Ami Lodge

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Ami Lodge is operated by Raj & Knoll Limited. The service has 28 beds. The building for Ami lodge was not purpose-built and had been modified to provide rehabilitation care. Ami Lodge is split over two floors, has 27 rooms and can accommodate 28 patients. All rooms with the exception of four, has ensuite facilities.

The service provides rehabilitation and support for patients in a residential setting who have just come out of hospital. This service is commissioned by a local NHS trust.

We inspected this service using our comprehensive inspection methodology.

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

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

Services we rate

We rated the service as inadequate overall.

- The service did not have managers at all levels with the necessary experience, knowledge, and skills to lead effectively, and provide high-quality sustainable care. Managers were not always aware of the risks, issues and challenges in the service. Leaders are not always clear about their roles and their accountability for quality.
- The service did not proactively identify where quality improvements could be made to the service and to patient care.
- The service did not have a clear governance structure. There was a lack of clarity for roles and responsibilities and a lack of accountability to support good governance. We found limited structures, processes and systems in place to support the delivery of good quality, sustainable patient care.
- The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service did not routinely collect, manage and use information to support all its activities.
- The service did not always manage patient safety incidents. The service did not have an incident reporting policy. The service lacked organisational learning, and made no changes to issues identified from incidents.
- Patients were not adequately monitored for the risk of deterioration. We found the service did not learn from patient transfers and therefore did not make improvements to the service as a result.
- The service did not have a clear or formal eligibility criteria to admit people to Ami Lodge from the commissioning NHS trust.
- Staff did not consistently keep appropriate records of patients' care and treatment. Records were not always legible, and there were gaps in the documentation. Nursing records were kept separately to the main patient records.
- Safety checks provided false assurance, as they were not fully accurate or contemporaneous.
- The service did not formally collect safety performance data. The service did not discuss safety data in meetings or use it to drive improvements to the service or patient care.

Summary of findings

- The service provided mandatory training in key skills to all staff but did not ensure everyone completed it. The data provided to us showed that staff had only achieved the completion target of 80%, on two out of 15 occasions.
- There were processes to protect patients against cross infection. However, these systems were not always effective. There were limited formal systems for monitoring staff compliance with infection prevention and control practices.
- The service did not have systems that monitored the effectiveness of care and treatment. Information about the outcomes of patient's care and treatment was not routinely collected and monitored.
- There was a lack of auditing to ensure compliance with policies and clinical practice. Audits that were in place, either lacked an action plan or where action plans were available, there were no timescales or people accountable for making sure the actions were implemented.
- The systems and processes for policy development and review were not effective. We found that some policies either did not have a review date or were out of date.
- The service did not have an adequate process to ensure people's concerns and complaints were listened to and used to improve the quality of care. Complaints were not monitored over time, and the managers did not monitor complaints for trends and themes, or to identify areas of risk.

However, we found the following areas of good practice:

- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise distress. Staff were on hand to offer emotional support to patients and were very happy to offer a listening ear. Patients told us they felt able to approach staff if they felt they needed any aspect of support.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients told us they were kept informed and included in their care decisions and treatment.
- Patients told us they were given time, could ask questions, and felt included in the decisions about their care.
- There were systems and processes to assess, plan and review staffing levels at the location, including staff skill mix.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.
- Staff gave patients enough food and drink to meet their needs. Nutritional assessments were completed on admission.
- Staff monitored and assessed patients regularly to see if they were in pain. Patients told us that staff would ask them regularly if they had pain, and would offer pain relief medication.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide care. Staff respected their colleague's opinions.
- The service took account of patient's individual needs.

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Inadequate 	Rehabilitation and support services were the main activity at the location. We rated this service as inadequate in the safe and well led domains. Requires improvement in effective and responsive, and good for caring.

Summary of findings

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Inadequate

Ami Lodge

Services we looked at
Community health inpatient services

Summary of this inspection

Background to Ami Lodge

Ami Lodge is part of Raj & Knoll Limited, based in Deal Kent. The service opened in 2014. Ami Lodge provides rehabilitation and support in a residential setting for up to 28 patients who have just come out of hospital. This is commissioned through a local NHS trust.

The provider Raj & Knoll Limited has been registered with the Care Quality Commission since 2010. Originally, the organisation registered to provide residential or nursing home care at Ami Court and The Knoll Nursing Home. Ami Lodge was added in 2014. Brooke Lodge was added in 2018.

The service has 33 staff that work across all locations. The building for Ami lodge, was not purpose-built and has been modified to provide rehabilitation care. Ami Lodge is split over two floors, has 27 rooms and able to accommodate 28 patients. All rooms except for four have ensuite facilities.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, one CQC inspector, and one specialist advisor with expertise in rehabilitation services.

The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Ami Lodge

Ami Lodge is based in Deal, Kent. They provide rehabilitation beds which are commissioned by the local NHS trust.

Ami Lodge is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Accommodation for persons who require nursing or personal care

During the inspection, we visited all areas of the service. We spoke with 10 staff including; registered nurses, health care assistants and senior managers. We spoke with four patients and one relative. We also received three 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed seven sets of patient records.

The service had no ongoing special reviews or investigations by the CQC at any time during the 12 months before this inspection.

The service was last inspected in May 2014 and was found to be compliant with the six outcomes inspected at that time. There were no previous requirement notices or enforcement actions associated with the service.

We inspected this service using our comprehensive inspection methodology.

Activity (November 2017 to October 2018)

- In the reporting period November 2017 to October 2018, there were 287 admissions to the service.

On 13 November 2018, the service told us they did not report incidents but they reported accidents involving staff or service users and issues with hospital admissions errors. However, on 22 November 2018, during our interview with the registered manager and the clinical lead, we were told the service reported incidents.

Track record on safety:

- Three incidents
- 71 accidents
- One complaint

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rates safe as inadequate because:

The service did not always manage patient safety incidents well. There were ineffective systems for reporting, monitoring and learning from incidents, including 'near misses'. The service did not have an incident reporting policy. We did not see incidents or accidents discussed at any of the meeting minutes reviewed. The service lacked organisational learning, and made no changes to issues identified from an incident.

Patients were not adequately monitored for the risk of deterioration. The service took patients vital signs twice a day, this did not include temperature or respiration rate. We reviewed the records of two patients who were transferred to the acute hospital with possible sepsis. We found the service did not learn from the patient transfers, or make improvements to the service as a result.

There was no clear or formal eligibility criteria to admit people to Ami Lodge from the commissioning NHS Trust.

Staff did not consistently keep accurate records of patients' care and treatment. We looked at seven sets of patient records, and found they varied in quality and completeness. Records were not always legible, and five out of seven had one or more gaps in the documentation. Records were not multidisciplinary. We saw nursing records were kept separately to the main patient records, where the healthcare assistants and the therapists documented.

Safety checks provided false assurance, as they were not fully accurate or contemporaneous. We found they were not consistently completed and we saw examples where sections of the record were completed retrospectively, long after the check or intervention had taken place.

The service did not formally collect safety performance data. We did not see safety data discussed in meetings or used to drive improvements to the service or patient care.

The service provided mandatory training in key skills to all staff but did not ensure everyone completed it. The data provided to us showed that staff had only achieved the completion target of 80%, on two out of 15 occasions. There was no system for monitoring staff mandatory training compliance.

Summary of this inspection

There were processes to protect patients against cross infection. However, these systems were not always effective. There were limited formal systems for monitoring staff compliance in infection prevention and control practices.

However:

There were systems and processes to assess, plan and review staffing levels at the location, including staff skill mix.

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The service gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

The service had suitable premises and equipment and looked after them well. The environment in all areas we visited appeared uncluttered and tidy.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

The service did not have systems to monitor the effectiveness of care and treatment, and did not consistently use the findings to improve them. Information about the outcomes of people's care and treatment were not routinely collected and monitored.

There was a lack of auditing to ensure compliance with policies and clinical practice. Audits that were in place, either lacked an action plan or where there were action plans, there was no timescale or designated person responsible for making sure the non-compliance was addressed.

The policy development systems were not effective. We found some policies did not have a review date or were out of date. In addition, we found policies had been brought over from other providers. We saw the policies had not been adapted for the service, and still had the original NHS logos.

The service made efforts to ensure staff were competent for their roles but did not always ensure staff had the right training to undertake their roles safely. We saw 100% of staff had an appraisal. We found the system did not always identify training needs or development opportunities for staff, or set objectives for the coming year. The records were kept in a folder, which were untidy, and it was difficult to see which records were the most up to date.

However:

Summary of this inspection

Staff gave patients enough food and drink to meet their needs. Nutritional assessments were completed on admission. We saw this was completed on admission in all the records we reviewed. During our inspection we looked at 18 patient surveys and saw 12 out of 18 rated the food as 'excellent', and six responded 'good'. We spoke with four patients, who all spoke positively about the quality of the food offered.

Staff monitored and assessed patients regularly to see if they were in pain. Patients told us that staff would ask them regularly if they had pain, and would offer pain relief medication. The service did not use pain scores to measure the level of pain.

Staff with different skills worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide care. Staff respected their colleague's opinions.

Are services caring?

Good

We rated caring as good because:

Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.

Staff provided emotional support to patients to minimise distress. Staff were on hand to offer emotional support to patients and were very happy to offer a listening ear. Patients told us they felt able to approach staff if they felt they needed any aspect of support.

Staff involved patients and those close to them in decisions about their care and treatment. Patients told us they were kept informed and included in their care decisions and treatment. Patients told us they were given time, could ask questions, and felt included in the decisions about their care.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

The service did not plan or provide services to fully meet the needs of the local population. The service did not arrange to meet regularly with the commissioning NHS trust.

The service did not have an adequate process to ensure people's concerns and complaints were listened to or used the information to improve the quality of care. Complaints were not monitored over time, and the managers did not have oversight of complaints to monitor trends and themes, or identify areas of risk. The service did not signpost complainants to the relevant ombudsman if a complainant remained unhappy with the response

Summary of this inspection

Although people could access services when they needed them, we were unable to determine the criteria for admission to the service.

The service did not have access to an interpreting service for patients whose first language was not English.

However:

The service took account of patient's individual needs.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

The service did not have managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. Managers did not have a good knowledge of performance in their areas of responsibility and did not understand the risks and challenges to the service.

The service lacked an internal process that proactively identified where quality improvements could be made to the service and patient care.The service did not have a clear governance structure. There was a lack of clear roles, responsibilities and systems of accountability to support good governance. We found limited structures, processes and systems to support the delivery of good quality, sustainable patient care.

The service did not have effective systems for identifying risks, planning to eliminate or reduce them or coping with both the expected and unexpected. The service did not have a risk register, but following inspection sent us a list of all risk assessments, title risk register. The 'risk register list' was not dated, contained no explanation of the risks, and there were no named members of staff that had responsibility to make sure existing risk controls and actions were completed for each identified risk, or a date for completion recorded. We did not see risks or the risk register list discussed at any of the meeting minutes we reviewed.

The service did not routinely collect, manage and use information well to support all its activities.

There were limited systems to gather staff feedback to enable more effective working and patient feedback to improve patient experiences.

However:

Staff within the service were committed and passionate about the work they did. Staff we spoke with showed a positive attitude towards caring for patients.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Inadequate

Community health inpatient services

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

Are community health inpatient services safe?

Inadequate

We rated safe as **inadequate**.

Mandatory training

The service provided mandatory training in key skills to staff not all staff had completed all the required mandatory training. There was no system for monitoring staff compliance with mandatory training.

Managers provided us with the mandatory training completion rates. The information was not recorded in one place. We were told they were in the process of making the information available in one place for managers to access. Following the inspection, the service sent us the new training matrix, which showed dates when mandatory training had been completed.

Mandatory training covered a range of 15 topics including safeguarding, infection control, first aid awareness, fire training, dementia care, moving and handling and equality and diversity. Data provided to us as part of the inspection, showed that staff had only achieved the completion target of 80%, on two out of 15 occasions (dementia care and fire training). Managers told us they reminded staff during staff meetings to complete their mandatory training. We looked at two team meeting minutes during our inspection for 3 May 2018 and 21 June 2018. We saw staff were reminded at the May meeting, but this was not discussed at the June meeting. In addition, we did not see that mandatory training compliance was discussed with staff at appraisals. The service could not be confident that all staff had the correct skills, knowledge and competence to keep patients safe.

Managers told us that staff were given access to an electronic tablet and a computer to complete the on-line training at work. However, they confirmed that staff would be expected to complete training at home.

We looked at the team leaders' minutes for 21 October 2018, where the deputy manager for the location attends, and saw mandatory training compliance rates were not discussed.

We looked at the minutes for the operational team meeting for 14 August and 19 October 2018. We saw training was discussed in the minutes of 19 October 2018, and how this could be made accessible to staff who did not have access to their own laptop or phone to complete the training. We saw an action arising from the meeting to provide group sessions of online training. However, it was unclear who was responsible for this action or when it would be completed, as there was no designated person for the action or an expected completion date.

Seven members of staff had completed 'train the trainer' courses and were able to provide face-to-face training to staff for moving and handling, infection prevention and control, nutrition and fluids, health and safety and food hygiene.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Overall 79% of staff had completed safeguarding training, which was just below the service target of 80%. Of these, 92% of nursing staff and 65% of healthcare assistants had completed the training. The safeguarding policy did not refer to the level of training staff were required to have.

Staff we spoke with had a good understanding of how to recognise a safeguarding issue, how to escalate this and report to the local authority safeguarding team. We saw posters around the location in communal areas and information in the staff room, which showed who to contact in the event of a visitor or staff member identifying a safeguarding concern.

Managers told us they only knew a safeguarding alert had been raised when the local authority team arrived at the location. In addition to this, they did not receive information about alerts and so were unable to carry out their own investigation. They told us they did not receive an outcome of the investigations.

Cleanliness, infection control and hygiene

There were processes to protect patients against cross infection. However, these systems were not always effective. There were limited formal systems for monitoring staff compliance in infection prevention and control practices.

The service had a range of up to date infection prevention and control policies for staff to follow. These included but were not limited to hand hygiene, waste management, and blood spillage.

We saw personal protective equipment, and hand-sanitising gel was available throughout the location.

Infection prevention and control training was mandatory for all staff. We saw from the figures provided that 49% of staff had completed this training against a target of 80%. Hand hygiene assessment was included in the mandatory training, we saw 74% of staff were compliant with the training which was below the target of 80%.

During our inspection we saw multiple staff had worn wrist watches and false coverings on their nails (including false colourings and or coverings such as false nails). We were told the service audited hand hygiene compliance. We requested to see the last three audits but the service did not supply them.

We were told the service monitored rates of infection. We asked how the data was collected and how it was stored and reviewed. The clinical lead told us it was not formally documented, but they confirmed there had been no infections at the service within the reporting period. However, there had been 59 transfers to the acute hospital from the location. The service was only able to tell the reasons for transfer for 20 out of 59 patients. Out of the 20 patients, whose reason for transfer were known, four were transferred with possible sepsis and one had a wound infection.

We saw waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations.

There were 'sharps' bins available for staff to use. We looked at two and noted that the bins were correctly assembled. However, one sharps bin was in use and had not been signed and dated when first used. None of these bins was more than half-full, which reduced the risk of needle-stick injury. We saw posters displayed which outlined what action must be taken if a member of staff sustained a sharps injury. We saw needle-stick injury training was provided. However, we saw only 21 out of 33 staff had completed this training.

Disinfectant/detergent wipes were available to clean equipment between patient contacts. Most equipment we checked was visibly clean. However, we checked two commodes that were not clean and they were stored with clean equipment. We told the deputy manager immediately, who confirmed there was no system to check and make sure these items were clean and safe to use.

We checked zipped/foam items such as pressure relieving cushions and static mattresses. We found one out of four mattresses and three out of six pressure relieving cushions had lost their impermeable protection and were visibly soiled when opened. We were told these items were not routinely checked. These items are a potential risk for cross infection. At our return visit on 22 November 2018, we saw the service had removed some of the pressure relieving cushions from the patient areas.

Inadequate

Community health inpatient services

Following the inspection, the service sent us their 'Mattress, Pillows, Chairs and Pressure Cushion Cleaning Policy and Procedure', dated 23 November 2018. This included a copy of their newly implemented audit tool for monitoring zipped/foam items.

As all patients were nursed in single rooms any patients with an infection were isolated. We spoke with staff who could tell us the infection control precautions they would put in place in the event of a patient developing an infection. There was one patient in isolation due to an infection, we saw there were gloves and aprons available for staff to use when delivering patient care. However, we did not see any notices on the door, informing staff or visitors of a potential risk. This could put people unfamiliar with or who had not worked at the location for a while (and did not know the patients) at risk, as they may not take the appropriate precautions to prevent the spread of infection.

The sluice room for the location was small. A small sink for hand washing was available. There was no bin present in the room to dispose of personal protective equipment or paper towels.

The service had a food hygiene rating of five out of five, which was completed in October 2018.

Cleaning products and equipment were not stored securely. A cleaner's cupboard contained all the cleaning equipment. We found the door unlocked, with the key in the lock. When staff did lock the door, they hung the key on a hook next to the door frame. It was generally untidy and not well ordered.

Cleaning products managed under the control of substances hazardous to health, were kept in the cleaner's cupboard. We saw three products stored at a height a child could reach, one was stored on a shelf higher. Two of the products were corrosive, but this was not clearly displayed to anyone looking at the cupboard. Neither the name of the product nor the hazard label was clearly visible. The product had to be removed for the label to be visible and the handle was covered with its contents.

During our inspection we looked at 18 patient surveys and saw 12 out of 18 rated the cleanliness as 'excellent', and six responded 'good'.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The environment in all areas we visited appeared uncluttered and tidy.

The building for Ami lodge was not purpose-built and had been modified to provide rehabilitation care. Ami Lodge was split over two floors, had 27 rooms able to accommodate 28 patients. All rooms with the exception of four had ensuite facilities. There was a dining room on the ground floor and a gymnasium on the first floor.

The service had a lift and stair lift available for patient and staff to gain access to the second floor.

In each room there was an electric bed, chest of drawers, wardrobe and lockable medicines cupboard for the patient's own medicine. Bedroom doors had no window recesses which meant staff could not see into the room if the door was closed. The ensuite facilities in the rooms consisted of a toilet and hand wash basin. We saw that there were rails present to help patients with their stability.

There were separate bathroom facilities, that had easy access showers, with no steps, and had handrails and chairs to provide extra support and stability when showering.

We saw bedroom windows had window restraints. **Window restraints** are devices that are fitted to windows, which prevent the window from opening more than a few inches.

All the bedrooms at the locations had call bells as well as inside the ensuite facilities, and shower rooms which meant patients could alert staff in an emergency. We asked if the emergency call bells were checked. The service could not be confident the emergency call system would work during an emergency as the clinical lead told us call bells were checked on an ad hoc basis, and was not formally recorded.

Patients we spoke with confirmed staff came promptly when they pressed the bell. However, we heard one patient who remained in their room calling out. The patient did not have a call bell near them and had been shouting for help. A member of the inspection team informed a member of staff that the patient required help.

The therapy gymnasium had parallel bars and sufficient equipment to support rehabilitation of patients. There was also a kitchenette located next to the gymnasium where staff could carry-out kitchen assessments and use for functional rehabilitation.

We saw there was a rolling programme of planned preventative maintenance for equipment. The provider serviced equipment regularly and the service records showed equipment had been serviced within the 12 months prior to inspection. We saw an electrical safety check certificate, dated December 2017. We saw all five pieces of equipment had safety checks completed within the last 12 months.

Staff told us there were no issues accessing equipment for patients who were being discharged home. They could order items from an external provider, to be delivered to a patient's home.

Assessing and responding to patient risk

Although some risks to patients were assessed, systems to assess risks to patients and to monitor their ongoing safety were not consistently applied. For example, patients were not adequately monitored for the risk of deterioration.

Ami Lodge did not have a clear or formal eligibility criteria for admitting people to Ami Lodge from the commissioning NHS Trust.

Referrals were emailed to the service, which included relevant patient information, including, patient details, past medical history, reason for referral and mobility assessment. This was initially reviewed by the deputy manager and passed to the registered manager, to confirm they fulfilled the admission criteria.

On 13 November 2018, staff told us there was a 'trusted assessor policy' that existed between the service and the commissioning NHS trust, to decide which patients could be transferred between the services. The deputy manager told us they did not have access to the policy, but the registered manager did. We saw an email, dated 20 November 2018, where the registered manager had requested the trusted assessor policy, however the commissioning NHS trust told us they did not have a trusted assessor policy.

We asked the registered manager at interview if there was a criteria or policy for admission to Ami Lodge. The clinical lead confirmed there was, but explained this was being updated as they felt they needed to have something more robust after the recent inspection of their other locations. We looked at the 'pre-admission policy' (dated 1 February 2018), which was a generic policy for admission to the provider at any of their locations, and did not outline criteria for admission to Ami Lodge.

On admission to the service, patients were assessed for risk through a set of risk assessments and transfer records from the local acute NHS trust. Risk assessments were completed in areas such as manual handling, mobility, falls, and skin integrity. In the records we looked at we saw these risk assessments had been completed, however they were not always updated. In addition, we found some risk assessments such as the malnutrition universal screening tool, was brought over from another provider and still had the original logo. This was dated 2008, and had not been updated or adapted for use by the service.

Patients were not adequately monitored for the risk of deterioration. The service had a policy for the management of deteriorating patients. We saw the policy was out of date, and had been brought over from another provider. The policy still had the original provider's logo in place, and had not been adapted for use at the service. For example, the policy referred to the use of early warning scores to highlight the potential early signs of deterioration of a patient's condition. Early warning scores were not in use at the service.

The service took patients vital signs twice a day. We saw staff took vital signs such as pulse, blood pressure and oxygen saturation levels. Vital signsare animportantpart of patientcare. They determine which treatment protocols to follow, provide critical information needed to make life-saving decisions, and confirm feedback on treatments performed. These were recorded in a central book, and then transferred to patients' records.

However, we saw that patients' temperatures and breathing rates were not routinely taken. Measuring a patient's temperature and respiration rate are useful

indicators of change in someone's clinical condition, and should be measured regularly. If a patient was deteriorating, the nursing staff would not be aware early enough to take preventative action.

The clinical lead told us they only recorded blood pressure, pulse and oxygen saturations, as they felt these were the most basic vital signs to monitor patients. They would only monitor a patient's temperature if they had concerns about a patient's condition and would increase the frequency of their vital sign monitoring. If a patient was on oxygen, they would monitor a patient's respiration rate. This was not evidenced-based but something they had always done at the location.

Between November 2017 and October 2018, there had been 59 transfers to the acute hospital from the location. The service did not record or review patient emergency transfers to an acute hospital. They could not identify risks or make improvements to the service if required.

We reviewed the records of two patients who had been transferred to the acute hospital with possible sepsis. We found the service did not learn from the patients' transfers, or make improvements to the service as a result.

In the first record we found that the patient's vital signs were not always recorded on their observations charts, but were written in the nursing records. This meant staff could not monitor or assess patients adequately, looking for changes or trends in their vital signs. We did not see an increase in frequency of vital signs, or that temperatures were taken.

In the second set of records, we found the patient's vital signs were recorded twice daily. We saw the patient had a temperature recorded which was higher than a normal temperature. Medication was given to reduce their temperature; however, we did not see evidence that the temperature had been taken to check the effectiveness of the medication. We did not see an increase in frequency of observations recorded or evidence that temperatures had continued to be monitored. The patient was transferred to the acute hospital two days later, following review by the GP. We did not see documentation of the review by the GP.

Staff told us in an emergency they would call 999 and the patient would be transferred to the local NHS acute hospital via an ambulance. Staff could give us examples of when this had occurred and how the situation had been managed. We were told all staff had basic life support training. However, this was not part of the mandatory training. We requested the training compliance rates but the service did not supply them.

We looked at a folder containing details of fire safety checks. We saw a record of annual servicing of the fire alarm, an external fire safety review had been completed annually and the most recent was dated February 2018.

Fire doors without automatic locking mechanisms were shut, luminescent strips were intact and fire extinguishers were located in communal areas of the locations. All extinguishers in seven different areas of Ami Lodge we looked at had service checks in the 12 months prior to inspection.

A fire drill occurred during the inspection. The alarm sounded clearly, automatic release mechanisms ensured doors shut and staff assembled in one area. Staff told us they assembled in one area so the nurse in charge could check the fire panel, to see where the fire was and decide what the next action to take was. However, during this period patients throughout the location were left unattended.

Staffing

There were systems and processes to assess, plan and review staffing levels at the location, including staff skill mix. Rotas were planned and covered all locations for the provider, including Ami Lodge. This allowed for adjustments to be made to make sure the correct skill mix was in place to ensure safe patient care. Shortfalls in staffing levels were covered by either their own staff, the registered manager or clinical leads.

At the time of inspection, the organisation had eight whole-time equivalent registered nurses and 25 whole-time equivalent nursing assistants. The service told us they currently had no vacancies. Staff turnover was low with three (10%) substantive members of staff leaving in the last 12 months. The vacancy rate was 0%, following a recent recruitment drive.

The service used a dependency tool to decide the number of nurses that are required. Additional staff are brought in when required. For example, at Christmas or patients' birthdays, national events such as the royal wedding or World Cup.

The service had a low sickness rate during the reporting period, which was 3%.

Staff told us the amount of staff was 'about right' to provide good nursing care. Patients told us they felt safe and there were adequate numbers of staff to meet their needs.

A physiotherapist, an occupational therapist and an occupational therapy technician worked at the location. They attended the location every day. They told us there was usually two of them present and staff from the acute trust would come across to support in the event of sickness absence.

They adjusted the times of attending the service dependent on the number and type of patients they were seeing.

Records

Staff did not consistently keep appropriate records of patients' care and treatment. Most of the records we reviewed were not accurate, legible, or complete. Methods to audit record keeping were not fully developed and the service audited care plan completion, but did not audit compliance with record keeping standards. There was clear recording from physiotherapists and occupational therapists.

Patient medical records were paper based. At the time of inspection, when medical records were not in use they were stored in the main office.

We looked at seven patient medical records, and found they varied in quality and consistency. Records were not always legible, and five out of seven had one or more gaps in the documentation. For example, a patient specific identifier was not included in all documentation, records were not all signed and dated.

Safety checklists staff were required to be completed for all patients receiving care and treatment at the location were not consistently completed. We saw many examples where sections of the record were completed retrospectively and after some considerable time following the check/intervention taking place. In one patient record we found the safety checklist had been fully completed on six out of ten occasions when the patient had not been at the premises.

Patients were routinely assessed for the risk of developing pressure ulcers, on admission. However, in one set of records we found conflicting information as to whether a patient had a pressure sore. We saw in one entry it was documented the patient had developed a 'red' area. Reddening of the skin, can be an early sign of pressure damage. We saw all subsequent entries for three days stated the patients pressure areas were intact, and did not mention any discolouration of the skin. Three days later the patient had developed a pressure sore.

Records were not multidisciplinary. We found healthcare assistants and therapy staff documented in one set of records, and registered nursing staff documented in a different set of records. This is not line with National Institute for Health and Care Excellence quality standard 15, statement 12, patient experience in adult services, which says health and social care professionals should ensure they support coordinated care through clear and accurate information exchange.

In addition, we looked at patients records who had been transferred from the location to the acute hospital with possible sepsis. We were told patients were transferred following review by the GP. We did not find a written record of the GP's review, assessment and rationale for sending the patient to the acute hospital.

There were no systems to audit the quality or compliance with record keeping standards. The service audited completion of care plans, and we saw in the general staff meeting compliance with documentation was discussed. There was an action resulting from the meeting to audit care plan for improvements. However, we did not see any feedback or results from this audit in the following meeting in June 2018, or any of the other meeting minutes we looked at. This showed the service had false assurances about record keeping standards, and did not use audit results to drive improvements to the service or patient care.

Medicines

Staff gave, and recorded medicines well. Patient's received the right medication and the right dose at the right time. Fridge and room temperatures were recorded. The service had recently implemented

weekly, monthly and six-monthly medicine audits. However, it was unclear when the service had non-compliance, and not all non-compliance had associated actions.

Staff stored medicines securely. We saw locked 'pods' available to hold patients' own drugs securely while they were in each room. We checked the medicines in the pods against prescription charts and dispensing labels, and saw they were correct.

Controlled drugs, such as morphine, are a group of medicines liable for misuse that require special management. All controlled drugs were kept securely in suitable locked cupboards, which were bolted to the wall and access to them was restricted. We saw the controlled drug register was completed, had the correct balance recorded and dated with two staff signatures.

Appropriate medicines were stored in dedicated medicine fridges, records showed daily temperature checks were undertaken. This provided assurance that refrigerated medicines within the recommended temperature range to maintain their function and safety. We also checked the records for the ambient temperatures of the treatment room, where medicines were stored, which showed these had been completed correctly.

The GP visited the location weekly, and would review patients' medicines. Any changes or additional medication would be prescribed on their medicine chart. The clinical lead explained if any medicine had been discontinued prior to discharge, this would be crossed off the patient's electronic discharge note, and would be dated and signed.

We did not see results of medication audits used to improve patient care or service delivery and they were not discussed at any of the meetings minutes we looked at.

The service had recently implemented weekly, monthly and six-monthly medicine audits. They told us this was in response to an audit by an outside pharmacy. We saw the weekly and monthly checks for September, October and November 2018. It was unclear when the service had non-compliance as we saw the 'findings' section was completed with either a 'yes', 'no', a tick or a cross. For example, on the weekly audit for 12 October 2018, we saw both 'have daily audits been undertaken' and 'are there any excesses or out of date medication requiring disposal', had crosses indicated in the findings. Neither had any actions associated with the findings, it was unclear if this meant non-compliance, as we saw on other sections the auditor had recorded 'not applicable'.

We also saw not all non-compliance had associated actions. For example, we saw the monthly audit dated 26 October 2018, recorded non-compliance against the standard 'are all medicines correctly checked in'. In the action section we saw it stated 'some issues with hospital admissions due to difference in boxes'. However, there were no actions documented on how to meet the standard.

Within the reporting period, there was one medicines incident reported. This was a member of staff who dropped a controlled drug on the floor, which had broken.

Safety performance

The service did not formally collect safety performance data. We did not see safety data collected, discussed in meetings or used to drive improvements to the service or patient care. In addition, we found the safety checks provided false assurance, as they were not fully accurate or contemporaneous.

Managers told us all patients were risk assessed on admission and regularly throughout their stay. Patients risk assessments included falls and pressure ulcers.

The service monitored falls as part of safety data collection. However, there was no evidence of learning from falls or any improvement as a result. Incidences of falls were not discussed at any of the meeting minutes we looked at. The service told us they looked for themes and trends for falls and found none. We reviewed the falls data and found at least one unwitnessed fall occurred every month. There was a lack of organisational learning around falls. We saw the service falls risk reduction strategy was to remind patients to use their call bell if they needed help.

We asked the registered manager if they monitored pressure ulcers. They told us they monitored them in their other locations, but not at this location. This was because there were "practically" no pressure ulcers at this location. However, we highlighted concern about

pressure area management and documentation. The registered manager confirmed pressure area management and tissue viability was one of their top three concerns for the location.

At an interview, the registered manager and clinical lead told us they knew they provided a safe service, due to regular safety checks staff undertook. The checks were a structured process, called 'intentional rounding' where nurses carried out regular checks with individual patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

Records were not completed at the time or as soon as possible after the event, in line with national guidance and legislation. We looked at five safety checklist charts. We found in all instances the safety checklist chart was not completed at the time of checking. For example, we saw two of the charts had not been completed between 8am and 1pm. We raised this with the clinical lead who told us this was because staff completed the forms in retrospect and not at the time the patient was reviewed.

In addition, we found the charts were not accurately completed. For example, we looked at one chart of a patient who has a regular outpatient appointment, three afternoons a week. We looked at the 22 days for November and found out of ten occasions when the patient was not on site, the safety checklist charts had been fully completed on six occasions. There was no indication the patient was not on-site at the location. We also saw on other days they were not fully completed, for example, for a day when the patient was on-site at the location, the chart had not been completed between 8am and 6pm.

Incident reporting, learning and improvement

There were ineffective systems for reporting, monitoring and learning from incidents. We did not see incidents or accidents discussed at any of the meeting minutes reviews. There was a lack of organisational learning, and the service made no changes as a result of learning from an incident.

The service did not have an incident reporting policy. They had a policy on accidents to service users and staff which was dated February 2018.

On 13 November 2018, the service told us they did not report incidents but they reported accidents involving staff or service users and issues with hospital admissions errors. As incidents were not routinely reported, managers could not identify any themes or trends in incidents or make changes as a result of learning from an incident. Staff were not encouraged to report incidents.

We asked staff if they would consider reporting an issue with equipment or staffing issues if required. They told us they would alert the clinical lead or registered manager.

Managers told us they looked at the reports of the accidents each month to identify any themes or trends. Seventy-one accidents were reported in total from January to October 2018. We looked at the review of accidents from this period and on seven out of 10 months, the reviews stated there were no themes or trends. However, when we reviewed the accidents we noted at least one unwitnessed fall occurred every month.

However, on 22 November 2018, during our interview with the registered manager and the clinical lead, we were told the service reported incidents. We asked to look at the incident reports and saw three had been reported, two in May 2018 and one in October 2018. The clinical lead told us if an incident occurred they would hold an ad-hoc meeting to discuss it. We did not see incidents discussed at any of the meeting minutes we looked at.

The registered manager told us they felt confident staff knew how to report incidents, including near misses. ANear Miss incident is an unplanned event that did not result in injury, illness, or damage, but had the potential to do so. During our interview with the clinical lead, they told us of an issue where they were unable get blood bottles supplied. They explained they contacted a local GP surgery and were able to get blood bottles in order to take the patients' blood. When we asked if this had been reported as an incident, they replied they did not as no harm had come to the patient.

Duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant person) of 'certain notifiable safety incidents' and provide reasonable support to that

person. No serious incidents had occurred at the location, so there was no requirement for duty of candour to be discharged. The accident reports we reviewed did not indicate any discussion between patients or their families following the accidents.

In addition, managers told us accidents would be discussed at staff meeting. We reviewed all the meetings minutes available to us and in all six sets of minutes, there was no record of incidents being discussed.

Are community health inpatient services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment

Care and treatment did not always reflect current evidence based guidance or best practice standards. The service had a range of polices, however, the policy development systems were not effective. We found some policies, were out of date or had been brought over from other providers, and not reviewed or adapted for use. There were limited systems to monitor the quality and safety of the service, including staff adherence to policy.

The service had a range of policies and protocols. We were told there was a system to make sure they were kept up-to-date with the relevant legislation, guidance and best-practice. We looked at a range of policies and saw that most of the policies had a review date. We found some policies did not have a review date or were out of date. In addition, we found policies had been brought over from other providers and they had not been adapted for the service, and still had the original NHS logo. We fed this back following our inspection.

There were limited systems to monitor the quality and safety of the service, including staff adherence to policy. We saw the service had some checks, such as monitoring the medicine fridge temperatures and medicines audits. The service had newly implemented other audits that monitored clinical practice, such as hand hygiene and clinical waste practice. We saw newly implemented infection control environment audits for 14 August 2018 and 26 October 2018, had an outdated audit tool, that had not been adapted to make sure it was relevant for the service. We saw action plans were not always developed where non-compliance was identified as part of the audit. The audit undertaken in October 2018 had a hand-written action plan on the back of the audit. However, no named person had been designated responsible for the action, and no dates for completion were recorded. This meant that measures to rectify the non-compliances were ineffective.

Pain relief

Staff administered pain relief in a timely way and patients we spoke with reported no issues in relation to pain management.

During our inspection we did not find any patients who were in pain and required pain relief. However, patients told us their pain was generally well managed. We asked two patients about pain management. Both confirmed that staff would ask them regularly if they had pain and would offer pain relief medicine. The service did not use pain scores to measure pain levels.

Staff used a rounding tool to check on patients' well-being and comfort. This meant staff proactively checked patients' pain levels at a minimum of every two hours. We saw the rounding chart had been completed every two hours, 24 hours a day. We checked with patients during our inspection, who confirmed staff did not wake them in the middle of the night to assess their pain levels. This showed the rounding charts had not been completed correctly.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. Nutritional assessments were completed on admission.

Staff completed nutritional assessments on admission. We saw this was completed on admission in all the patient records we reviewed.

Eating and drinking care plans were in use. A care plan provides direction on the type of nursing care a patient may need. It can include a set of actions the nurse needs to carry out to resolve a condition or support a patient as identified by the nursing assessment. However, we saw

care plans remained generic even though there was room for individualising these care plans, by the addition of extra information unique to the person's needs. For example, we reviewed one eating and drinking care plan for a patient who had diabetes on insulin. The care plan did not refer to the patient being diabetic or any special considerations they may need. When we spoke with the chef, they confirmed they knew which patients needed special dietary requirements.

During our inspection we looked at 18 patient surveys and saw 12 out of 18 rated the food as 'excellent', and six responded 'good'.

We spoke with four patients and reviewed five 'patient performance surveys', who all spoke positively about the quality of the food offered. They told us they were offered a choice of food and drink. One patient told us the choice of food was "very good – no complaints", another patient told us the food was "good".

Patient outcomes

The service did not have a formal system for the monitoring, auditing and benchmarking the quality of care, services and outcomes for people using the service.

The service monitored discharge and delays via their multidisciplinary meetings, where issues are reviewed and blocks identified and addressed. The service reported weekly to the commissioning NHS trust. The monitoring data sent included which hospital patients were admitted from, admission date, clinical commissioning group, weight bearing, expected date of discharge, actual date of discharge and discharge destination.

Between November 2017 and October 2018, there were 287 admissions to the service of which 98 (34%) resulted in a delay in discharge. The service told us received no feedback from the commissioning NHS trust on the delays. The service did not review, investigate or monitor delays in discharges, or request feedback from the commissioning trust on the delayed discharges.

There was a lack of oversight and ownership, by the service, for patients who experienced a delayed discharge. The service did not get feedback on their compliance with their key performance indicators. The service told us they used to have weekly conference calls with the commissioning NHS trust, where delayed discharges were discussed. However, these discontinued after March 2018. The service confirmed that they had not contacted the commissioning trust to request that these formal meetings were continued or reinstated. They told us they assumed they were complaint with their key performance indicators, as they felt they would be emailed by the commissioning NHS trust if there were any problems. The service did not incident report or discuss delayed discharges at any of the meeting minutes we looked at to see if there were any themes or trends, or if the service could make any improvements.

There were 59 patients between November 2017 and October 2018, who were transferred from the service back to the acute hospital. This accounted for 21% of admissions. We asked the reasons for the transfers. The service was only able to tell us the reasons for 20 patients as they do not routinely review, investigate, learn lessons and monitor for themes and trends.

Competent staff

The service made efforts to ensure staff were competent for their roles but did not always ensure staff had the right training to undertake their roles safely. Staff had a yearly appraisal, but we found none of the records we looked at had objectives for the coming year, identified additional training needs, or addressed compliance with mandatory training.

Within the reporting period, 100% of staff had received an appraisal. Staff we spoke with confirmed they had an appraisal and found it useful. During our inspection we looked at 10 appraisal supervision forms. However, we found the system did not always identify training needs or development opportunities for staff or set objectives for the coming year. The records kept in a folder, were untidy and it was difficult to see which records were the most up to date.

Managers failed to ensure that staff received the mandatory and essential training for their roles. This is evidenced in the mandatory training section of this report. This left staff vulnerable and posed a risk to patients' safety.

In addition to the mandatory training courses, staff had access to 29 other online courses. These included but

were not limited to, dying, death and bereavement, consent, mental capacity, pressure care, challenging behaviour, continence promotion, record keeping and risk assessment.

The clinical lead told us staff received one appraisal and five supervision meetings per year. From our review we saw there were two different forms in use. One had four sections that included a review of the previous supervision, agenda items, issues discussed and training. From review of this form, we saw they were not always fully completed and there was no section available for staff to complete. None of the records had objectives and not all had actions resulting from the meeting.

The second form covered key points discussed and outcomes. From review, the amount of information documented varied and not all had outcomes. None of the records had objectives and not all had actions resulting from the meeting.

We saw the system was used when poor or variable staff performance was identified. However, we found no evidence that staff were managed or supported to improve.

We reviewed seven staff personnel records. All contained records of interviews, references, identification checks, contracts of employment and enhanced disclosure and barring service checks, and were completed within the last three years.

Multidisciplinary working

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Doctors, nurses and other health care professionals supported each other to provide care. Staff respected their colleague's opinions.

There was good multidisciplinary team working. Staff had input into the planning, assessing and delivering of patients' care and treatment. Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another.

Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the service. We observed good communication amongst all members of the staff. They reported that they worked well as a team.

Staff attended a multidisciplinary team (MDT) meeting every Wednesday. This meeting was attended by therapists, nurses, an occupational therapist and a care manager (social worker). We saw documentation of MDT meetings in patient records. This documentation included discharge dates and referrals that were needed.

Health promotion

We did not gather evidence for this as part of the inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew how to support patients who lacked capacity to make decisions about their care. Consent was obtained in line with legislation and when patients did not have the capacity to make specific decisions, the principles of the Mental Capacity Act were followed.

The Mental Capacity Act 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

The service reported between November 2017 to October 2018, 77% of staff had completed deprivation of liberty training, which was below the provider's target of 80%. We spoke with staff who were knowledgeable on the subject and knew the procedure to follow.

Staff supported people to make decisions about their care and treatment. We saw evidence of written consent being obtained from patients or their families to share information about them with other health professionals

Patients we spoke with told us staff did not provide any care without first asking their permission. We observed

staff asking consent whenever they undertook an action or treatment. On checking patient records, we saw copies of signed consent forms and that consent to treatment was obtained appropriately.

Systems and processes were in place to ensure the service informed the Care Quality Commission about any deprivation of liberty outcomes. This is in line with the Health and Social Care Act 2008 (Registration) Regulations 2019: Regulation 18 notification of other incidents.

Are community health inpatient services caring?

Good

We rated caring as **good.**

Compassionate care

Patients were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who are close to them was positive about the way staff treated people.

Patients were treated with dignity and respect. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received the best patient-centred care possible. Patients told us staff were caring, attentive and professional.

We saw and heard staff delivering kind and compassionate care, and helped patients feel at ease. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence Quality Standard 15, statement one.

We observed many positive interactions between staff and patients during our inspection. We witnessed staff approached people rather than waiting for requests for assistance. A patient told us “staff are very good, I cannot fault them”. Another said, “staff are caring and respectful”. Patients told us staff were “helpful”, “kind”, “efficient,” and “reassuring”.

We saw how staff spoke to patients with respect and gave them time to respond. Staff showed an understanding and a non-judgemental attitude when talking with patients.

Patients with additional needs were supported by staff. For example, we saw one patient had a regular outpatient appointment three times a week. Staff made sure this patient had a packed lunch to take with them.

Where possible staff made the service feel as normal as possible, for example, we saw patients were encouraged to sit in a chair to eat their meals. Patients confirmed this when we spoke with them. One patient told us “they make you as independent as you can be”.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff were on hand to offer emotional support to patients and were very happy to offer a listening ear. Patients told us they felt able to approach staff if they felt they needed any aspect of support.

All patients’ bedrooms were private and could be used to deliver any news, which may adversely affect a patient’s future.

Patients’ spiritual needs were considered irrespective of any religious affiliation or belief. Although staff told us there were no existing relationships with religious or other support organisations, if a patient wanted pastoral support, they would make sure this happened.

Patients had access to support from clinical nurse specialists, and other specialists such as the tissue viability nurses and dietitians.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff communicated well with patients and those close to them in a manner so they could understand their care, treatment and condition. Staff responded positively to patient’s questions and took time to explain things in a way patient could understand. This is in line with National Institute of Health and Care Excellence quality standard 15, statement two.

Inadequate

Community health inpatient services

The patients and relatives we spoke with told us they found all members of staff respectful, responsive and approachable. They reported staff of all levels listened to what they had to say, acted upon their concerns and addressed any issues.

We saw effective interactions between staff and patients. Patients told us they were kept informed and included in their care decisions and treatment. Patients we spoke with confirmed this and told us their care had been discussed with them. Patients told us they were given time, were able to ask questions and felt included in the decisions about their care. One patient told us "everything was explained". Another patient said they were asked if they were "agreeable" to the planned treatment. This is in line with National Institute of Health and Care Excellence, quality standard 15, statement four.

We saw patients were assured their personal information would be dealt with confidentially. We saw on admission, staff spoke with patients about who their information would and would not be shared with. This allowed patients to make and review choices about who their personal information could be shared with.

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

(for example, to feedback?)

Requires improvement

We rated responsive as **requires improvement.**

Service delivery to meet the needs of local people

The service was told by the commissioning NHS trust on 19 November 2018 that they would be decommissioning 32 beds at Raj and Knoll limited (all 28 at Ami Lodge and five elsewhere in the group). This would be completed by 30 December 2018.

Prior to this, the service provided was specific to the commissioning trust's needs.

Meeting people's individual needs

The service took account of patients' individual needs.

Staff assessed the physical and mental health of all patients on admission. Care plans were in place. However, we saw care plans we generic with limited space to add extra information unique to the person's needs. It was not clear whether they were updated when needed.

Therapy staff told us they tailored the amount of therapy a patient had and when they had it, dependent on their needs. This was established at the initial assessment.

Patients would be given individual exercise programmes to help with their rehabilitation and so they could continue to exercise independently.

Staff carried out home visits to assess patients' own homes and to establish any further assistance that might be required, when patients were discharged home.

As all patients were nursed in single rooms, we found no mixed sex accommodation breaches. There was one double room and we were told they would only admit another person of the same sex to that room.

Arrangements were in place for patients living with a learning disability. Staff could give examples of adjustments they had made to make sure the patient's admission was as stress free as possible. For example, staff told us they identified a patient had learning difficulties so they produced pictures of food with large print words, to ensure the patient could select their meals that way.

The service did not have access to an interpreting service for patients whose first language was not English. We saw the service had a picture book, which was used to aid communication.

We saw there was a choice of food options for patients. We spoke with the chef who told us they could make sure patient preferences, religious or cultural needs, such as vegetarian, vegan or kosher meals. This was in line with the National Institute for Health and Care Excellence quality standard 15, statement 10.

The service provided three meals a day for patients, on a rolling four-week programme. Choices could be seen on menus and the chef spoke with patients daily to discuss any individual needs.

As the food was cooked fresh daily, the service could cater for any special dietary requirements such as

allergies and intolerances or religious preferences. The chef told us they would be informed of any special requirements, which would be written on a white board in the kitchen. We also saw patients' likes and dislikes for food were recorded and catered for. For example, one patient only liked brown bread and another did not like chips or onions.

The service was accessible by patients with a physical disability. We saw there were dedicated disabled toilets throughout the location. There were bathrooms which had easy access showers, with no steps, and had handrails to provide extra support and stability when showering. Patients had access to a lift and stair lift, to allow them to access other levels in the building.

Signs and posters were not dementia friendly or suitable for someone who may have poor vision. However, staff told us large print advice leaflets could be accessed if they were needed.

As part of the admission process, patients were asked about their normal routine, for example the normal time they went to bed, or if they liked a light left on. We saw on the welcome leaflet that patients were encouraged to go to their rooms by 7pm; this was to make sure that patients are rested for the next day's therapy. Prior to inspection we received a complaint from a member of public informing us that patients were being put to bed by 6pm. The registered manager explained that patients are encouraged to be in their rooms by 7pm, but not necessarily in bed. If patients wished to stay in the communal areas longer this would be accommodated, such as during the world cup, where patients had wanted to watch the match together. During our inspection we spoke with patients who confirmed they were in bed earlier than they would be if they were at home.

Access and flow

People could access the service when they needed it.

Ami Lodge had a service level agreement to provide rehabilitation services for patients to a local NHS trust. We were unable to determine the criteria for admission to the service.

Between November 2017 and October 2018, there were 287 admissions to the service. The length of stay depended on the reason for admission. The agreed length of stay at the time of inspection was 18 days for standard rehabilitation, 21 days for social assessment and 43-56 days for patients who are admitted because they are unable to put weight through the affected limb following their operation or accident.

Referrals were emailed to the service which included relevant patient information such as patient details, past medical history, reason for referral and mobility assessment. This was initially reviewed by the deputy manager, and passed to the registered manager to confirm they fulfilled the admission criteria.

On the 13 November 2018, the deputy manager told us there were no waiting list for admission currently to Ami Lodge. However, during periods of increased pressure at the commissioning NHS trust, there were times when patients were waiting to access the service. Following inspection, we were told no patients had waited to access the service.

Learning from complaints and concerns

The service did not have an adequate process that made sure people's concerns and complaints were listened to and used to improve the quality of care. Complaints were not monitored over time, and the managers did not have oversight of complaints to monitor trends and themes or identify areas of risk. The service did not signpost complainants to the relevant ombudsman if a complainant remained unhappy with the response

The service had one formal complaint within the reporting period which had been referred to the Parliamentary and Health Service Ombudsman, However, we were told there were four complaints made to the service.

The deputy manager and quality manager could explain the complaints procedure. Complaints could be made to the service in three ways, face to face, via the telephone, or in writing by either email or letter. Where possible the complainant would be spoken with immediately, if issues could not be resolved they would be referred to the registered manager. Staff were not always made aware of complaints about the service, unless the complaint directly involved them. We saw in staff supervision notes, that staff were spoken to about any complaints made

against them, but there were no actions or reviews following these discussions found. This meant issues found, outcomes and lessons learnt were not shared with staff and used to drive improvement within the service.

The service had a policy for the management of complaints, which was updated in 2018. However, the complaints policy refers the complainant to the Care Quality Commission if they remain unhappy with their response, and not to the relevant ombudsman. We fed this back during the inspection 13 November 2018. Following inspection, we received an updated copy of the policy.

We were unable to review any complaints during our inspection. However, the service confirmed they did not signpost complainants to relevant Ombudsmen. If patients, relatives or carers were not satisfied with the service's response to their complaint, the service referred them to the Care Quality Commission.

The service did not monitor complaints overtime, for themes and trends or areas of risk that may needed to address. The service did not have a complaints log, and we were unable to determine the status of any complaints made to the service. The deputy manager confirmed that they would write about a verbal complaint in the patients records and discuss this at multidisciplinary meetings, but there was no formal system of recording, and monitoring. This meant there was no record of outcomes, action taken or learning following a complaint and that managers did not have oversight of complaints to monitor for trends and themes, or areas of risk identified.

There was limited information or guidance available or accessible for people to see to be able to make a complaint. During the inspection we were unable to find written information available for patients, visitors or carers to know how to make a complaint. During the interview with the deputy manager, they confirmed there were no leaflets available to inform people how to make a complaint, but there was one poster on display. We were taken to the poster, which was not in an area available for everyone to see, and the writing was small, meaning not everyone would be able to see or read how to complain to the service.

Are community health inpatient services well-led?

Inadequate

We rated well led as **inadequate.**

Leadership

The service did not have managers at all levels with the necessary experience, knowledge, and skills to lead effectively, and provide high-quality sustainable care. Managers did not have a good knowledge of performance in their areas of responsibility and did not understand the risks and challenges to the service. The service lacked an internal process that proactively identified where quality improvements could be made to the service and patient care.

The service had a registered manager. The registered manager for Ami Lodge, was also the registered manager for the three other registered locations.

The registered manager led the management team, supported by the area clinical lead and operational and quality assurance lead. An additional four deputy managers who were part of the management team, managed the individual locations owned by the provider. Each deputy manager was supported by a clinical lead.

The operational and quality assurance lead was new in post and had been a deputy manager at another location. We asked them to describe their roles and responsibilities in their new post, they described they would be going to all locations to check risk assessments and charts are being completed.

The registered manager or area clinical lead carried out the supervision and appraisals of all nursing staff. The deputy manager carried out the supervision and appraisals of all other staff.

Managers could not demonstrate adequate systems and processes that assured us they had full oversight of the service in terms of risk, quality, safety, and performance. For example, patients were not adequately monitored for deterioration, the service did not have an incident reporting policy or standard way of reporting incidents or

near misses. We saw safety check records were not completed at the time or as soon as possible after the event, in line with national guidance and legislation, and provided false assurance to managers who were aware that safety checks were not always completed at the time or as soon as possible. There was no system for checking equipment had been cleaned regularly. Some policies were out of date or were brought into the service from another organisation, but had not been reviewed and adapted for use, and still had the original organisation's logos in place.

In addition, when we asked the registered manager about how they assured they provided high-quality service, they told us the acute trust carried out regular quality visits, and described the Care Quality Commission inspection process as ways the service gained quality assurance. They did not articulate any internal processes of gaining assurance.

On 13 November 2018, the service did not have a formal internal process for monitoring the quality of care delivered by the service. We looked at the 'Quality Assurance' policy (up dated February 2018), which detailed the Care Quality Commission's inspection process. We fed this back following the inspection. Following inspection, the service sent us their updated 'Quality Assurance policy', dated 15 November 2018. However, as this was a newly developed policy, we could not assess the impact of it on the delivery of the service.

Vision and strategy

There was no written strategy or vision for this service.

The registered manager told us "Promoting independence is fundamentally what we stand for". It was clear staff were passionate about the service they provided and told us their primary aim was to make sure patients were discharged home in safe and timely manner.

Culture

Staff had effective working relationships with each other. There were clear staff support networks and all staff we spoke with felt supported by their colleagues.

It was clear from our observations that all staff within the service were committed and passionate about the work they did. Staff we spoke with showed a positive attitude towards caring for patients.

Staff reported positive working relationships, and we observed staff were respectful towards each. Staff we spoke with were passionate about the service they provided; we saw that staff worked well together and supported one another during their day to day work.

Staff told us they worked well with their managers, who would often be on shifts with them, and found them approachable.

The service had a low sickness absence rate during the reporting period, which was 3%.

Governance

There was a lack of clear roles, responsibilities and systems of accountability to support good governance. We found limited structures, processes and systems to support the delivery of good quality, sustainable patient care. The service did not have a proactive quality improvement process to drive improvements to the service or patient care. We did not see meetings minutes where key governance issues were discussed and addressed.

The service did not have a clear governance structure. When we spoke with managers, they were unclear on the structure and spoke about external bodies visiting the location. For example, when we spoke with managers on 13 November 2018 and asked them how they gained assurance in the quality of their service. They told us the acute trust carried out regular quality visits, and described the Care Quality Commission inspection process as ways the service gained quality assurance.

We saw there were four main meetings that took place, once a month. These were a general staff meeting, team leaders meeting, nurses and clinical leads meeting and organisation meeting. There was no set agenda for the meetings, and the clinical lead confirmed the only set agenda for these meetings was apologies and thanks. We did not see key governance issues were discussed for example, incidents, complaints, results of audits, patient outcomes, safety performance data or the risk register. Organisational issues were not escalated up or cascaded down through the reporting structure.

The clinical lead and registered manager told us they would only call an ad-hoc meeting to discuss an incident or complaint, with those involved, to resolve issues. Learning outcomes were shared with the individual and those who need to know, and not organisation wide.

The policy development systems were not robust. Managers told us policies were reviewed every year. However, we looked at all the policies available at the time of inspection and found several were out of date for review, or had been brought across from other providers. They still had the original providers' logo, and had not been reviewed or adapted for use within the service. in addition, we found key policies such as incident reporting, were not available and others such as infection control policies lacked reference to key evidence-based practice or professional guidance.

There were limited systems, such as auditing, to monitor the quality and safety of the service, including staff adherence to policy. We saw the service had some checks, such as monitoring the medicine fridge temperatures and medicines audits. The service had newly implemented other audits that monitored clinical practice. However, we found where non-compliance was identified as part of an audit, action plans were not always developed, or lacked a designated person responsible for the action and timescale for completion.

We saw in minutes there were actions for quality audits to be completed at all locations. However, there was no documentation of what audits would be undertaken or evidence they had been discussed and findings used to improve services and patient care.

Arrangements with partners and external bodies, such as the commissioning NHS trust were not managed or governed to encourage appropriate interaction and promote coordinated, person-centred care. The service had not met formally with the commissioning trust since December 2017, and weekly telephone conversations had discontinued in March 2018. The service confirmed that they had not contacted the commissioning trust to request that these formal meetings are continued or were reinstated.

The service did not receive regular feedback on their key performance indicators. The service confirmed they did not contact the commissioning trust to request feedback on their performance indicators.

Managing risks, issues and performance

The service had ineffective systems for identifying risks, issues and performance and planning to eliminate or reduce them. There was a lack of a robust system for identifying, recording and managing risks, issues and ensuring effective risk reduction strategies.

The service did not have a risk register when we inspected on 13 November 2018. We saw the service undertook a variety of risk assessments, but these were located in multiple folders. On the 21 November 2018, the service sent us a 'risk register list'. We saw this contained a list of 90 risk assessments, that had been categorised as low (85) or medium (5). The risk register list, was undated, had no explanation of the risks and there were no named members of staff that had responsibility to make sure existing risk controls and actions were completed for each identified risk, or date for completion.

We looked at 12 of the risk assessments on the risk register list. We saw all risk assessments were not dated. In addition, there was no review date, or designated member of staff for ensuring risk controls and actions were completed or an expected completion date. We did not see risks or the risk register list discussed in any of the meeting minutes we reviewed.

For example, the service provided us with the risk assessment for the control of substances hazardous to health (COSHH), which were undated, and assessed as low risk. However, one of the ways described to lessen the risk was to make sure all staff received COSHH training at induction and updated yearly. From the data provided to us we saw 39% of staff were up to date with this training.

The folder containing details about the safety data for the chemicals managed under the COSHH was stored in the manager's office. When asked to see the folder, staff had difficulty locating it as it was stored on a high shelf, which they had to climb on a chair to access. When we asked to see the risk assessments, we were told they were located at another location owned by the provider. We found the door to the cleaner's cupboard unlocked, and chemicals easily accessible. This meant the risk assessments provided false assurances and risk reduction strategies were not effective.

Managers told us policies were reviewed every year. However, we looked at all the policies available at the time of inspection and found several were out of date for review, others referenced guidance from other providers.

There were limited systems or programmes for clinical and internal audit to monitor the quality and operational processes and systems, to identify when action should be taken. For example, we found audit results were not discussed at meetings. Where non-compliances were found there were no or limited action plans, which were hand written, no person had been designated responsible for the action, and no dates for completion. Completion was inconsistent, for example on the medicines audits, it was unclear when the service had a non-compliance.

The service carried out environmental risk assessments and we saw these were kept in paper form in a folder. They indicated different aspects of different areas had been risk assessed, such as door handles, flooring, décor, odour and lighting. They did not include detail of how they were assessed, the risk rating was indicated with a tick. Every assessment of every aspect of every area we reviewed, was assessed as low risk.

The service had a business continuity plan dated September 2010. It contained a list of staff names and contact numbers. It was a generalised plan from a national organisation and was not specific to the service. There was a section about the layout of the building the service could have completed, but this had not been done.

Managing information

The service did not routinely collect, manage and use information to support all its activities.

The service did not formally or routinely collect safety performance data. We did not see safety data, that was collected, discussed in meetings or used to drive improvements to the service or patient care.

Senior managers demonstrated to us they did not have an understanding of performance across the service and were unable to give examples of how audit, performance and patient and staff feedback were used to drive improvements across the service.

Systems and processes were in place to ensure data and notifications were submitted to external bodies as required. For example, statutory notifications about serious injuries were made, as required, to the Care Quality Commission.

Records for patients were kept securely at all times.

Engagement

The service engaged with staff. Patient feedback was sought by staff but we did not see evidence of comments shared amongst the team and used to influence change within the service. They did not engage collaboratively with the commissioning NHS trust effectively.

We saw patients were asked to complete satisfaction surveys. During our inspection we looked at five patient performance surveys, and saw that all five would recommend the service. In addition, we looked at 18 patient surveys and saw 16 out of 18 responded staff were 'very' helpful and two responding average. We did not see patient feedback discussed in meetings or used to drive improvements to the service or patient care.

There were limited systems to gather staff feedback to enable more effective working and improved patient experiences. The registered manager told us they received staff views during team meetings. In addition, we saw 26 staff satisfaction surveys, which were undated. We saw 25 out of 26 felt supported in their role.

The service did not engage collaboratively with or meet regularly with the commissioning NHS trust. They told us they did have regular meetings but these were discontinued in December 2017, due to the person managing the contract leaving. They told us they had regular 'Quality' visits from the commissioning NHS trust, where they were given verbal feedback but did not always receive written reports. The service confirmed they did not request formal meetings or feedback from the commissioning trust. When we asked the service for evidence where they had contacted the commissioning trust for their quality visit report, they were only able to provide us with evidence from January 2018.

Learning, continuous improvement and innovation

Inadequate

Community health inpatient services

The service was not committed to improving services by learning from when things go well and when they go wrong.

For example, we saw there was there was a lack of organisational learning around falls. We saw the falls risk reduction strategy was to remind patients to use their call bell if they needed help. In addition, patients were not adequately monitored for the risk of deterioration. Basic vital signs were not recorded, and we found instances where patients were not adequately monitored. There was no reporting, investigation or monitoring of patients who were transferred to the acute trust from the service.

The service did not have a proactive quality improvement process to drive improvements to the service or patient care. We saw the service would respond and make improvements when identified by an outside organisation, but lacked an internal process that proactively identified where quality improvements could be made to the service and patient care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that all patient safety risks are captured on an appropriate risk register, which must describe planned and completed mitigating actions.

The provider must develop governance systems to provide assurance of the efficiency and effectiveness of systems to ensure to monitor quality and safety information to ensure the delivery of safe and effective, good quality, sustainable care and treatment on an ongoing basis.

The provider must ensure that all key policies are in place, and are reviewed, updated, and reflect current legislation.

The provider must improve the completion of mandatory training rates so it meets organisational targets.

The provider must ensure patient records are readable, accurate, complete and contemporaneous record of the patient care and treatment.

The provider must develop a comprehensive audit system to provide assurance that patients' records are completed.

The provider must ensure clinical oversight of activity provided and ensure audit trails and quality measurement tools are in place.

The provider must ensure that systems to ensure the ongoing monitoring of patients and to identify deteriorating patients, are consistently complied with.

The provider must ensure there are systems that identify quality improvements that could be made to the service and patient care.

The provider must ensure there is a formal admission or eligibility criteria for admission to the service developed between the service and the commissioning NHS Trust.

The provider must ensure all substances hazardous to health are stored in a secure area.

The provider must ensure that incidents are reported, investigated and monitored, and that appropriate guidance and support is available to staff.

The provider must ensure its managers have sufficient dedicated time to monitor the quality of their service.

Action the provider SHOULD take to improve

The provider should conduct a review of pressure area care to identify any care failings or necessary improvements that are required.

The provider should introduce systems to make sure patient equipment is clean, and intact.

The provider should monitor the effectiveness of pain relief provided.

The provider should consider improving the quality of appraisals.

The provider should consider monitoring patient outcomes, monitoring, auditing and benchmarking the quality of care, services and outcomes for people using the service.

The provider should consider formally collecting safety performance data, to drive improvements to the service or patient care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment** (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— · (a) assessing the risks to the health and safety of service users of receiving the care or treatment; · (b) doing all that is reasonably practicable to mitigate any such risks; · (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; · (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983

This section is primarily information for the provider

Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 Good Governance

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

- (a) 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);
- (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;
- (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.