Renovo South Newton Limited

South Newton Hospital

Inspection report

Warminster Road
South Newton
Salisbury
SP2 0QD
Tel: 01732833924

Date of inspection visit: 13 October 2021
Date of publication: 22/12/2021

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	Inspected but not rated
Are services safe?	**Inspected but not rated**

Summary of findings

Overall summary

We carried out an unannounced focused responsive inspection of the safe question in response to specific concerns.

We have not previously inspected this service.

We did not rate the service at this inspection.

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

Some patient records were not up to date or comprehensive, and there was little evidence of audit prior to the registration visit in September 2021. Some patients lacked individualised care plans. Patients with diabetes had no care plans for managing this condition and the service had no specific diabetes management policy.

Staff training records did not reflect the current workforce and did not contain details of specialist training undertaken by staff. Less than half of the current workforce had received supervision sessions or an appraisal.

Incidents were reported but there was no evidence of provider intervention to manage the potential of serious patient harm and the service did not always notify the Commission of certain incidents as defined as part of their legal duties.

However:

Staff spoke highly of some managers providing support above and beyond their role. Patient records were securely stored but were easily accessible to authorised staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to South Newton Hospital

We carried out an unannounced focused responsive inspection of the safe key question on 13 October 2021 in response to specific patient safety concerns following a serious incident. We did not rate the service at this time. We have not previously inspected this service.

South Newton Hospital is owned and operated by Renovo South Newton Limited and registered since December 2020. The service is registered for the regulated activity:

- Treatment of disease, disorder or injury.

The service does not currently have a manager registered with the Care Quality Commission.

The provider, Renovo South Newton Limited, is an independent specialist service for the assessment, treatment and rehabilitation of adults with neurological conditions including acquired brain injury and progressive neurological disorders.

The location, South Newton Hospital, located six miles from Salisbury in Wiltshire, is an independent specialist service for the assessment, treatment and rehabilitation of adults with neurological injury and conditions, including people with challenging behaviours and/or long-term conditions.

At the time of our responsive focused inspection the service had seven patients on Wylye ward and was expecting one admission. Avon ward was currently closed. The total number of beds available across both wards was 17.

The provider employed 15 nurses (two of whom were ward managers), 14 rehabilitation and senior rehabilitation assistants, three physiotherapists, one occupational therapist, one speech and language therapist, eight administrative staff plus other rehabilitation staff such as dietitians on a contractual session by session basis.

The service employed two resident medical officers who worked one week on, and one week off. There was additional consultant doctor cover 24 hours a day provided by three specialist consultant doctors.

The service currently has conditions placed on its registration:

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

Before the inspection we reviewed information we already held from previous registration inspections and other information about the provider.

Summary of this inspection

How we carried out this inspection

The team that inspected this location compromised of a CQC inspection manager and two CQC inspectors. It was overseen by Catherine Campbell, Head of Hospital Inspection. During the inspection we spoke with three members of staff including two members of the management team. We reviewed documents, policies and patient records as necessary. We also inspected individual patient rooms, communal areas and wards.

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

Action the service MUST take to improve:

- The registered person must make sure they notify the Care Quality Commission of incidents specified in paragraph (2) which occur while services are being provided in the carrying on of a regulated activity, or because of the carrying on of a regulated activity. Care Quality Commission (Registration) Regulations 2009 (part 4) Regulation 18 (1), (2) (e) and (f)
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Action the service SHOULD take to improve:

- Develop a specific diabetes management policy to underpin diabetes care for patients.
- Ensure risk assessments relating to health, safety and welfare of people using the services are carried out and completed by staff with the correct training, skills and competence to do so.
- Review the process surrounding incident management to ensure all learning is identified, captured and shared.
- Improve governance of staff training records to reflect current workforce and include all training both mandatory and specialist.
- Develop specific care plans for management, care and treatment of anaphylaxis and risk of swallowing or ingestion of foreign bodies or noxious substances.
- Give all policies indexes that are clear so staff can find guidance quickly in an emergency.
- Establish a regular programme of audits to include records and clinical observation early warning scores and demonstrate changes made to improve quality and accuracy as a result of the audits.

Improve the sharing of key information to keep patients safe when handing over their care to others.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Inspected but not rated	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated

Inspected but not rated

Medical care (Including older people's care)

Safe	Inspected but not rated

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

Inspected but not rated

We did not rate this key question.

Mandatory training

The service provided mandatory training in key skills. We are reporting on more specialist training under Nursing staffing below.

In those records we reviewed, some staff received and kept up to date with their mandatory training, but not all nursing staff were up to date in all subjects. The service provided data which covered all training subjects, but they could not explain which were mandatory and which were competency based or specialist training for the role. Following the inspection, the provider submitted data which showed mandatory subjects only. The majority of staff, (22 out of 23 staff) had completed this training.

The service provided update training in 55 subjects, tailored to each role. Compliance against these subjects was variable but at the time of the inspection the provider was not able to explain which training was mandatory and which was specialist. Managers informed us face to face training sessions had been stopped during COVID-19 which had impacted face-to-face training figures. However, compliance with online training was good, for example, 91% of staff had undertaken online manual handling training which was part of the mandatory training subjects.

Medical staff received and kept up to date with their mandatory training. We saw two staff profiles which contained details, certificates and expiry dates of all training held by each resident medical officer (RMO). Resident medical officers were engaged through an agency who was contractually responsible for ensuring that the staff supplied kept their training up to date, however the provider did not undertake its own checks to make sure this was being done. Staff told us following a suspected anaphylactic reaction, managers had been prompted to retrospectively check both resident medical officers had up-to-date advanced life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw notices, emails and notes in diaries to remind staff to attend training, although managers told us, due to staff shortages, it had not always been possible to allow staff to leave during their shift. We saw signs asking staff to join courses on days off which offered additional payment to support them to attend.

Safeguarding

Staff understood how to protect patients from abuse and the service generally worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, it was not entirely clear how compliance with training for medical staff was monitored.

Nursing staff received training specific for their role on how to recognise and report abuse and training compliance against this subject was 86% across all nurses and rehabilitation assistants (RA).

Staff and managers explained they had notified the local authority of a recent safety incident and were awaiting advice from them before deciding if the incident was a safeguarding or serious incident. At the time of our inspection the managers had not yet heard from the local authority and had not chased it.

Medical staff received training specific for their role on how to recognise and report abuse. We saw evidence in the resident medical officer profiles of safeguarding training. However, it was not clear how ongoing compliance was monitored and acted upon internally.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and knew how to make a safeguarding referral and who to inform if they had concerns. Staff could explain who they would contact, and we saw memos reinforcing the reporting structure.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments and care plans for patients to remove or minimise risks. Staff did not always identify and act upon patients at risk of deterioration. Staff were not up to date with risk assessment training.

Staff used a nationally recognised tool to identify deteriorating patients, but there was no evidence of escalation, when required, recorded in patient notes. Early warning scores had not always been acted upon correctly (this is a tool for the detection and response to clinical deterioration in adult patients. This is a key element of patient safety and improving patient outcomes). In two records we reviewed, some high scores were not escalated, and further observations were not taken in line with instructions. For example, in one patient's records, when the patient scored eight, observations should have been taken hourly, but there was a gap of 15 hours before the next set of observations were taken. After the inspection managers informed us the gap was due to the patient withdrawing their consent for the observations, however this was not clearly documented, although the patient was reviewed by the medical team instead.

The service had a medical emergency and resuscitation policy which outlined roles and responsibilities of staff in a medical emergency. As part of the policy it was stated all staff needed up-to-date basic life support (BLS) training with qualified and medical staff requiring immediate life support (ILS) training. Both registered medical officers were complaint with this training requirement, but at the time of our inspection no qualified nurses were up to date with immediate life support training. Overall basic life support face-to-face training compliance for all clinical staff was 92%. Managers told us that since the inspection, 11 out of 15 nurses had since completed their ILS training.

Staff did not always complete risk assessments for patients with diabetes on admission and those that we saw were not reviewed regularly. There were no care plans or assessments for two patients with known diabetes, and the service did not have a specific managing diabetes policy. Instead, managing hypoglycaemia (low blood sugar) was covered in the medical emergency and resuscitation policy. We reviewed this policy and saw specific guidance of management of hypoglycaemia was contained within appendix 5 of the policy. However, this was not reflected in the index which meant it was not immediately clear where in the policy staff should look for guidance.

Some patients were at risk from a lack of risk assessments. There was no care plan to guide staff in recognition, treatment and after care of anaphylaxis. This meant that the patient was at risk of deterioration as staff may not be aware of the anaphylaxis reactions and what emergency actions to take. There was no review or modification of any risk assessment after care records showed a patient had experienced three suspected anaphylactic reactions in the two months since their admission. Actions taken were generally in line with the provider's medical emergency and resuscitation policy however they failed to document referrals for further investigation and follow-up by an allergy specialist."

Staff knew about but did not always deal effectively with specific risk issues, for example around diabetes management. We reviewed a set of notes for a patient who had Type 2 Diabetes Mellitus. It was well documented in the notes the patient had diabetes and it was noted on the nutrition risk assessment. However, there was no plan for staff to follow to manage this condition. The staff measured the patient's blood sugar daily but there were no parameters for escalation if the blood sugar was too high or too low. In another set of records for a patient with confirmed Type 2 Diabetes Mellitus, there was also no diabetes care plan. Instead there were a handwritten set of parameters on a blood glucose monitoring sheet in the patient's notes which included what to do if blood glucose readings were outside of the defined parameters. The information was not recorded in a care plan with actions to be taken in certain circumstances. When we brought this to the attention of the senior nurses, they agreed patients needed a diabetes care plan and escalated it to the ward manager for review.

Staff did not always correctly score risk assessments for patients thought to be at risk of self-harm or suicide. A self-harm and environmental ligature risk assessment had been completed on admission for a specific patient. This assessment was to recognise points of risk for the patient and how to use control measures to mitigate risk. The assessment included risks identified with bed rails, sheets and pillowcases, various electrical cords, the patient's urinary catheter tubing, risk of swallowing/ingesting items, fire safety and sharp objects that could be used to harm themselves.

It was well documented within the patient's notes, care plans and preadmission assessments, how the patient was at high risk due to mental health needs. We found the ligature risk assessment had been completed but it did not give a high enough risk score to certain aspects of the patient's previously known history. The risk assessment did not mention other items which were known risks and should have been identified and removed from the patient's immediate environment, as they could have been used by the patient to harm themselves.

The mitigating actions for the risks to the patient included nursing the patient on a one-to-one basis and the availability of a ligature cutter. The ligature cutter was kept in a drawer in the locked nurse office which could have presented a delay in the cutting of any ligature. This was despite the assessment stating it needed to be in the patient's room with the staff member on duty.

Records also showed the nursing staff were not up to date with risk assessment training.

Staff shared key information to keep patients safe when handing over their care to others but did not always act upon it. For example, it was noted on the handover sheet a patient was an insulin dependent diabetic, but it was recorded they could eat and drink normally and did not state they needed a sugar free diet and drinks.

Nurse 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. Not all staff had been provided with a performance review (appraisal).

The number of nurses and healthcare assistants did not always match the planned numbers. Where that was the case, therapy and management staff, including the clinical services manager, were deployed to ensure patient safety. In addition, the service utilised bank and agency nurses on the wards to address absences brought about by COVID-19 and increased demand for one to one care whilst carrying out recruitment.

The provider faced particular challenges in relation to the complex needs of one specific patient. The provider had requested that the patient be transferred to another service due to their needs being significantly different to those anticipated on admission. As the commissioners were unable to arrange this transfer, they provided dedicated registered

mental health nurses and support workers to work alongside regular staff employed by the provider. The commissioners' staff were intended to be employed to cover five shifts over one weekend. These staff had not attended for one of the shifts and attended in lowered numbers than intended for others. The provider had covered these absences from their own staff, but the inconsistency of staffing had triggered an anxiety attack for the patient.

The service had also experienced increasing sickness rates as two staff members had been injured by a patient.

Not all nursing staff had up-to-date training in specialist skills. The service provided training in 55 subjects, but at the time of the inspection it was not clear which were mandatory, and which were competency/specialist training. Out of the 55 subjects, 39 had compliance between 64% to 100%. In the training records we reviewed, 96% of staff had received their mandatory training, but not all nursing staff had up-to-date training in specialist skills. The provider told us that arrangements for training had been impacted by Coronavirus-related restrictions and staff absences. Managers explained that, due to coronavirus restrictions and the impact of the pandemic on staffing, the service had struggled to arrange face-to-face training or to free staff to attend sessions and many update sessions were now planned before the end of 2021.

Managers told us they were assured the service had enough trained staff to respond in an emergency situation although data did not support this. We were told all nurses had been trained in ILS in August 2020 although training data showed one nurse's training had lapsed in January 2020. Managers said that because staff had historically had ILS training (which was required annually), they were assured they could deal with emergency situations, and also because 92% all clinical staff had received recent BLS online training. Additionally, the RMO was ALS trained and was on site 24 hours a day. However, there was no evidence of assurance that staff would be up to date with any changes to practice in relation to resuscitation.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Records showed compliance against this training was 96% for nurses and rehabilitation assistants. However, staff we spoke to told us they felt they had not received adequate specialist training to help support one patient. We were told staff had been affected and some had resigned, and others were away on sick leave. Managers explained they had escalated the situation to commissioners of the service for the particular patient but felt that had not received prompt support or help.

Managers told us staff had undertaken psychologist-led scenario-based training to help support one patient. However, this was not included on the training spreadsheet, so we were not assured of the provider's governance and oversight of this specialist training.

The situation around training remained unclear after the inspection. Further data was supplied after the inspection which showed only 38 training subjects were required instead of the original 55. Subjects no longer on the spreadsheet included sepsis, catheter care, bowel management, tracheostomy, PEG care, risk assessment and oxygen therapy, so it was not clear if these were core or specialist training subjects or not. We also saw blank competency sheets which covered some of these subjects but did not see any further training figures to show us who had achieved these competencies.

Records viewed at the time of the inspection suggested staff did not always receive an appraisal or supervision. However, data submitted post inspection showed all staff had received their initial induction. We reviewed records which showed 42% of all staff had received an appraisal and 50% had received some supervision sessions. A member of the leadership

team told us that due to staff changes, sickness absence and prioritisation of delivering patient care, staff appraisals were "a long way from where they need to be, and we recognise this as an area we need to prioritise". Managers further clarified that figures reported reflected supervision sessions which had taken place in the past six weeks and that all staff had received supervision in the past six months although we did not see data to support this.

Records

Records of patients' care and treatment were stored securely and easily available to all authorised staff providing care.

Staff did not always keep detailed records of patients' care and treatment. Some records were not clear, or up to date. However, those we reviewed were stored securely and easily available to all authorised staff providing care. Managers had conducted a recent sample audit of patient records and as a result, they consulted with staff to seek their view on record keeping improvement. A member of the leadership team had committed to undertake a full deep-dive records audit. However, at the time of the inspection had only audited records for two of the eight patients at the hospital. Previous care plan audit data supplied showed 100% compliance against the six areas audited including care plans being re printed every six months. However, we saw in one patient record, care plans had dates crossed out and replaced by updated handwritten dates, instead of being reprinted. We did not see any evidence that this impacted on the quality of the care plans.

Incidents

The service did not manage patient safety incidents well. Although staff recognised and reported incidents and near misses, managers did not fully investigate incidents and share lessons learned with the whole team and the wider service. Managers did not ensure that lessons were learned from patient safety incidents and that learning from events was not implemented and monitored.

Staff knew what incidents to report and how to report them. We reviewed incidents for the time period of two months prior to our inspection. We saw from the incident report system that staff raised concerns and reported incidents and near misses in line with the provider's policy.

There had been a significant number of incidents relating to one patient, in a two-month period prior to our inspection. The provider made a safeguarding referral to the local authority, however these incidents and near misses were a concern due to the lack of provider intervention to manage the potential of serious patient self-harming.

Managers did not investigate incidents thoroughly. In the records we reviewed there was no evidence of incidents being investigated thoroughly and where it was appropriate, patients and their families were not involved in these investigations. Written de-brief records which supported staff with any learning to prevent re-occurrence after any serious incident were not always completed fully. Staff met to discuss incident feedback but did not look at improvements to patient care or learning to prevent reoccurrence.

We attended a multidisciplinary early morning huddle to discuss issues across the hospital. This did not include any reference to learning after incidents or any change in practice, however, managers explained this was not an appropriate forum for such discussions. Instead they explained that learning from incidents was shared using an after-action review document.

The provider did not formally notify the Care Quality Commission of all incidents it was legally bound to report. During the inspection we found two incidents, covering a two-month period prior to the inspection, of which we were not formally notified about. We saw a report of an incident which occurred in September 2021 where the police were contacted.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider did not formally notify The Care Quality Commission of incidents it was legally bound to report. During the inspection we found two incidents, covering a two-month period prior to the inspection, of which we were not formally notified about. We saw a report of an incident which occurred in September 2021 where the police were contacted. We also found in the week before the inspection there were staff cover issues, which affected the provider's ability to continue to carry on the regulated activity safely, in accordance with their registration requirements. Regulations 2009 (part 4) Regulation 18 (1), (2) (e) and (f)