St Cyril's Rehabilitation Unit

Quality Report

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

Overall summary

St Cyril's Rehabilitation Unit is operated by St George's Care UK Limited

We undertook this unannounced focused inspection of St Cyril's Rehabilitation Unit in response to concerns that were raised with us about the safety and quality of the services provided to patients. This inspection focused on the safety of the services provided and how well led the service was. Where we observed practice in other areas we have included this information in the report. As this was a focused inspection we did not rate the service.

We previously inspected this service using our comprehensive inspection methodology. We carried out the previous announced inspection on 1 and 2 of March 2017.

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

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

The main service provided by this hospital was Community Inpatient Services.

We found the following areas for improvement:

- Staff did not always recognise, assess and mitigate risks to patients' safety. This included lack of compliance with the provider's early warning scoring system. Staff were not always following the provider's policy for recording and acting on early warning scores.
- Nurse staffing of an appropriate skill mix to provide senior nurse cover was inconsistent. Senior nurses (band 6) were in charge on most shifts but there were an excessive number of shifts, particularly night shifts, where the senior nurse was a band 5.
- The safe management of medicines continued to require improvement. Audits had identified areas for improvement but these had not been addressed and no action had been taken to improve standards.
- The medical cover arrangements were provided on a sessional basis by two consultants from local trusts which did not provide dedicated substantive medical oversight. However, the provider had advertised for a substantive full time consultant. In addition the senior clinical nurse role was vacant, this meant staff were not always able to seek senior clinical nursing advice

Summary of findings

and support. This also meant that there was a risk of insufficient clinical oversight and challenge within the hospital to recognise and act on areas of poor clinical practice.
- The hospital manager role was vacant and despite temporary cover being provided by a senior member of the corporate team this meant that there was insufficient oversight of the hospital business.

However,

- Staff treated patients with kindness and provided care to patients while maintaining their privacy, dignity and confidentiality.
- Controlled drugs were stored and managed appropriately.
- We found improvements in the way patients individual needs were catered for and considered since the last inspection.

Following the inspection, we told the provider that it must take some action to comply with the regulations and that it should make other improvements, even where a regulation had not been breached, to help the service improve.

When we formally warn a service, or propose action to add or remove a condition, we have to give it time to submit representations to us or appeal to an independent tribunal. We can only publish information about action we've taken when this period has ended.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Summary of findings

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Background to St Cyril's Rehabilitation Unit

St Cyril's Rehabilitation Unit is a single storey purpose built facility which provides a wide range of accommodation to meet the needs of patients. Facilities include; quiet lounges, television rooms as well as dining areas, a therapy suite, a gym and a purpose built hydrotherapy pool.

All patients' bedrooms are single with en-suite bathrooms offering privacy. All bedrooms are fitted with electronic ceiling hoists and a nurse call bell system.

The unit comprises of four patient bedroom wings, a therapy wing and an administration wing. The therapy wing includes a gym, occupational therapy, and speech and language therapy.

St Cyril's has a total of 26 beds, two of which are one-bedroom bungalows designed to help patients transition to a higher level of independence prior to discharge.

The primary function of the service is to provide a facility for those who have complex needs as a result of neurological impairment or physical disability. There are seven beds in use to meet the needs of patients with challenging behaviour as a result of neuro-disability. These patients may or may not be detained under the Mental Health Act (1983, amended 2007).

The service has four separate care and bedroom areas and central communal facilities.

- The Cheshire Suite supports patients with complex physical needs, including those with low awareness or with continuing care needs.
- The Grosvenor Suite provides active short to medium rehabilitation with physiotherapy, occupational therapy and speech and language therapy available as required.
- The Westminster Suite offers specialist care to individuals who present with challenging behaviours as a result of neurological impairment.
- The Dee unit adjacent to the Westminster suite is intended for patents that are progressing along their rehabilitation programme and supports patients with a higher level of independence.

Services provided at the hospital under service level agreement:

- Pharmacy
- Consultant cover
- Specialist nurses for example Tissue Viability Nurse.

The hospital does not currently have a registered manager. The nominated individual is the Chief Executive.

Our inspection team

The inspection team was led by Lorraine Bolam, Head of Hospital Inspection, and comprised of three CQC inspectors.

Why we carried out this inspection

We inspected this service as a focused inspection due to concerns we had about the provider.

Summary of this inspection

How we carried out this inspection

During the inspection we interviewed the deputy chief executive, the director of governance, we spoke with eight staff members including; registered nurses, therapy staff, health care assistants, known as Rehabilitation Co-therapists (RCT), and reception staff.

We observed care and treatment, spoke with two patients and four relatives visiting patients. We reviewed six sets of patient records, 15 prescription records and 10 staff files.

Before the inspection we reviewed information we held about the location.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- Liquid medicine bottles did not have the date of opening recorded on them. We were therefor not assured that these medicines were discarded within the recommended timeframes.
- Areas of concern highlighted on medicines management audits did not identify actions to be taken to address these areas of concern.
- Records of transdermal patches were incomplete and incorrect and prescription cards did not always have the staff signature on them. Some care records did not provide consistent information on how to give certain medicines that were prescribed for patients as they needed them, for example simple pain relief.
- Not all staff were following the policy on recording early warning scores for observations. Senior staff acknowledged that further action was required but there had been recent improvements.
- The provider had a policy in place to care for the deteriorating patient, which included sepsis. However, staff we spoke with were not knowledgeable about the symptoms of sepsis.
- All nursing staff had completed tracheostomy theory training but it was unclear from the records how many of these staff had completed practical training to ensure they were competent.
- There were a large number of shifts when there was a band 5 on duty as the senior nurse instead of a band 6 senior nurse.
- There was an on call system available for staff to contact a doctor when they were not at the hospital, but there was no alternative option for staff if they could not contact the on call doctor.

However,

- There was a safeguarding policy in place which staff understood and there was evidence that safeguarding incidents had been reported in line with policy. Safeguarding training had been reviewed since the March 2017 inspection and met the national standards.
- Care records had improved since the last inspection and were now easier to understand and the majority reviewed were completed and up to date.
- Staff said they very rarely experienced staff shortages.

Summary of this inspection

- The hospital was visibly clean and tidy. Staff were observed to be compliant with hand hygiene techniques and followed good practice guidance in relation to infection prevention and control.

Are services effective?

- Capacity assessments were completed on patients during their admission. However, we found that these were not always reviewed and did not reflect the patients' mental health care plan.
- National guidance on mental capacity assessment was not always followed and not all patients who required a capacity assessment received one. We saw one patient where an application had been made for a deprivation of liberty, but the patient had not undergone a mental capacity assessment.

However,

- Patients received a nutritional screening using a validated tool. The records we looked at were all completed and available in all care records reviewed.

Are services caring?

- Staff spoke to patients with care and compassion.
- All patients gave positive feedback about how staff treated and interacted with them and relatives told us that they had noticed improvements since the last inspection and staff were kind and caring.
- Personal care delivered by staff respected patient's privacy and dignity.

Are services responsive?

- Since the last inspection we found that there had been improvements in care records and these included ways to meet the needs of the patients so that staff could be responsive.
- There had been improvements in patients being involved in social activities outside the hospital and families were being invited to attend social outings and events.

However,

- Patient's personal preferences and choices around food were not always being consistently recorded.

Summary of this inspection

Are services well-led?

- There were still a number of key clinical staff vacancies at the time of the inspection, but the provider was in the process of advertising for these roles and appointing new clinical leadership roles.
- Some clinical governance processes were not effective, for example medicines management and the reduction of risk.There was limited assurance that actions taken to improve concerns identified by the provider were having an impact on reducing the risk.

However,

- We were told by patients' relatives that they were more involved in the care planning for the patient and their views were taken into account and systems were now in place.

Community health inpatient services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health inpatient services safe?

Incidents reporting, learning and improvement

- Staff told us that they had access to the hospitals electronic incident reporting system. All staff were able to tell us how they would report an incident using this system. Incident reports showed comprehensive information and detailed actions taken by the management team in order to maintain the safety of patients.

Safeguarding

- There was a provider wide safeguarding policy. This policy set out how issues of a safeguarding nature should be identified and acted on. This policy was comprehensive and contained clear instructions for staff to follow.
- The safeguarding policy in place stipulated that safeguarding referrals issues should be made to local authority and the police within 24 hours of identification.
- We found that in two cases that were reported as safeguarding incidents, both had been reported appropriately within this timeframe
- The 'Intercollegiate Document; Safeguarding Children and Young People (2014)' states that the identified safeguarding lead should be trained to level 4 for children.
- The director of governance had undertaken an advanced level of safeguarding training that was in line with the intercollegiate guidance. They acted as the lead for the site and were available for advice 24 hours a day. Staff told us they felt comfortable and confident in raising issues with the safeguarding lead.
- Documentation reviewed recorded that training rates for mandatory training in safeguarding adults were 100%, which met the hospital target and indicated that all staff had received training in safeguarding adults. We found that the safeguarding training program had been reviewed and adapted to meet national standards since our last inspection in March 2017.

Medicines

- In one of the two medicine storage areas we found 16 bottles of liquid medicine that had been opened without recording the opening date. It is important that liquid medicines have the date they were opened clearly documented. This is to ensure they can be discarded within the timeframes recommended by the manufacturer and patients do not receive medicine that has been open for longer than the recommended time frames. This was an issue we highlighted to the provider during our last inspection. We found that this had not improved during this inspection.
- The hospital commissioned their pharmacy provision from a hospital pharmacy. The pharmacy team carried out weekly and monthly audits of medicines management. We reviewed four audits and saw that there were areas of concern identified which included similar themes to issues identified on the last inspection. We found that no actions had been recorded to address these areas of concern. These audits also identified a number of issues regarding stock reconciliation that had not been addressed. For example, one patient record showed that of their stock of medicine 42 tablets were not accounted for. We found that the stock reconciliation for every patient we reviewed was incomplete or incorrect. We reviewed 15 records. This had been highlighted on the monthly and weekly audits but no action had been taken.
- We found during the last inspection that the management of transdermal patches was not well managed. During this inspection we found that all of the four records we reviewed in relation to transdermal

patches were incomplete and incorrect. Examples included missing times and dates and charts not completed when the patch had been changed. This was despite the provider previously providing assurances to CQC that this issue had been addressed.
- We reviewed prescription cards for 15 patients. We found that in four of those records there were omitted signatures which had not been actioned by the management team of the hospital following medication audits being completed.
- Staff told us that records regarding as needed (PRN) medicines did not provide sufficient detail for them to make evidence based decisions to give this medicine. For example, the prescriber cards recorded the use of medicines PRN as, “for pain” or “for agitation”. A review of care records showed that there was inconsistent information available. Some care records contained guidance to staff regarding how to safely give PRN medicines other records did not. This meant there was a risk that staff did not always have the guidance they needed to determine when a patient required a PRN medication or how to monitor its effectiveness.
- Controlled drugs were correctly stored, recorded and managed in line with legislation. Records for controlled drugs were accurate and checks indicated that there were no items unaccounted for.
- We observed that the doors to both medicine storage areas were kept locked and secure.

Environment and equipment

- Emergency resuscitation equipment was in place in the main lounge. A review of the records indicated that the equipment was checked weekly. We found that records reflected that these checks were carried out fully each week.

Quality of Records

- Care plans were paper based and we saw that they were securely stored in the nursing offices.
- During the last inspection we raised that the files were very large and cumbersome and difficult to navigate. We found on this inspection that records previously called treatment plans had been rewritten and where now called care plans. They were now easier to understand although senior staff told us there was still action to be taken to improve the records. This included working to reduce the size of records and streamlining the care and treatment plans.
- We reviewed eight sets of patient treatment records including care plans. In all the records reviewed we found that the majority of sections were completed and up to date. We found some minor omissions in records which did not impact significantly on patient care and treatment.

Cleanliness, infection control and hygiene

- All areas of the hospital observed were visibly clean and tidy.
- Staff members were observed using personal protective equipment (PPE), such as gloves and aprons and changing this equipment between each patient. We saw staff washing their hands using the appropriate techniques and all staff followed 'bare below the elbow' guidance.

Assessing and responding to patient risk

- The hospital used a national early warning score (NEWS) system to monitor patients’ clinical condition and identify any deterioration so that appropriate action could be taken. The NEWS system was designed to assign a score to each clinical observation, for example blood pressure and temperature, to indicate potential deterioration in patients’ condition and prompt clinical action. The associated outline of clinical response to NEWS document provided stipulated set actions to be taken when patients overall score reached a specified level.
- We reviewed an audit undertaken in May 2017 by the provider. This showed that the documented frequency of observations was not completed in any of the records checked. The NEWS was only totalled correctly in 11% of records audited, documented evidence of escalation to a nurse when the NEWS was 1 or above was not recorded in any of the records reviewed and there was no evidence recorded in any of the records audited to show if a patient triggered further review due to deterioration, they were reviewed in line with the Outline Clinical Response to NEWS Triggers.
- The overall compliance with this audit was 61%. This showed staff members were not following the providers’ internal policy on early warning scores. This issue was identified at the last inspection and the provider had implemented actions to address these concerns. While we noted that there had been improvements to this

area there was still further action required which was acknowledged by senior staff. This action included increased audit frequency and monitoring of scores and compliance

- A review of patient observation charts also showed that a high proportion of them had not been completed in a consistent or accurate way and in four cases the records had been altered to reduce the NEWS. Staff also told us and we saw examples in records that when a patient scored highly for a parameter their observations were retaken and the earlier high score crossed out and discounted. This was not in line with good practice and a safety concern.
- Some staff members were following the providers' internal operating procedure for escalating patients with deteriorating conditions. We reviewed the records for a patient who had been transferred to an acute hospital. These records showed that the patients' condition was identified and escalated appropriately.
- We reviewed the arrangements in place for staff to recognise and act on the key signs of sepsis and what they would do if a patient was suspected of developing sepsis. Sepsis is a rare but serious complication of an infection that can lead to shock, multiple organ failure and death if not addressed rapidly. We observed that the provider had a deteriorating patient policy in place which covered sepsis recognition and signs were displayed with common symptoms outlined. However staff we spoke with were not knowledgeable about these symptoms and we observed one patient who had two signs of sepsis and there was no evidence in the care records what action had been taken.
- During the last inspection we were concerned about the low number of staff with up to date tracheostomy training. We were concerned that this meant staff could not deal with complications during the procedures with these devices. On this inspection we found that all qualified nursing staff had undertaken up to date and fit for purpose theory training in this subject.
- However the practical competency of staff to undertake care duties relating to specific areas of care, for example, percutaneous endoscopic gastrostomy (PEG) tube feeds and tracheostomies was unclear. Records were poorly kept and there were various formats of the competency documentation. There was certification of training but we saw no evidence that practical application had been tested.
- We witnessed one occasion whilst on the unit of care being given by a member of staff untrained in the procedure of PEG care. This was raised with the provider, they provided immediate assurance that this staff member would be trained and that they would reissue instructions.

Staffing levels and caseloads

- The hospital was staffed in line with guidance in respect of frontline nursing staff and care staff at the time of the inspection. Staff told us that they felt they had time to care for patients and very rarely experienced shortages of staff.
- Agency and bank staff members were used and they were usually returning staff members who were experienced in working in the hospital. These staff were inducted appropriately and briefed on any new procedures.
- Staffing of an appropriate skill mix to provide senior nurse cover was inconsistent. Senior nurses (band 6) were in charge on most shifts but there were an excessive number of shifts, particularly night shifts, where the senior nurse was a band 5.
- There were two medical doctors for the unit who were available via a call system seven days a week 24 hours a day. The doctors were on site five days a week for half day sessions. There was no alternative option if the staff could not contact these doctors. The provider told us that they were looking at recruiting a full time doctor. This was advertised shortly after the inspection.

Are community health inpatient services effective?

(for example, treatment is effective)

Nutrition and hydration

- Nutritional scores were completed and were available in all care records reviewed. The service used the validated malnutritional universal screening tool which had five steps, designed to identify adults at risk of malnutrition. The tool allows patients to be categorised as being at low, medium or high risk of malnutrition and enables care plans to be developed.
- Special diets were recorded and available to assist the kitchen staff and ensure patient's received the correct diet.

Community health inpatient services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Patients can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
- We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The DoLS orders that were in place demonstrated that these had been applied for to the local authority and the orders granted. Where conditions were in place for DoLS, these were monitored.
- In three out of four records we reviewed we found that mental capacity assessments were at an overarching level. For example a patient admitted to the acquired brain injury unit had a capacity assessment completed on admission in April 2017. This had not been reviewed since admission and did not reflect the mental health care plan, which stated the person did not have capacity to make decisions, but did not detail if there were time or decision specific decisions. The hospital is reviewing how they manage assessments of capacity and have introduced new records. These were not all in place at this inspection but progress had been made to addressing specific decisions.
- In one record we could not locate a capacity assessment and this was despite there being a DoLS application. This meant we were not assured that DoLs applications were being made in line with national guidance.

Are community health inpatient services caring?

Compassionate care

- We observed that all staff spoke to patients with care and compassion.
- We spoke with two patients, who all gave us positive feedback about how staff treated and interacted with them. We spoke with four relatives who told us that staff were kind and caring and they all noted a significant improvement in the care provided since the last inspection.
- We observed that when personal care was delivered, doors were closed to protect privacy and dignity.

Understanding and involvement of patients and those close to them

- Staff ensured that patients' relatives were consulted with. We observed that they were invited to meetings and to attend social outings with patients.

Are community health inpatient services responsive to people's needs?
(for example, to feedback?)

Meeting the needs of people in vulnerable circumstances

- During the last inspection we found that there was minimal consideration to providing treatment and support specific to patients' individual needs, choices and preference. During this inspection we found that this had improved and some care records detailed patients' personal preferences and suggested ways to meet these needs. The provider was working to reflect needs and preferences in all records but was doing this in a staged process.
- During the last inspection some relatives we spoke with informed us that their relatives had not been involved in any social activities external to the hospital. During this inspection we found that this had improved significantly. Patients and their families told us that they were frequently invited to attend social outings and events. These included trips to museums, shops, restaurants, film nights and cooking clubs.
- There was inconsistent recording of patients' personal preferences of what they liked to do and choices of food.

Community health inpatient services

Are community health inpatient services well-led?

Leadership / culture of service

- The corporate management team were actively involved with the day to day running of the hospital with an executive presence on site seven days a week.
- Members of the executive team were providing operational support and cover but they did not have all the clinical expertise required.
- The medical cover arrangements were provided on a sessional basis by two consultants from local trusts which did not provide dedicated substantive medical oversight. However the provider had advertised for a substantive full time consultant.
- The senior clinical nurse role was vacant at the time of the inspection. There was evidence that this lack of senior nurse leadership was impacting on the quality of patient care.

Vision and strategy

- There was a corporate strategy and vision. This strategy and vision set out the behaviours and values expected of staff working for the organisation. The vision was set out by the corporate provider St George Care UK Limited. This vision was that the group strives to provide high quality patient centred care, improving the quality of life for patients with brain injury. To support the people in their care to achieve their maximum potential, whether it is determined by them or for them, in an environment where clinical governance guides compliance and best practice to promote a culture of continuous learning, self and service development. The shortened vision was displayed on the services website and was “Ethical practice, transparency and accountability underpinning all we do".
- The vision was demonstrated by staff we spoke with.
- The provider also had a number of fundamental service values which were built upon the fact that the patient is the centre of all aspects relating to their care. These included recognising the central importance of communication in delivering forensic mental health services to service users and encouraging formal participation, consultation and involvement in all aspects of care delivery.

Governance, risk management and quality measurement

- The governance arrangements had improved since the last inspection with increased oversight of key areas of concern. However it remained that senior staff were not able to evidence how improvements had been implemented and were being monitored. One example of this was the non-compliance with key medicine management areas and no actions identified to improve standards. Therefore, we were not assured they had robust monitoring systems to show that changes had the desired outcomes or reduced the risk.
- The corporate governance team had also introduced early warning scores audits since the last inspection but there were still action required to improve the audit results.
- There was a corporate risk management policy in place. This set out the responsibilities of managers and senior managers in relation to risk management.
- The managers were unable to quantify the use of specialist nurses in the unit as this would only be monitored through the patient’s individual records. Therefore there was no system to ensure appropriate use of specialist nurse input.

Public and staff engagement

- Patients’ relatives told us that they felt their views were taken into account more and felt more engaged in the care planning.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff follow effective safety systems to consistently recognise and respond appropriately to the deteriorating patient.
- The provider must ensure that medicines are safely and effectively managed.
- The provider must ensure that areas for improvement identified through internal and external review and audit are actioned appropriately and governance systems and processes are operated effectively to assess, monitor and improve the quality and safety of the services provided.
- The provider must ensure that there are sufficient; suitably qualified leaders working within the service and providing robust clinical oversight to the running of the service.
- The provider must ensure that there is adequate medical cover at all times.
- The provider must ensure that there is adequate clinical leadership and management over sight of the location to ensure that they can recognise and act on issues and improvement within the service as needed.
- The provider must ensure that there are accurate and complete records of staff competencies.

Action the provider SHOULD take to improve

- The provider should make sure that staff are supported to appropriately access and be aware of the contents of all current policies and procedures.

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 The provider failed to provide care and treatment in a safe way; as all practicable actions to mitigate risks of unsafe care and treatment were not in place.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to establish and operate effectively systems or processes; as they failed to sufficiently mitigate the risks to service users and ensure that they assessed, monitored, accurately recorded and improved the quality and safety of the care and treatment provided.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider failed to make sure that sufficient numbers of suitably qualified, competent, trained, supported and appropriately skilled persons were deployed to enable them to carry out the duties they are employed to perform.