was comparing its performance to others; either locally or nationally.
- Not all risks to staff and patients were assessed and well managed. The provider did not have a risk register in place in relation to this service or location. Not all staff had a lone worker risk assessment carried out. The lone worker policy was out of date. We did not see evidence of adequate security measures in place for lone workers when working in the community and visiting patients alone.
- There were limited policies and procedures in place. Those we did see such as infection control, lone working and medicines related polices were either out of date and/or did not refer to this service/location.
- There was no evidence of formal clinical supervision, mentorship and support in place for all members of staff including staff provided through agencies.

The areas where the provider must make improvements are:

Summary of findings

- Review governance arrangements including systems for assessing and monitoring risks and the quality of the service provision such as implementing a system of clinical audits, gaining assurance of the suitability, professional registration, training requirements and qualifications of all staff including agency staff and effective processes for the induction of new staff and clinical supervision, mentorship and support for all staff including agency staff.
- Ensure all staff complete all mandatory training requirements.
- Ensure that there are appropriate systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control and emergency situations including risks associated with lone workers.
- Ensure a process is in place for identification and driving licence checks for members of staff.
- Ensure that there are appropriate systems and processes in place in relation to the safe management of medicines, PGDs, clinical equipment and clinical supplies.
- Ensure effective governance arrangements are in place in relation to information governance including systems to monitor patient identifiable information and update and quality of patient information into electronic patient care records.
- Ensure that patient safety alerts (including MHRA) are received by the practice, and then actioned if relevant. Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure there is effective clinical leadership in place and a system of clinical supervision/mentorship for all clinical staff.
- Embed processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.

In addition the provider should:

- Ensure policies and procedures are delivered consistently across the practice.
- Ensure an effective process is in place to collect and act upon feedback from staff and service users.

On the 14 October 2016, the Commission served an urgent notice of decision to impose conditions upon the registration of this service provider in respect of a regulated activity. The following conditions were imposed:

- A supernumerary member of staff is on duty at the Grace Dieu Ward, Loughborough Hospital, Loughborough, Leicestershire, LE11 5JY where the clinical response team and 7 day acute visiting service operate from, 7 days per week, in addition to the current workforce. This is to provide clinical leadership, oversight and management support to all staff on duty and to support the delivery of required improvements.
- To provide the Commission with an update on progress against your action plan received on Tuesday 4 October 2016 and further review of your action plan during a quality assurance meeting on Thursday 13 October 2016, by the 28th day of each month along with supporting evidence.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

- Patients were at risk of harm because systems and processes were not in place to keep them safe. There was no process in place to ensure that staff provided by recruitment agencies were suitable to perform the duties expected of them or that appropriate inductions, security and identification checks were carried out before commencement of shifts. No driving licence checks were carried out for agency staff.
- There was not an effective process in place in relation to infection control. Sharps bins were stored in vehicles overnight in the boot and on passenger seats. The safe use of sharps policy dated 2014 had not been reviewed and was not relevant to this service/location. We observed that some clinical waste stored in vehicles overnight was not in clinical waste bags.
- Medicines were not stored or managed safely and appropriately. Medicines were permanently stored in vehicles overnight and were exposed to large variations in temperature which could alter the effectiveness of these medicines. Some medicines were found to be out of date. There was no stock control system in place for medicines transferred from the main stock to the vehicles.
- The medicines management policy was out of date and did not refer to this location. Patient group directives (PGD's) were in use however, not all staff working under these PGDs had signed them, there was no evidence of all agency staff using these PGD's to ascertain exactly who either had or hadn't signed them. There was no evidence of authorisation of these PGD's within the organisation for use by the organisation.
- There was not an effective system in place for the reporting and investigation of incidents or lessons learned as a result.
- Clinical items and equipment was not stored or maintained appropriately and was permanently stored in vehicles overnight such as a defibrillator which had been exposed to large variations in temperatures. Some clinical items were out of date such as defibrillator pads.
- Not all risks to staff and patients were assessed and well managed. The provider did not have a risk register in place in relation to this service or location. Not all staff had a lone worker risk assessment carried out. The lone worker policy was out of date. We did not see evidence of adequate security measures in place for lone workers when working in the community and visiting patients alone.

Summary of findings

- There was not an effective process in place for the receipt of, dissemination and actioning of medicines alerts (MHRA).

Are services effective?

- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the service was comparing its performance to others; either locally or nationally. Clinical audits did not demonstrate quality improvement.
- The provider did not have systems in place to keep all clinical staff up to date. Staff did not have access to guidelines from NICE to ensure the delivery of care and treatment that met patients' needs.
- Induction programmes for all newly appointed staff or agency staff that were new to this service were not effective. For example, we saw examples of induction forms during our inspection, however these forms were incomplete.
- The provider had not ensured that all members of staff had completed all mandatory training requirements such as safeguarding children and safeguarding adults training.

Are services well-led?

- The provider was not registered correctly with the CQC. The location where services operated from had not been registered appropriately with CQC. Their statement of purpose had not been updated to reflect these services being provided.
- The provider had an overarching governance framework in place, however there was not an effective governance structure in place at the location where services operated from to support the delivery of the strategy and good quality care.
- There was a lack of clinical supervision, leadership and clinical oversight on site on a daily basis. There was no evidence of formal clinical supervision, mentorship and support in place for all members of staff including staff provided through agencies.
- There were limited policies and procedures in place. Those we did see such as infection control, lone working and medicines related polices were either out of date and/or did not refer to this service/location.
- The provider had not proactively sought feedback from staff or patients.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Review governance arrangements including systems for assessing and monitoring risks and the quality of the service provision such as implementing a system of clinical audits, gaining assurance of the suitability, professional registration, training requirements and qualifications of all staff including agency staff and effective processes for the induction of new staff and clinical supervision, mentorship and support for all staff including agency staff.
- Ensure all staff complete all mandatory training requirements.
- Ensure that there are appropriate systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control and emergency situations including risks associated with lone workers.
- Ensure a process is in place for identification and driving licence checks for members of staff.
- Ensure that there are appropriate systems and processes in place in relation to the safe management of medicines, PGDs, clinical equipment and clinical supplies.
- Ensure effective governance arrangements are in place in relation to information governance including systems to monitor patient identifiable information and update and quality of patient information into electronic patient care records.
- Ensure that patient safety alerts (including MHRA) are received by the practice, and then actioned if relevant. Put systems in place to ensure all clinicians are kept up to date with national guidance and guidelines.
- Ensure there is effective clinical leadership in place and a system of clinical supervision/mentorship for all clinical staff.
- Embed processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.

Action the service SHOULD take to improve

- Ensure policies and procedures are delivered consistently across the practice.
- Ensure an effective process is in place to collect and act upon feedback from staff and service users.

SSAFA Care CiC CRT/AVS Service

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a member of the CQC medicines team and a community nurse specialist advisor.

Background to SSAFA Care CiC CRT/AVS Service

SSAFA Care CIC (the provider) provide a seven day acute visiting service and clinical response team 'SSAFA Care CiC CRT/AVS Service' to the population of Leicester City, West Leicestershire and East Leicestershire. Three separate services are commissioned with three different Clinical Commissioning Groups. A clinical response team service is commissioned by Leicester City CCG and also with East Leicestershire CCG, a seven day acute visiting service is commissioned by West Leicestershire CCG. All three services are operated from one office which is located in the Grace Dieu Ward, Loughborough Hospital, Hospital Way, Loughborough, Leicestershire, LE11 5JY. Services began operating across Leicester City in 2013, across West Leicestershire in 2014 and across East Leicestershire in early 2016. Twelve vehicles are used by this service to visit patients in their own homes and are parked overnight in a secure area of the hospital.

The clinical response team provides services for the population of Leicester City and East Leicestershire from 8am until 8pm seven days per week. The seven day acute visiting service provides services for the population of West Leicestershire from 9am until 5pm Monday to Friday and from 9am until 8pm on a Saturday and Sunday.

The service employs nine staff which includes an assistant director of urgent community services whose main base is located in Doncaster and a clinical lead that is based at the location where services operate from. Each day, a team co-ordinator is on duty. The service employs mainly agency staff who provide emergency care practitioner duties including minor illness and minor injury and also dispense medicines to patients in the community.

GPs across all three CCGs triage their own patients and refer them directly into these services by telephone. A call taker records the details of the referral in paper format and allocates the patient for a visit by an ECP. Calls are received using mobile telephones and the service uses laptops which give all staff who are trained, access to a clinical system enabling staff to access patient care records to update details of visits when they have been undertaken.

At the time of our inspection, the provider was not registered correctly with the CQC. The location where services operated from had not been registered appropriately with CQC. Their statement of purpose had not been updated to reflect these services being provided. The provider addressed this immediately following our inspection.

Detailed findings

Why we carried out this inspection

We undertook this focused unannounced inspection in response to receiving information of potential concerns from various sources. These concerns were in relation to the safe management and security of medicines, concerns in relation to the storage of medicines and medical equipment in vehicles used by this service, information governance and the management of patient identifiable information and the suitability of clinical staff.

How we carried out this inspection

We carried out an unannounced focused inspection on 3 October 2016.

During our visit we:

- Spoke with a range of staff which included an assistant director of urgent community services, team co-ordinator who was also an ECP and two other ECPs on duty.
- We looked at two vehicles used by visiting teams to visit patients in their own homes and those residing in care homes.
- We looked at how medicines were managed and looked at the processes in place in relation to medicines management.
- We looked at clinical equipment used by this service which included equipment stored in vehicles.
- We reviewed a range of information which included policies and procedures, patient report forms and staff training records.

Are services safe?

Our findings

Safe track record and learning

There was not an effective system in place for reporting and recording incidents and significant events.

- We were told that there was an electronic system in place which enabled staff to report incidents. We were informed that two incidents had been reported across all three services since these services began. We saw evidence of these incidents during our inspection.
- During our inspection, we found patient identifiable information stored in a box file in a cabinet which was located in a lockable office accessible by staff only. Some of this information constituted reporting as an incident for further investigation. For example, we saw a patient care report with a note attached from a member of staff asking if this was being dealt with, a comment had been added to the top of this document which stated *red flag*. A further note was attached with an instruction from a member of staff to notify the referring GP practice about allegations of serious concerns in relation to a patient which staff may be required to visit in the future which may have posed a risk to members of staff when visiting this patient. We were unable to see evidence that this had been actioned, this had not been reported as an incident through the incident reporting system. We also saw information relating to a patient who had allegedly been given antibiotics inappropriately. We saw information regarding a deceased patient with a note attached which stated that the referring GP wanted a copy of this information for the Coroner's Office, there was no evidence that this had been actioned or dealt with. These incidents had not been reported through the incident reporting system, there was no evidence that further investigations had taken place or that that they had been actioned.

Overview of safety systems and processes

The provider did not have clearly defined and embedded systems, processes and practices in place to keep patients safe for example:

- The provider did not always maintain appropriate standards of cleanliness and hygiene. For example, we looked at two vehicles during our inspection and found sharps bins stored in the boot of these vehicles which were used by staff to visit patients. These sharps bins were more than three quarters full which was against best practice and national guidance in relation to the safe disposal of sharps, and increased the potential risk of a sharps injury. We also saw a full sharps bin stored in the passenger area of the vehicle. There was a safe use of sharps policy in place however this policy was last reviewed in 2014 and was not relevant to this service or location. We saw an infection management policy which was last reviewed in 2014 and was also not relevant to this service or location. The infection control lead was not named within the policy and we were informed during our inspection that the infection control lead was not based at the location where services, staff and vehicles operated from. There was no evidence that infection control training such as handwashing technique training for any members of staff including agency staff had taken place as part of an induction process for new members of staff or agency staff who may be new to this service. There was no cleaning schedules in place for clinical equipment at the time of our inspection.
- During our inspection, we observed clinical waste stored in the vehicles. Some clinical waste was not in clinical waste bags, we saw waste for example, swabs which appeared to be contaminated with bodily fluids which were distributed between the contents in the boot of the vehicle and medical gloves were found scattered on the vehicle floor. We found contaminated clinical equipment such as 'ring cutters' (used to remove rings from a patients finger in an emergency) in the vehicle. Immediately following our inspection, we were informed that these issues would be addressed with all members of staff. We were also informed that a full review of infection management procedures would be carried out.
- We saw two oxygen cylinders which were stored on the floor underneath a desk in the office. We were told by members of staff that these cylinders were empty and had been removed from a vehicle. We were told that there was no other storage available for oxygen bottles due to lack of space. These cylinders were not stored appropriately in line with the health and safety at work act 1974 HTM02 guidelines, the room was not labelled with appropriate warning notices. We were told during

our inspection that there was an agreement with the hospital to share their oxygen storage and that these cylinders would be removed from the office and stored appropriately.

- The arrangements for managing medicines, including emergency medicines for use by this service did not keep patients safe (including dispensing, recording, handling, storing, security and disposal). For example, we looked at two vehicles and within these vehicles we found numerous out of date medicines such as Adrenaline which had expired in August 2016, Paracetamol suspension which had expired in February 2016, Phenoxymethyl Penicillin suspension which had expired in August 2016 and sealed water for injections which had expired in September 2016. We found an open clinical waste bag which contained various antibiotic items. Medicines had been stored in these vehicles overnight and had been exposed to large variation in temperatures which may alter the effectiveness of these medicines. We were informed during our inspection that all medicines, equipment and clinical items were stored in the vehicles at all times and were not removed at the end of each shift. Immediately following our inspection, we were informed that both vehicles we looked at had been inspected and all out of date medicines were removed.
- Patient group directives (PGD's) were in use however, not all staff working under these PGDs had signed them, there was no evidence of allagency staff employed by this service who used these PGD's to ascertain which members of staff had or hadn't signed them. There was no evidence of authorisation of these PGD's within the organisation for use by the organisation. There was also no PGD in place for rectal paracetamol of which we found a stock of, we found two rectal paracetamol items in a vehicle which had expired in September 2016. We were given a copy of a 'new' PGD procedure that had been approved by the provider in January 2016, however this was not currently being used. This procedure stated that all staff could sign one sheet to state that they are working under a suite of PGDs which is inappropriate. This procedure also described arrangements for holding medicines contrary to what we saw during our inspection. Immediately following our inspection, we were informed that a process would be implemented to ensure all staff working under these PGDs read and sign them. Arrangements had been made for all PGDs to be signed by the organisation for use within the organisation. There was no stock control system in place for medicines transferred from the main stock at the Grace Dieu Ward to the vehicles.
- During our inspection, we requested to view a copy of the medicines management policies in place. We were provided with a 'British Forces Germany Health Service' medicines management policy that was out of date (date of r/v 7/2012). This policy did refer to this service and did not cover the processes we observed during our inspection.
- At the time of our inspection, there was no evidence of an effective process in place for the receipt of, dissemination and actioning of medicines alerts (MHRA). Immediately following our inspection, a member of the management team completed an on line registration to ensure alerts were received from MHRA for dissemination and actioning of these alerts within the service.
- During our inspection, we were provided with a copy of records of regular checks to ensure that members of the nursing team were registered with the Nursing and Midwifery Council (NMC). These records were for employed staff only. The day after our inspection we were provided with evidence that checks of NMC and other professional registrations had been carried out for 39 members of agency staff.

Monitoring risks to patients

Risks to patients were not assessed and well managed.

- We found defibrillator pads in a vehicle which had expired in April 2016 and there were no spare pads for use in this vehicle. The defibrillator had been stored in the vehicle overnight and exposed to large variations in temperatures. (Defibrillators should not be stored in temperatures below 0 degrees celsius, this is due to risk of prolonged exposure to freezing conditions causing the battery to deteriorate). We checked a pulse oximeter which did not work correctly.
- We found oxygen masks in vehicles which were out of date. For example, two paediatric masks had expired in February 2015 and an adult mask which had expired in January 2015. There was also oxygen tubing items which had expired in June 2015 and October 2015. We found oxygen valves which had expired in January and

November 2015. We found airways which had expired in April 2014 and July 2014 and also some airways which had expired in October 2015. We found five microlance needles which had expired in May 2014 and medical gloves which had expired in 2014.

- We were unable to see evidence of calibration of all clinical equipment in use. However, immediately following our inspection we were provided with an inventory of clinical equipment and calibration dates although some items still required calibration.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw evidence of rotas for clinical staff during our inspection for all three services.

Arrangements to deal with emergencies and major incidents

The provider did not have adequate arrangements in place to respond to emergencies and major incidents. For example:

- We did not see evidence of adequate security measures in place for lone workers when working in the community and visiting patients alone. There was a lone worker policy in place however, this policy was out of date, dated 2012 and referred to a risk assessment being carried out for all lone workers. We were unable to see any risk assessment during our inspection however, we were provided with seven risk assessments on 5 October 2016 although this was not for all members of staff including agency staff. The policy referred to security equipment which should be available in all vehicles for use by staff. We observed this equipment was not provided in vehicles as stated within the policy.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- The provider did not have effective systems in place to keep all clinical staff up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We were informed during our inspection that all clinicians were autonomous practitioners and were responsible for their own practice. However, immediately following our inspection, a member of the management team completed an on line registration to ensure alerts and updates were received from NICE for dissemination and actioning of these alerts within the service.

Management, monitoring and improving outcomes for people

There was evidence of audits which were completed on a monthly basis for each service. We saw evidence of a monthly audit for both the acute visiting service and the clinical response team services. These audits monitored activity rate, monitored referral rates into the services and reason for referral. PGD usage and types of medicines dispensed were monitored as well as diagnosis types.

There were no audits in place to monitor patient outcomes or the update of patient information following visits onto electronic patient care records. At the time of our inspection, we observed a hand written process for incoming referrals, these hand written details were then passed to the visiting emergency care practitioner (ECP). A hand written patient care report form was completed during a patient visit which would then be used to update electronic patient care records when staff returned to the main base. However, we were informed that not all staff were trained in the use of electronic patient care records, those staff that were trained would update patient care records which would enable the referring GP to view details of the visit to include any medicines which may have been dispensed to the patient. Those staff that were not trained to update electronic care records were required to fax a copy of the patient care report form to the referring GP. There was no system in place to ensure all electronic care records were either updated or that all information had been faxed. There was no system in place to check that contemporaneous records were recorded following visits.

We saw an example of a significant event which had been reported and investigated which had involved a patient being given a medicine which they had sensitivity to. A lesson learned from this incident was for all clinicians who do have access to electronic patient care records were to ensure they utilised their full access to summary care records to check for any allergies the patient may have.

Effective staffing

- At the time of our inspection, we were unable to ascertain if staff including all agency staff had the skills, knowledge and experience to deliver effective care and treatment. However, details of all agency staff were provided on the 5 October 2016 which included details of their professional registration.We had no assurances regarding the suitability and qualifications of agency staff employed to carry out the duties expected of them as at the time of our inspection, we were unable to see evidence of qualifications and training for all agency staff used. There was no system in place to ensure that all agency staff were up to date with mandatory training requirements.
- Induction programmes for all newly appointed staff or agency staff that were new to this service were not effective. We saw examples of induction forms during our inspection, however these forms were incomplete. Staff we spoke with were unable to provide details of all members of staff who covered shifts for this service including those who had been employed through an agency.
- The learning needs of staff were identified through a system of appraisals for those staff who were directly employed. However, there was no process in place for the effective monitoring or clinical supervision of both employed or agency staff including competency assessments of staff or coaching and mentoring to meet their learning needs and to cover the scope of their work. Immediately following our inspection, we were provided with information in relation to clinical supervision processes in place. However, we were not provided with documentation evidence to support this. We were told that the provider would ensure all one to one meetings would be documented and held on personnel files and dates would be diarised to ensure sample audits of clinicians patient report forms were carried out as per policy.

Are services effective?

(for example, treatment is effective)

- We were provided with evidence of staff training that included: safeguarding, fire safety awareness, basic life support and information governance. However, these records were for employed staff only, not all members of staff had completed these training requirements for example, six out of nine members of staff did not have details of safeguarding children training recorded. Five out of nine members of staff did not have information governance training recorded and six out of nine members of staff did not have safeguarding adults training details recorded. There were no records of mandatory training for all agency staff. Staff we spoke with told us they had not had basic life support refresher training arranged for them. Basic life support training did not appear on the register of training we were provided with. Immediately following our inspection, we were informed that the provider would ensure all staff complete all mandatory training requirements.

Coordinating patient care and information sharing

- This service used mobile telephones to receive incoming patient referrals. We were advised that calls received were recorded for a period of six months. Laptops were used by the service which gave access to electronic patient care records for all patient registered with GP practices across all three CCGs. We were advised that some staff were trained in the use of electronic patient care records and some staff were not trained. We were informed that those staff trained would update electronic patient care records following visits. Those staff untrained were required to fax patient information to the referring GP. Hand written records were taken of clinical details when accepting referrals. There was no audit processes in place to ensure that all patient information following visits was either updated onto the electronic patient care record received by the referring GP or that contemporaneous records were recorded.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Governance arrangements

The provider had an overarching governance framework in place, however there was not an effective governance structure in place at the location where services operated from to support the delivery of the strategy and good quality care. For example:

- During our inspection we saw limited policies and procedures in place. Those we did see such as infection control, lone working and medicines related polices were either out of date and/or did not refer to this service or location.Following our inspection, we were informed that a full review of all policies and procedure would be carried out.
- There was a lack of clinical supervision, leadership and clinical oversight on site on a daily basis. At the time of our inspection, the clinical lead was on a period of annual leave, there was no other clinical lead in post to cover his duties. We were informed that previously, two clinical leads had been in post however one clinical lead had left employment which had left this post vacant. There was however a team co-ordinator on duty who took responsibility for the shift on a daily basis.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not robust. We did not see evidence of a risk register or risk assessments in place during our inspection.
- There was no system in place to ensure regular driving licence checks were carried out for all staff including agency staff.

Seeking and acting on feedback from patients, the public and staff

The provider did not have an effective process in place to gain feedback from patients, the public and staff. For example:

- We were informed that patient surveys were carried out bi-annually however, we did not see evidence of patient feedback results, reports or action plans implemented as a result of during our inspection. During our inspection, we did see some examples of completed care home manager surveys which had been received.
- The provider held monthly meetings which staff were invited to attend however these meetings were for employed staff only. Immediately following our inspection, we were provided with evidence which showed that 39 members of staff were employed through an agency compared to nine members of staff who were directly employed. There was no mechanism in place to gain feedback from agency staff.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. For example: The provider did not have systems in place to properly assess and mitigate against risks including risks associated with infection prevention and control, managing emergency situations and risks associated with lone workers including lone worker risk assessments and completion of driving licence checks. There was a lack safe of systems and processes in place in relation to medicines including emergency medicines, PGDs, clinical items and clinical equipment. There was not an effective process in place for reporting, recording, acting on and monitoring significant events, incidents and near misses. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. **How the regulation was not being met:**

This section is primarily information for the provider

Enforcement actions

The provider did not have effective governance arrangements in place including systems for gaining assurance of the suitability, professional registration and qualifications of all staff including agency staff, and effective processes for the induction and identification of new staff and clinical supervision, mentorship and support for all staff including agency staff. The provider had not ensured all staff had completed all mandatory training requirements.

The provider did not have a programme of regular audit or quality improvement methods to assess, monitor and improve the quality and safety of the services provided.

The provider did not have effective governance arrangements in place in relation to information governance including systems to monitor patient identifiable information and update and quality of patient information into electronic patient care records.

Policies and procedures were not consistently implemented, reviewed, updated and followed across the organisation.

Effective clinical leadership was not in place on a day to day basis or a process of formal clinical supervision, mentorship and support in for all members of staff including staff provided through agencies.

There was no evidence of an effective system being in place for dissemination, reviewing and actioning NICE and MHRA alerts or evidence of any actions taken.

These matters are in breach of regulation

17(1) Health and Social Care Act 2008 (Regulated Activities) Regulations