Renovo Hollanden Park Limited

Hollanden Park Hospital (currently known as The Raphael Hospital)

Inspection report

Hollanden Park, Coldharbour Lane
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Date of inspection visit: 22 and 29 September 2021
Date of publication: 19/01/2022

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

Ratings

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

Summary of findings

Overall summary

We are placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated it as inadequate because:

- Not all staff were compliant with mandatory training. The service reported a low compliance rate in key modules including safeguarding and life support training.
- The premises and equipment did not always keep people safe. Clinical waste was not managed well.
- Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or reflective of the care provided.
- The service did not always use systems and processes to safely administer and record the use of medicines.
- Staff did not keep records of patch rotations or body placement for patients prescribed medicinal patches.
- Staff did not always complete risk assessments for each patient in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.
- Incidents were not always effectively investigated to reduce the risk of potential harm from similar or repeated incidents.
- Staff did not always give patients enough food and drink to meet their needs and improve their health.
- Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.
- Not all staff were able to describe what lessons were learnt from the incidents they reported. They were not aware of any changes to practice to prevent incidents from happening again.
- Staff did not routinely involve patients and their families in making decisions about their care.
- The service did not operate effective governance systems to improve the quality of services.
- The culture of the service was not centred on the needs and experience of patients.

However:

- Staff knew the patients they were caring for, including their preferences and medical histories.
- Staff provided patients with timely care to minimise their distress.
- Patients were assessed for pain regularly and received pain relief in a timely way.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
People with long term conditions	Inadequate 	We rated the hospital as inadequate because it did not always provide a safe, effective, caring, responsive and well led service.

Summary of findings

Contents

Summary of this inspection

Background to Hollanden Park Hospital (currently known as The Raphael Hospital)

Hollanden Park Hospital located in Hildenborough, Kent is part of the Renovo Care Group, an independent specialist provider for the assessment, treatment and rehabilitation of adults with neurological conditions including acquired brain injury and progressive neurological disorders.

The service provides neurological care and rehabilitation in both hospital and community settings across the South of England. Patients are admitted to one of the following defined care pathways following a comprehensive initial assessment and review:

- Acute Neurorehabilitation
- Acute Neurobehavioural
- Extended Rehabilitation
- Assisted Independent Living

Service users are funded by Clinical Commissioning Groups, Local Authorities, insurance providers or are self-funded and a mixture of public sector joint commissioning arrangements.

Patients were cared for in one of four areas within the hospital site depending on their needs. These were Hardwick House, Rachel McMillan Unit, St Michael's Court and Raphael Court.

The hospital could accommodate 35 patients in total; 23 patients in Hardwick House, seven patients in its Rachel McMillan Unit, three in St Michael's Court and two in Raphael Court.

The hospital employed 115 members of staff.

Hollanden Park Hospital has never been inspected since registering with the Care Quality Commission in October 2020. However, the service was inspected five times under a different provider. The last inspection was in January 2019 when it was rated as requires improvement.

Hollanden Park Hospital is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 22 and 29 September 2021 and interviewed the hospital leaders remotely on 26 October 2021. We spoke with one relative, three patients and over 15 staff. We reviewed 10 patient records.

Summary of this inspection

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with three people to tell us their experience

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

Areas for improvement

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

Action the hospital MUST take to improve:

- The hospital must ensure that all staff complete mandatory training in key skills. Regulation 12(1)
- The hospital must ensure all staff wear approved surgical face masks in line with hospital guidance. Regulation 12(1)
- The hospital must ensure that all staff complete safeguarding training. Regulation 12(1)
- The hospital must ensure that staff have completed the relevant life support training for their clinical roles. Regulation 12(1)
- The hospital must ensure that the design, maintenance, use of facilities, premises and equipment are suitable to ensure patient safety. This includes the management of clinical waste. Regulation 12(1)
- The hospital must ensure staff complete appropriate resuscitation equipment checks in line with hospital policy. Regulation 12(1)
- The hospital must ensure individualised clinical and environmental risk assessments are completed to identify, assess and mitigate risks. Regulation 12(1)
- The hospital must make sure all staff understand and report incidents correctly, investigations are robust, and learning is shared. Regulation 17(1)
- The hospital must ensure patients are given enough food and drink to meet their needs. Regulation 14(1)
- The hospital must maintain securely an accurate, complete and contemporaneous record of each patient of the care and treatment provided. Regulation 17(1)
- The service must ensure governance and risk management processes are fully embedded and sustainable. Regulation 17(1)

Action the hospital SHOULD take to improve:

- The hospital should ensure it records and monitors the placement of medicinal patches to avoid causing skin irritations.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
People with long term conditions	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Inadequate

People with long term conditions

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

Are People with long term conditions safe?

Inadequate

We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff however, the hospital target for completing training had not been met.

Human resources monitored mandatory training and alerted managers when staff needed to update their training. At the time of inspection, the overall completion rate for mandatory training was 71%. This was lower than the hospital's target of 95%.

Mandatory training consisted of, but was not limited to, basic and immediate life support, moving and handling and fire training. Courses were provided as face to face or online training.

Staff said they could easily access mandatory training and were clear on which courses they must complete. However, some staff said they were not given enough dedicated time to complete training.

Safeguarding

Staff did not meet the hospital target for safeguarding training however, they could recognise and report abuse.

At the time of inspection, the overall completion rate for safeguarding and protection of adults training was 67%. This was significantly lower than the hospital's target of 95%. However, staff understood their responsibilities to keep people safe and knew what constituted abuse.

Staff gave examples of safeguarding concerns they had identified and escalated to their manager or safeguarding lead. Staff we spoke with could describe different types of abuse and were knowledgeable on signs of abuse. Staff were confident that they could access support and advice from the safeguarding lead.

Inadequate

People with long term conditions

Safeguarding information, including contact numbers and details of the hospital lead were easily available, and most staff were aware of how to access support.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not use equipment and control measures to protect patients, themselves and others from infection.

Some of the flooring in the communal areas of the Rachel McMillan Unit and Hardwick House were in a poor state of repair. We saw the flooring had holes in it and carpets were torn, stained and visibly dirty.

There were processes to monitor and audit the cleanliness of the environment. Cleaning audits were undertaken regularly and the compliance rate for the three months before our inspection was 99%. However, the audit process was unreliable, and the leadership team recognised that audit results were not always accurate.

Not all staff wore surgical face masks which were approved as personal protective equipment in line with the hospital's own guidance. We saw some members of the clinical and administrative staff wearing cloth or face coverings which are intended for use by the general public rather than a healthcare professional.

Personal protective equipment, such as gloves and aprons, were readily available for staff in all clinical areas to ensure their safety when performing procedures. This meant staff had the correct equipment available to adequately ensure staff safety and reduce the risk of cross infection when staff performed procedures. However, we saw staff did not use personal protective equipment correctly. We observed staff carrying out general tasks in between providing personal care to patients while wearing the same personal protective equipment. At no time during the two days of our inspection did we observe any staff member challenging the incorrect use of personal protective equipment by other staff.

The hospital did not display signs indicating the maximum capacity of each room in line with COVID-19 guidelines. This meant staff did not always know how many people could be in a room at any one time to safely maintain social distancing. However, throughout the hospital there were signs reminding people to keep a safe distance from each other.

Staff undertook lateral flow tests for COVID-19. Staff told us they were audited at random and asked to show proof of a negative result.

The hospital carried out a lateral flow test compliance audit in July 2021 which looked at the evidence that staff could produce to confirm routine testing. The results showed poor compliance amongst clinical staff. Seventy-one per cent of allied health professionals, 25% of nursing staff and 14% of rehabilitation assistants were compliant with the completion and recording of lateral flow tests. Medical and senior rehabilitation assistant staff had no record to show compliance with the testing programme. The audit stated that six staff who were audited did not produce any evidence to demonstrate compliance. There were also staff who reported they had not tested within this period, giving a date of “since May” or “since February” in one case.

The hospital tested patients for COVID-19. Staff told us patients were initially polymerase chain reaction tested monthly, but this was changed to monthly lateral flow tests. Patients were polymerase chain reaction tested on admission to the hospital and when discharged from the hospital.

Inadequate

People with long term conditions

There were low infection rates. Hospital data showed there were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus, hospital acquired Meticillin-sensitive staphylococcus aureus or hospital acquired Clostridium difficile.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The hospital did not manage clinical waste well.

Patients were cared for one of four areas within the hospital site depending on their needs. These were Hardwick House, Rachel McMillan Unit, St Michael's Court and Raphael Court.

The design, maintenance and use of facilities and premises did not always keep people safe.

We found the hospital environment was in a poor state of repair and did not keep the patients and staff safe. We found holes in the floors, torn and stained carpets, and peeling wall paint. This was not in line with the *Department of Health and Social Care Health Building Note (HBN) 00-09: infection control in the built environment*. Non-intact surfaces, flooring and walls can harbour dirt and dust and make cleaning difficult. Hospital leaders recognised the building was not in a fit state and had plans to renovate the hospital.

Maintenance issues or concerns were not always escalated. We reviewed the hospital's health and safety record book for Hardwick House and saw the same non-compliance was identified by multiple audits, and no corrective action was taken. For example, in room 21, staff had noted in March 2021 that there was no window restrictor and the wardrobe needed to be fixed to the wall. The same issue appeared on the August 2021 check. We spoke with the estates manager who told us that these issues had not been escalated to their team, therefore repairs had not been carried out.

The arrangements for managing waste did not always keep people safe. Storage areas should be secure, located away from public areas and kept locked when not in use. We found the storage area unlocked and accessible to the public. Bulk clinical waste storage containers were not locked and had clinical waste bags in them. Sharps bins were not stored securely, the bin used to contain these was overflowing and there were multiple sharps bins stacked-up and on the ground. A bin used to dispose of gloves and aprons after taking clinical waste to the storage area was overflowing.

Next to the storage area, were two domestic waste bins overflowing with cardboard boxes which created a fire risk. We raised waste management as a concern to the leadership team. Leaders were unclear about when the bins were due for collection or had last been collected. However, in clinical areas, waste was segregated, and waste bags were filled to a safe level. Used sharps were disposed of in signed and dated sharps bins, which were kept closed to prevent injuries. Following the inspection, the hospital sent us an action plan of how they planned to manage waste including installing a padlock and securing access to the clinical waste storage.

The cleaning cupboard and the dirty utility room containing substances hazardous to health including, toxic and corrosive cleaning agents, was not kept locked. For example, we found 36 bottles of spray and wipe sanitisers, one bottle of lime scale remover and a bottle of alcohol-based gel in an unlocked cupboard in the dirty utility room of Hardwick House. We raised this as a concern with the hospital's leadership team during our inspection. When we returned to inspect the following week, we found that all doors were kept locked when not in use.

Inadequate

People with long term conditions

Equipment was mostly maintained and serviced in line with the manufacturer's guidelines. We reviewed various pieces of equipment which were within their service date. However, we found no evidence of a recent electrical appliance test of the main charging unit in the atrium of Hardwick House. Additionally, we saw an extension cord used to charge the hoists which had not been tested since 2019.

Resuscitation equipment was available but not safely managed. The resuscitation trolley was not checked in line with the hospital's medical emergencies and resuscitation policy. The policy stated, "there must be a daily checking system to make sure equipment is available and not expired at all times". Records reviewed showed checks were completed on Mondays and Fridays and staff confirmed this was the procedure. This meant the hospital was not assured the emergency equipment was fully stocks and fit for use on the other days.

Not all staff knew where the resuscitation equipment was kept. We asked a member of staff in Rachel McMillan Unit who initially took us to the manager's office but there was no trolley present. We were then told the trolley was kept locked in the medicines room of the unit and the ward manager held the key for this. We asked the ward manager who confirmed the trolley in Hardwick House was the only available trolley which was shared by all hospital areas. The decision to have one resuscitation trolley was due to the equipment being used infrequently however, staff were unable to provide us with a risk assessment to inform this decision.

Staff used inappropriate areas to store equipment. The bathroom in flat two in the Rachel McMillan Unit contained a bathtub overfilled with boxes, mats and various other items. The leadership team told us the bathroom was not used by staff or patients however, staff confirmed they sometimes used the toilet. The estates manager told us there was nowhere to store the contents of the bath and they were unsure what was currently in use by patients. When we returned onsite a week later the bathroom was empty.

Fire marshal bags were located in areas easy to access in the event of a fire. The bags contained personal evacuation plans for each patient detailing the arrangements for an evacuating patient in the event of a fire. Staff regularly updated personal evacuation plans for each patient however, the plans did not always document the number of staff required to assist patients in the event of an evacuation. We found three of the four personal evacuation plans we reviewed did not have this information. Such information was important particularly for patients who were noted as totally dependent on staff.

Foam and carbon dioxide extinguishers were available throughout the hospital for staff to use in the event of a fire. Staff reported fire training was part of the mandatory training programme. Fire training and an evacuation drill was completed in July 2021. However, a fire assessment report carried-out in August 2021 had recommended for staff to have training in the use of a fire extinguisher within three months of the assessment. The hospital had planned to provide internal training to staff in October 2021 to meet the recommended completion date of 10 November 2021. However, it was unclear whether this has been completed.

The hospital had a system for single use equipment. We reviewed 25 consumables and found them to be stored in sealed packaging and in date. Consumables due to expire were identified during stock checks to remind staff to use these items first before the expiry date.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not identify and quickly act upon patients at risk of deterioration.

Inadequate

People with long term conditions

Patients did not always have access to emergency equipment to manage their care. In Hardwick House there were seven tracheostomy patients. Guidance from the National Tracheostomy Safety Project states each patient must have emergency equipment immediately available, some of which should be at their bedside. Only one of the seven patients had a fully stocked tracheostomy emergency box. One patient had percutaneous endoscopic gastrostomy (PEG) equipment instead of tracheostomy equipment, in error, and one other patient did not have any emergency equipment available.

None of the emergency tracheostomy boxes had an index checklist of its contents. Staff did not complete daily checks of equipment to ensure equipment was always available and in good working order in line with national guidance.

We escalated this to the hospital's leadership team on 22 September 2021. When we visited on 29 September 2021, all tracheostomy patients had their personalised emergency tracheostomy equipment available in their rooms.

Staff did not always update patient risk assessments or care plan records to reflect the patient's current care needs. We reviewed three patients' assessments of needs, and all these had the same total risk score. However, two of the patients were dependent and required PEG (a feeding tube to deliver food, fluids and medicines directly through the skin into the stomach) feeding and one was described by staff as independent requiring occasional support from staff. Records provided for another patient were dated January 2020. Although we were told the patient was "very independent" we could not be assured due to the lack of a recent assessment.

COVID-19 had impacted on the provider's ability to deliver face to face training. Not all staff had received basic or immediate life support training. Records showed only 64% of staff had completed basic life support while only 29% had completed immediate life support training. The registered manager assured us each shift was staffed by a nurse with immediate life support training. However, based on the low completion rate, we were not assured this was always the case particularly in the event of staff absence. We were told all staff were informed to call 999 in any emergency and take instructions from the ambulance crew.

Staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

There were systems to assess, plan and review staffing levels on the wards, including staff skill mix. The registered manager told us they followed recommendations set by the British Society of Rehabilitation Medicine to maintain staffing levels.

There were enough staff to provide care. In Hardwick House the day shift was from 7.30am to 8.30pm and was staffed with three registered nurses and nine rehabilitation assistants. The nightshift started at 8.30pm until 7.30am and was staffed by two registered nurses and nine rehabilitation assistants. A ward manager was available five days a week during the day and another covered three nights a week. A member of the nursing staff in Hardwick House was responsible for the care of four patients in St Michael's Court and Raphael Court.

Rachel McMillan Unit followed the same shift patterns as Hardwick House. Both the day and night shifts were staffed by two registered nurses and a rehabilitation assistant.

Inadequate

People with long term conditions

Some patients told us there were not always enough permanent staff and this meant agency staff who were not as experienced were used to cover staff shortages. Staff told us they used the same agency staff, who were familiar with the patients and the hospital for consistency.

Agency staff usage was higher than the hospital target of 5%. For the three months before our inspection, agency usage was 12% in June, 8% in July and 9% in August 2021.

At the time of our inspection, staff turnover was 3% which was better than the hospital target of 10%. Records showed three members of staff had left the hospital in August 2021.

The sickness rate was 2% which was lower than the hospital target of 5%.

The hospital had no nursing vacancies at the time of our inspection. There was a vacancy for a speech and language therapist. The role was currently being covered by a locum member of staff.

Medical staffing

The service had medical staff with the right qualifications, training and experience to provide the right care and treatment.

Hollanden Park Hospital had a consultant led model of care and patients were admitted to the hospital under the care of a neuro rehabilitation consultant. The neuro rehabilitation consultant was available on-site on Tuesdays and Saturdays, and a psychiatric consultant was on-site on Thursdays.

An associate specialist was present on-site Monday to Sunday from 10am to 6pm. Outside these hours medical support was available remotely on call via telephone. We were told the on-call doctor lived a considerable distance from the hospital therefore in the event of an emergency would not be present on-site but would give advice remotely. The registered manager told us there were no issues with this arrangement. The hospital had a contract with a locum agency if they required additional medical support. A consultant round was carried out on Saturdays.

The service had an assistant psychologist, but there was currently a vacancy for a part time consultant psychologist. The service was recruiting to the psychologist vacancy and the assistant psychologist was providing interim cover.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not clear, up-to-date or reflective of the care provided.

Not all information needed to deliver patient care was available or easily accessible to all staff, including agency staff, when they needed it. Patient records were both paper based and electronic which meant staff did not always have the most recent patient information available to them. We reviewed 10 patient records and found it difficult to follow the patient care plans or build a picture of the aims of admission or patient medical history.

Records varied in quality and completeness. In one patient's records, we saw an entry stating that the patient had the usual appetite and mostly finished their meals despite the patient solely feeding through a PEG.

Inadequate

People with long term conditions

Patient records were not contemporaneous with the delivery of care. We saw staff completing care records a few hours after delivering that episode of care.

We identified a significant risk to patient safety with records being completed in advance of the relevant care or treatment being required. We reviewed one patient's care records on 29 September at 6.30pm and saw staff had signed off the 6.00am feed and 8.00am flush for the following day confirming nutrition and fluid had been provided before it was due. There was a risk the patient would go without their feed or flush as it appeared to have already been given.

Records, including confidential information were not always stored securely. In Hardwick House, patient records which included medical assessments and monitoring charts were kept near the entrance of the building. Records were not securely locked away and could be easily accessed by unauthorised people.

In addition, we saw some care records kept in the entrance of Hardwick House belonging to patients in St Michael's Court and Raphael Court. Staff explained that this was for when the patients visited Hardwick House however, it meant that staff did not have access to the patients' complete care record in whichever area the patient was receiving care. Secondly, the records were not locked away and could be accessed by anyone passing by, including other patients and visitors.

The provider had commissioned external audits to identify areas of improvement including audits of its care records. The audits took place shortly after our inspection and the provider added the recommendations made to its action plan.

Medicines

Staff were not always aware of where medicines were stored, and the service did not always store the correct dosages of emergency medicines in line with guidance. The hospital did not always use systems and processes to safely prescribe, administer and record medicines.

Medicines were not always stored appropriately so they remained safe and effective for use. For example, ambient room temperatures in July 2021 for the medicine room, exceeded the recommended temperature on four days and there was no record of corrective action recorded. However, staff we spoke with were aware of the procedure to follow if the temperature was out of range in the medicines room.

Staff had access to emergency medicines. However, the resuscitation trolley did not contain the correct adult dose of emergency medicines to treat anaphylaxis (a severe reaction on an allergy) as per anaphylaxis Resuscitation Council UK guidelines published in May 2021. Instead they stocked two intramuscular autoinjectors suitable for children between the age of six and 12. Staff were not aware they stocked the incorrect dosage until we identified this. After we highlighted this, the clinical educator told us there was a national shortage of the adult dose of adrenaline in autoinjector form. When we asked for the protocol for the administration in light of the shortage and recommendations, we were told there was not one available, but they would administer the lower dose and wait five minutes before administering the second. We were not assured that in the event of an emergency patients would receive the appropriate dose to manage an anaphylactic reaction.

When we returned to the hospital a week later, it had updated their policy and had replaced the autoinjectors with adrenaline vials. However, it was not clear how adrenaline from a vial would be used in an emergency.

Inadequate

People with long term conditions

Intravenous paracetamol recorded as part of the resuscitation trolley check list, stated this was available in the medicines room. Initially, staff could not show us where they obtained this from in the event of an emergency, and there was confusion with staff between oral paracetamol availability and intravenous paracetamol. The ward manager was able to locate the intravenous paracetamol over twenty minutes later.

We found medicine administration records difficult to read. The template used for recording prescriptions had limited space to write the medicines, dosage and frequency. The service provided us with a medication administration record (MAR) audit for August 2021. This identified some issues, including illegibility and lack of dose having been recorded. It was unclear from the audit what action the hospital took in response to the audit findings.

Staff did not keep records of patch rotations or body placement for patients prescribed medicinal patches. There was a risk of staff placing a new patch in the same area of the body as the previous patch, which could irritate the patient skin.

Some medicines given to patients for 'when required' did not clearly state the reason why they were prescribed on the MAR chart.

The service had a clinical pharmacist who attended the service weekly. Nursing staff told us the pharmacist conducted medicine audits and checked medicine processes. Medicines were delivered monthly to the hospital. Staff said it was possible to get access to newly prescribed medicines within one or two days outside of the regular cycle by contacting the pharmacy directly. Doctors also had a stock of some core medicines such as antibiotics.

Staff were aware of the requirements of medicines with additional administration instructions and could demonstrate how these were followed. Staff reviewed patient's medicines regularly and provided specific advice to patients and their carers about medicines. Each patient had a record of medicine review and any changes including reasons for those changes in their medicines folder. Staff had access to a range of specialist prescribers and a clinical pharmacist who all provided input into discussions about how to best care for the patients.

Staff stored and managed all medicines and prescribing documents in line with hospital policy. Information relating to patients' medicines was restricted to authorised staff only. Staff had access to all relevant information at the point of administration.

Staff followed current national practice and guidance to check patients had the correct medicines. There was a process to ensure that people had access to the correct medicines at the point of admission or discharge. When patients left the service, staff worked with the carers or family to ensure they knew how to support the patient.

The pharmacist carried out monthly medicine audits. Feedback was given verbally at the time of the audit and followed up in written form. Staff were able to explain the process which they followed in the case of a medicines error or incident. The explanations given were consistent with the hospital's policy. Staff were aware of historic medicine incidents and how information would be shared to ensure that learning from these were carried forward.

Access to medicines storage was appropriately restricted. Senior nurses held the keys to the medicine's room.

Staff were able to access lab-based tests including blood tests from an external company to ensure they made informed decisions about a person's care.

Incidents

Inadequate

People with long term conditions

Incidents were not always effectively investigated to reduce the risk of potential harm from similar or repeated incidents. However, staff understood their responsibilities to report incidents.

The investigations of incidents were not comprehensive and lacked detail. We reviewed four completed investigations. These showed that the root causes of these incidents were not identified or explored, and recommendations were not made to mitigate the risk of similar incidents occurring. Managers were responsible for investigating incidents and had received training. However, the registered manager recognised there was a need to improve incident management.

One of the incidents reported did not appear to be an incident. The investigation was not comprehensive enough to understand why this was reported as an incident. The registered manager told us all staff received training on incidents as part of their induction and further training was completed when the hospital changed their incident reporting system in October 2020.

Staff were not able to describe learning from incidents or how processes had changed to prevent incidents from happening again. Some staff told us they did not receive feedback. We were not assured lessons were learnt and there was no evidence of sharing of learning from any of the incidents we reviewed.

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

Are People with long term conditions effective?

Inadequate

We rated it as inadequate.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Policies, procedures and guidelines were accessible to staff. Managers raised awareness of policies through sharing a 'policy of the week' and ensured staff had read and signed to confirm their understanding of the policy.

We reviewed several policies and procedures and found they were developed in line with relevant national guidelines and best practice from bodies which included National Institute for Health and Care Excellence and Resuscitation Council UK. However, staff did not always follow policies.

The hospital had systems to ensure staff knew about safety alerts and incidents. Staff were able to show us the most recent Medicines and Healthcare products Regulatory Agency alerts and actions taken.

Nutrition and hydration

Inadequate

People with long term conditions

The provider could not assure us that staff gave patients enough food and drink to meet their needs and improve their health.

Patients nutritional and hydration needs were not always identified, monitored and met. We reviewed 10 patient records and found significant gaps for food and fluid intake in all. Some patients were not able to feed themselves or drink fluids without the assistance of staff. Staff told us the patients received adequate food and fluids however, due to the missed entries we could not verify this. In three patient's records we found no record of food and fluid on 21, 22 and 25 September 2021.

In all 10 patients it had been assessed as necessary to monitor their food and fluid intake. We found long periods where there were no records that showed the nutritional or hydration needs of these patients were met.

Staff did not always follow recommendations. The hospital had a dietitian who worked with individual patients to support their dietary needs. However, we found discrepancies in documentation in what was prescribed in the dietitian chart and the daily observations chart. For example, in one patient's records we saw instructions from the dietitian with a start date of 18 September 2021 however, staff were using the previous instructions displayed in the patient's room with a start date of 19 June 2021. We found no record of medicine flushes on 19 and 20 September as prescribed by the dietitian for the same patient.

In another set of records, we saw a dietitian had prescribed an intake of 350ml bolus (tube feeding in specific volumes over a short period of time) but on the patient's observation chart, there were entries where less was recorded as given. There was no reason documented as to why staff had not followed the dietitian's instructions.

We reviewed another patient record and saw their food and fluid intake records were incomplete and there were significant gaps in the records for 9, 10, 16 and 17 September 2021. On 9 and 10 September there was no record that food was given. However, we found a note in the electronic record indicating that feeding was started and stopped after one hour due to vomiting, and under the direction of the doctor.

Some patients told us the food was of good quality and they could access snacks and drinks at any time. All food was freshly prepared in the kitchen in Hardwick House. Food for Rachel McMillan Unit was delivered in a hot cupboard to keep it warm. Patients were offered a choice of meals from a menu each day and provided with snacks and drinks throughout the day.

The hospital accounted for patients' religious, cultural and other needs. Patients were asked if they had any special dietary needs and this was recorded by the nursing staff. Patients we spoke with confirmed their dietary needs were met and there was a choice of food.

Staff had completed fluid and nutrition training and met the hospital target with 95% completion rate.

Pain relief

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

We reviewed care records and saw patients had appropriate pain assessments and pain care plans. Staff recorded when 'as required' medicines were prescribed and given for pain relief.

Inadequate

People with long term conditions

Staff used an appropriate tool such as a body map to help assess and indicate the level or area of pain in patients who were unable to communicate verbally.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

Hollanden Park Hospital participated in national audits, including those outlined by the UK Rehabilitation Outcomes Collaborative. Data was submitted quarterly with a yearly report published so the hospital could benchmark themselves against similar services nationally. However, due to the COVID-19 pandemic a report had not been published in 2021.

The hospital was part of the Independent Neurorehabilitation Providers Alliance and attended regular meetings with other organisations to share experience, expertise, knowledge and best practice.

The therapy teams audited patient outcomes by using a goal setting approach to each patient's rehabilitation. We saw every patient had an individual goals action plan in their patient records. The multidisciplinary team discussed and reviewed these goals at internal team meetings.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, supervision and appraisals rates were below the provider's own target.

The clinical directors supported staff to develop skills and knowledge. Staff told us they felt they received good training and advice from senior staff on meeting the needs of patients. For example, the clinical quality director had delivered a practical training session on the care and management of patients with a tracheostomy.

Staff competencies were assessed at induction, and then ongoing as part of staff performance management. The service offered staff clinical supervision every four to six weeks depending on the individual staff experience and competence. Staff told us they felt supported by their managers and had opportunity to raise any concerns with their manager. At the time of our inspection, the supervision rate was below the 90% target at 85%.

Appraisal rates did not meet the hospital target of 90%. At the time of our inspection the appraisal rate was 74%. Staff told us they had not received an appraisal and relied on the supervision meetings to seek support from their managers and discuss any concerns they had.

Feedback from the staff survey showed that some staff felt there was a lack of support or comprehensive induction and managers did not address any issues of poor performance. However, when we asked senior managers, they gave us examples of when they had identified and managed poor performance.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients.

Inadequate

People with long term conditions

Hollanden Park Hospital was supported by staff from different disciplines including doctors, nurses and therapists. All staff we spoke with told us staff from different disciplines worked well together and routinely attended multidisciplinary meetings to discuss patients and care plans.

The structure of the handover lacked clarity and the understanding of the process differed between senior staff. The therapy lead told us when the therapy team made changes in care plans, it was the responsibility of the therapists to update the plan, notice boards and handover to the nursing team who update the care plan. However, this was contrary to what we were told by the ward manager and clinical quality educator. They said changes were discussed at handover or in the multidisciplinary ward round and then nursing staff updated the plan. This was corroborated by our findings reported under nutrition and hydration where nursing staff followed the previous dietitian plan instead of a recently updated plan which potentially had an impact on the quality of care given to patients.

Seven-day services

The service provided care 24 hours a day, 365 days a year.

The dietitian was available on site on Tuesday, Wednesday and Thursday from 8.30am to 4.30pm.

The music therapist was available Monday to Friday from 8.30am to 4.30pm.

Physiotherapy and occupational therapy were available 6 days a week from Monday to Saturday.

A pharmacist was available onsite on Friday, Saturday and Sunday and provided remote support via telephone for all other days.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always support patients to make informed decisions about their care and treatment.

Patient records did not show recorded evidence of a patient's ability to consent or any record of obtaining consent to care before providing care. Capacity to consent to care and treatment was assessed on admission to the hospital and recorded in the care and treatment notes. Where a patient lacked the mental capacity to consent to treatment, the service completed referral documents for a Deprivation of Liberty Safeguards authorisation to the relevant local authority.

Staff had access to Mental Capacity Act 2005 guidance through the hospital's information system. Staff knew how to access the policy and told us they could get advice on the Mental Capacity Act and Deprivation of Liberty Safeguards from their managers.

Staff had a varied understanding of the Mental Capacity Act despite training data showing that 92% of staff had received training on the Mental Capacity Act. An external provider had recommended that the hospital arrange immediate training for all staff in consent, Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff infrequently and proportionally used sedation to manage patients' behaviours. Staff completed a capacity assessment and best interest decision document when medicines were hidden in food or drink (covert administration) and kept records of when and why medicines for the management of agitation and aggression was used.

Inadequate

People with long term conditions

Are People with long term conditions caring?

Requires Improvement

We rated it as requires improvement.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with three people to tell us their experience.

Compassionate care

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

Staff knew the patients they were caring for, including their preferences and histories. They supported patients to understand the plan for their day. We saw staff ensured they displayed cards to help patients remember what activity they had next. Activities such as therapy sessions therapy sessions were also noted on the patient's calendar as an additional reminder.

When interacting with patients, staff showed they were discreet, and respectful. Patients told us staff treated them well, were helpful and friendly.

We saw staff closing the door and drawing curtains when delivering care and treatment to ensure that privacy and dignity was respected.

Emotional support

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

Friends and family could visit however, in line with COVID-19 guidelines, the hospital had limited visiting times to an hour a day and each patient was allowed four designated visitors a week. Several patients and a relative we spoke with told us they would like more time with family especially since the guidance around restrictions had been relaxed, and they felt that the hospital could make further changes to accommodate their wishes.

Patients were given timely support. Staff answered call bells quickly to respond to patients and patients we spoke with said they did not have to wait long to receive assistance.

Understanding and involvement of patients and those close to them

Staff did not always involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Inadequate

People with long term conditions

Staff did not routinely involve patients and those close to them in planning and making decisions about their care and treatment. All patients and a relative we spoke with told us they would like to be more involved with and informed of the discussions about their care and the outcome of review meetings. One patient said they were due to move soon but they were not sure why there had been a delay. Another patient also due to move, told us they were not aware of the discharge plans and thought staff should involve them and their family in the decision about moving.

Are People with long term conditions responsive?

Requires Improvement

We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The hospital admitted patients from all over the South East and London.

The hospital mainly treated NHS patients, but also treated those who were either privately funded, or funded through insurance companies. At the time of inspection, there were 26 NHS funded patients.

Hollanden Park Hospital provided services to meet the different needs of patients and ensure continuity of care. These included complex care, assisted independent living, extended rehabilitation, acute neurobehavioural and acute neurorehabilitation pathways. Each pathway had a recommended length of stay and goals. However, if the goals were not achieved in the expected time or patients had reached their recovery potential, the pathway was extended, or patients were reviewed and placed on another pathway to provide the necessary ongoing support.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Patients had access to various therapies including but not limited to, physiotherapy, occupational therapy and music therapy. Sessions ran for 30 to 45 minutes and each patient had up to three sessions of each form of therapy a week.

The music therapist assessed patients for their suitability. Patients were invited to an initial session to identify if they wished to have music therapy and if they were suitable for it. The therapist saw acute neuro-rehabilitation patients with the aim to support their functional goals. At the time of our inspection seven patients were undergoing music therapy.

The hospital coordinated care with other services to support patient care and treatment. The hospital had planned for a local GP to visit the hospital and vaccinate all eligible patients for COVID-19.

Inadequate

People with long term conditions

The hospital had facilities to support patients transitioning from an acute rehabilitation pathway to an assisted independent living pathway. This focused on promoting patient independence with the end goal of returning to a home environment. As part of the transition, staff supported patients with cooking, food shopping and other household tasks.

Staff did not always support patients to have a healthier lifestyle. Patients did not have access to a range of social, cultural and leisure activities or education and vocational resources in the wider community. COVID-19 had impacted on the availability of these activities. However, a relative expressed concern that patients were not receiving rehabilitation due to the lack of activities despite COVID-19. During the inspection, we saw patients either sat in their bedrooms with limited interactions or activities or sat outside the entrance of Hardwick House. Staff did not provide evidence of what alternative activities they had implemented for patients. Feedback from a relative stated that the care given was not indicative of a rehabilitation approach and felt that their relative spent a lot of time without any activities.

Access and flow

People could access the service when they needed it however, therapy services had been reduced significantly.

New referrals were discussed at the admissions committee to identify the suitability of the patient based on the information received. Once approved the hospital worked in partnership with the commissioners to transfer the patient and throughout their stay at the hospital. On admission staff carried out nursing, therapy and psychological assessments for all patients.

There was an admissions criterion to ensure only those patients who could be cared for on the units were accepted.

The hospital used technology to support timely access to care and treatment. Out of hours, staff would contact the on-call doctor for advice and patients could get electronic prescriptions to avoid delay.

The hospital used technology to carry out assessments in preparation for discharge. Due to the COVID-19 pandemic, occupational therapists were restricted from completing home visits as part of discharge planning. The hospital was trialling other ways to gather evidence for example, by asking relatives and carers to send pictures or videos of the patient's home environment to assess. Staff told us they had received mixed results from this, but felt it was 'better than nothing'.

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

We were given examples of conflicting priorities of rehabilitation versus that of staffing. These examples included individual patients' independence being reduced due to lack of staff to support therapeutic interventions. Staff and a relative told us patients used to be offered up to seven therapy sessions a week however, over time this had gradually been reduced to three sessions which they felt was reversing and impeding any progress made.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Inadequate

People with long term conditions

Patients, relatives and carers knew how to complain or raise concerns. The hospital clearly displayed information about how to raise concerns or make a complaint. People could make a complaint face to face, via the telephone or in writing. Staff were able to describe how they would deal with a complaint and told us they always tried to resolve any issues immediately. If issues could not be resolved in a timely way, the patient, relative or carer was directed to the complaints process.

The registered manager was responsible for responding to all written complaints. The hospital acknowledged complaints within two working days of receiving the complaint. There was an expectation that complaints would be resolved within 20 days. If they were not, a letter was sent to the complainant explaining why.

We spoke with a relative who told us they were reluctant to formally raise any concerns with staff in fear of their visits being limited and the repercussions towards their relative. We were given examples of previous experiences the relative had had after verbally complaining to staff including the limiting of video calling sessions and virtual interactions.

Are People with long term conditions well-led?

Inadequate

We rated it as inadequate.

Leadership

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

The leadership team did not have oversight of all the issues. They did not always prioritise them appropriately and take timely action to resolve them. The leadership team told us they had inherited various issues from the previous provider such as the environmental issues. Since registering with CQC in October 2020, issues that posed significant risks had not been prioritised. However, the provider had made some improvements such as some changes to the environment and a change to the nurse call bell system.

The hospital had a clear leadership structure. This was led by the chief executive officer and included a director of operations and nursing who was also the CQC registered manager. The director of operations and nursing was supported by a quality lead, a head of therapies, an education lead, a support services lead and an estates manager.

The leadership team were visible, and staff told us they were approachable. Staff told us the chief executive officer visited the hospital weekly and we saw positive interactions between the leadership team and staff during our inspection.

Vision and Strategy

The provider had a mission statement underpinned by its values.

Inadequate

People with long term conditions

The hospital's mission was "to be recognised as the leading provider of neurorehabilitation services to the communities we serve by consistently providing high quality care that promotes and supports the best rehabilitative care outcomes possible". However, our findings during this inspection did not correlate with the hospital's mission statement. We did not find the overall care to be of high quality and the provider was unable to demonstrate that they provided the best rehabilitative care outcomes. Our findings were supported by feedback from some staff in the staff survey and a relative of a patient who shared their concerns about rehabilitative care outcomes.

Staff did not know what the hospital's values were and we did not see them displayed in any of the areas we visited.

The leadership team told us they had plans to improve the hospital but there was no evidence to demonstrate how the strategy was being delivered. Structure to support the delivery of the hospital's aims and objectives were not effective, and this was evidenced by the lack of discussion at governance meetings. Minutes from the clinical governance and risk management meetings referred to a quality strategy however, there was no recorded discussion on the strategy in the minutes.

Culture

The culture of the service was not focused on the needs of patients receiving care. However, staff felt respected, supported and valued.

The culture did not encourage openness and honesty at all levels in the organisation. Our interactions with staff highlighted the acceptance of poor standards and a lack of integrity. We found a lack of accountability when we spoke with staff, and staff often placed responsibility on other staff groups or made excuses. For example, on our second visit, we asked two members of the therapy team about the feedback given on our previous visit. They said the feedback was about nursing staff and it had not affected or changed how they worked. Some feedback related to incomplete patient records which therapy staff were involved in completing therefore any changes would affect them.

As explained above, staff did not always take responsibility when issues arose in order to resolve them. We had highlighted that the resuscitation trolley did not have the correct adrenaline autoinjector, in line with the recommendation by Resuscitation Council UK. We were initially told this was due to a national shortage. Staff we spoke with were not aware the incorrect dose was present on the trolley despite twice weekly checks. When we returned to the hospital a week later, we noted the service did not have a protocol on how to draw the adrenaline from the ampoules that were replacing the autoinjector. Staff should have been aware of the medicines held on the trolley and when it was identified that the incorrect adrenaline dosage was available, staff should have updated their protocol to reflect how they would manage an anaphylaxis incident with the medicines they had available.

During our tour of the site on the first day of our inspection, we were shown the Hardwick House and Rachel McMillian Unit. We requested a patient list and were only provided with a list of patients in these two buildings. On the second day, shortly before we were about to conclude our inspection, we became aware that there were an additional four patients we had not been told about. When we asked why we had not been told about these patients, we were told it was an oversight.

Staff we spoke with felt positive about the leadership team and the proposed renovations of the hospital. They said that leadership at the service had improved during the past year, and that they had confidence in the team to improve the service.

Inadequate

People with long term conditions

Staff were proud to work in the organisation. They said they felt that the team worked well together, and they also felt that they were achieving positive results with patients.

Staff knew about the whistleblowing procedures and were confident that they would be listened to if they raised a concern, although they told us they'd had no reason to raise any concerns.

Governance

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

The hospital held two governance meetings a month. One meeting reviewed the quality improvement plan while the other reviewed the previous month's quality report. These meetings fed into the monthly organisational governance meeting chaired by the chief executive officer.

Not all levels of governance and management functioned effectively. The hospital did not have a two-way process of cascading information up and down the organisation. The leadership team told us information from the governance meetings was not routinely shared with staff and there was no clear process of disseminating information about the hospital's performance. Therefore, staff were not aware of the overall performance of the hospital or actively involved in making improvements.

We saw actions from governance meetings were not comprehensive and the leadership team did not take ownership to ensure actions were followed up and improvements embedded. We reviewed the hospital's quality improvement plan and found a recurring theme of identifying risks, agreeing actions and closing the risks. However, we saw the same risks appearing in the quality improvement report a few months later showing that the issues had not been resolved. For example, in the June 2021 agenda, it was noted that "Not all PRN doses were recorded in the case of variable doses being prescribed." However, this action was closed on 1 March 2021 with the carrying out of audits being the measure that would deliver the necessary improvement.

Similarly, an action appeared in the July 2021 quality improvement plan showing that the first aid kits in Hardwick House were incomplete. That action was closed but reappeared in the September 2021 quality improvement plan.

Actions were not always timely and there was not a process of prioritising actions nearing their deadline, which resulted in deadlines being changed and not followed up on to ensure they were met. For example, the hospital planned to increase infection prevention and control fogging (a process of disinfecting an environment or equipment by spraying droplets of chemicals) as infection prevention and control procedures were not being followed. However, when we reviewed the quality improvement plan the target date for this had changed from 1 August to 1 September 2021. This action appeared in the agenda dated 27 September 2021 stating that the plan was due to be agreed on 7 September 2021 but still had a target date of 1 September 2021.

The hospital could not demonstrate how they closed the loop and they could not be assured that improvements were made and sustained.

We escalated concerns after our first day of inspection with regards to incomplete patient records, emergency medicines and emergency tracheostomy equipment. When we returned a week later some issues were remedied however, we still found issues with incomplete patient records.

Management of risk, issues and performance

Inadequate

People with long term conditions

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

We were not assured that risks to the service were always effectively identified and managed. Some concerns we identified during our inspection, for example those relating to storage of control of substances hazardous to health and the management of patient records, had not been identified as risks and did not appear on any quality or performance reports or the risk register.

The hospital's performance measures were reported through the quality dashboard however the quality dashboard was ineffective not reflective of performance. The dashboard regularly showed all areas assessed as green meaning there were no issues highlighted except for the July 2021 results which showed some variance in performance. Various issues noted during our inspection were green or documented as passed however, our findings did not verify what was reported as part of the routine audits. When we spoke with the provider on 29 September 2021, they told us that they were aware that the dashboard was not an accurate record.

Water supplies were not always maintained to minimise the risk of legionella and pseudomonas bacteria. Hollanden Park Hospital carried out monthly water testing however, this practice was inconsistent. We reviewed the shower head/ hose cleaning and disinfection records and saw not all outlets were flushed in line with hospital policy. In rooms that were currently not in use by any patients there was no record completed of the outlets being flushed weekly as part of the infrequently used outlet checks. We looked at the records for the Rachel McMillan Unit, and saw not all infrequently used outlets were flushed in line with guidance. When we raised this with the estate's manager, they confirmed our findings. This meant the service did not have adequate systems and processes in place to make sure the risks were managed.

In contrast, staff told us the bathroom we found in the McMillan Unit filled with boxes and other items was emptied weekly to run the shower and taps as part of the water safety checks. However, we were not assured that this was taking place due to the volume of items stored and the lack of entries to confirm safety checks had been completed in the water quality records book.

The hospital's audit programme was ineffective. Leaders told us they had a clinical documentation audit tool however; at the time of our inspection they were not able to provide any examples of where the tool was used.

There were some processes to identify risk. Hollanden Park Hospital had a risk register and we saw some risks within the service on the register. These risks were recorded and managed using the hospital's electronic risk reporting system. The registered manager was responsible for reviewing and monitoring the risk register. We reviewed the risk register and saw risks were in date and were reviewed monthly.

Hollanden Park Hospital had 10 active risks on their risk register. The registered manager told us all risks with a score of 16 were added to the register. The risk register included infection prevention and control, COVID-19, supervision and appraisals, waste management and disposal procedures, recruitment and wiring for Hardwick House. However, mitigating actions were not always robust enough to reduce the associated risks.

Information Management

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

Inadequate

People with long term conditions

Data collected by the hospital was not always reliable enough to monitor performance, identify areas of concern and make improvements. We saw several examples of data not reflecting performance. For example, we found monthly health and safety checks were not in line with our findings. Entries for room five in the Rachel McMillan Unit, showed the room had passed all checks. However, we saw the flooring in the bathroom was not intact which staff told us made the room unsuitable for accommodating patients. The ward manager told us that patients would not be admitted to this room due the poor condition of the bathroom floor. The estates manager confirmed the entries were incorrect and the room should not have been marked as passed.

Clinical audits were not comprehensive enough to provide reliable data. Audits were often carried out on a limited sample size which was not sufficient enough to form robust conclusions. The quality dashboard and quality reports often showed 100% compliance for most audits; therefore, the hospital's performance was not accurately reflected and could not be scrutinised to be able to deliver the necessary improvements. Following feedback from our inspection, the leadership team told us that they recognised that the monthly quality reports were unreliable and felt that there was insufficient independent checking of audit data.

Information systems were not always integrated and secure. Paper records were not locked away when not in use however, electronic records required staff to use their individual passcodes to access them.

Staff could not always find the data they needed in easily accessible formats. Patient records were recorded and stored in several areas making it difficult for staff to document all aspects of care and for others to follow the patient journey.

Engagement

Leaders actively engaged with staff to plan and manage services.

Engagement with staff had increased in the six months before our inspection. The registered manager and the head of human resources held several meetings in different formats including one to one meeting, team meetings, staff forums and exit interviews to get feedback and reassure staff about the future of the hospital.

The registered manager had begun attending staff meetings to update staff, thank them for their work and gain feedback from staff. Staff confirmed this and said engagement with hospital leaders was good and had significantly improved in the last year. They told us they felt that the chief executive officer was open to suggestions and they told us they felt listened to.

All staff told us the leadership team kept them informed about progress relating to the expansion and renovations the hospital was due to have. However, when asked if they were told of any dates, staff told us works were to begin soon. When we asked the hospital leaders, we were told an architect was currently drawing the plans and the hospital had not applied for planning permission.

Learning, continuous improvement and innovation

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

Inadequate

People with long term conditions

The provider had managed the location for 11 months prior to our inspection and any quality improvement methods introduced during this time had not proven to be effective. Therefore, prior to our inspection the hospital had commissioned an independent review of their governance and framework which was addressing the concerns we had raised and making changes to other aspects of the hospital. The review had begun shortly after our inspection and the hospital was regularly updating CQC with their progress.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Not all staff were compliant with mandatory training. The service reported a low compliance rate in key modules including safeguarding and life support training. • Not all staff wore surgical face masks which were approved as personal protective equipment in line with hospital guidance. • The premises and equipment did not always keep people safe. Clinical waste was not managed well. • Resuscitation equipment was not managed safely and in line with hospital policy. • Staff did not always complete patient and environmental risk assessments in a prompt manner. They did not always act to remove or minimise risks or update the assessments when risks changed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs • Staff did not always give patients enough food and drink to meet their needs and improve their health.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- Incidents were not always effectively investigated to reduce the risk of potential harm from similar or repeated incidents. Staff could not describe what lessons were learnt from the incidents they reported.
- Staff did not keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or reflective of the care provided.
- The service did not operate effective governance systems to improve the quality of services.