HCRG Care Services Ltd

Gravesham Community Hospital

Inspection report

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Date of inspection visit: 6 July 2022
Date of publication: 15/09/2022

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	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This was the first time we rated this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff were not fully compliant with all mandatory training in key skills. The service used multiple IT systems to monitor and record compliance, which were not fully integrated meaning that performance figures for training were not always up to date.
- The ward environment at the Sapphire Unit was not entirely dementia friendly so patients admitted with a dementia diagnosis could not always orientate themselves.
- Community nursing teams did not always have easy to find care plans with patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good 	This was the first time we rated this service. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. • Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually. However:

Summary of findings

- The service should ensure that care planning documentation is provided to patients which is easy for patients to recognise and understand.
- Staff were not fully compliant with all mandatory training in key skills.

Community health inpatient services

Good 

This was the first time we rated this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- The service controlled infection risk well. The service used systems and processes to administer and record medicines safely.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. The patients we spoke with were happy with their care; one patient described the service as “first class”.
- The service planned care to meet the needs of local people and took account of patients’ individual needs. People could access the service when they needed it and received the right care in a timely way. It was easy for people to give feedback and patients we spoke to told us they felt confident to raise concerns about the care received.
- Leaders ran services well and staff felt respected, supported and valued. They were focused on the needs of patients receiving care and clear about

Summary of findings

their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff were not fully compliant with all mandatory training in key skills.
- The ward environment was not entirely dementia friendly so patients admitted with a dementia diagnosis could not always orientate themselves.
- Staff told us they received one-to-one meetings with their managers on an ad-hoc basis, and clinical supervision was being carried out, although the frequency of supervision was inconsistent. Managers did not routinely record supervision with staff.

Summary of findings

Contents

Summary of this inspection

Background to Gravesham Community Hospital

Gravesham Community Hospital is one of four locations within the North Kent business unit under HCRG Care Services Limited, who are an independent healthcare provider with over 5,000 staff nationally working in partnership with the NHS and local authorities. After more than 10 years as part of the Virgin Group, Virgin Care rebranded as HCRG Care Services Limited in 2021 and was acquired by Twenty20 Capital.

Gravesham Community Hospital provides community adults services across the Dartford, Gravesham and Swanley boroughs in Kent, which align with the local Health and Care Partnership.

This location has not previously been inspected or rated.

This location provides the following core services:

- Community adult services
- Community inpatient service

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. We announced this comprehensive inspection 48-hours prior to the inspection visit. We announced the inspection due to the dispersed locations in community health services and so that we could ensure that we could speak with staff.

Community adult services:

During the inspection, the team:

- visited the Gravesham community team base
- spoke with senior leaders in the services including service managers, team leaders and clinical leads
- spoke with 10 other members of staff including nurses, occupational therapists, physiotherapists, administrators, nursing associates, student nurses and district nurses

Summary of this inspection

- spoke with 10 patients and families who were using services or their carers/relatives
- reviewed six patient care and treatment records
- observed one shift handover meeting,
- observed four schedules of care in patients' homes
- held four focus groups to capture staff who were unavailable on the days of the inspection
- looked at a range of policies, procedures and other documents related to the running of the services.

Community inpatients:

During the inspection, the team:

- visited Sapphire unit
- spoke with 15 staff including the head of the business unit, ward manager, ward matron, physiotherapists, physiotherapist assistants, occupational therapist, a doctor, registered nurses, nursing assistants, healthcare assistants, administrative staff and the safeguarding lead. These were carried out via onsite interviews as well as virtual staff focus groups where staff could join and give feedback on the service.
- spoke with six patients who were using services or their relatives
- reviewed four patient care and treatment records
- observed a staff board round
- observed staff providing care to patients on the ward
- looked at a range of policies, procedures and other documents related to the running of the service.

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.

Outstanding practice

We found the following outstanding practice:

Community adult services:

- The community neuro rehab team held a monthly multi-disciplinary team meeting (MDT) for patients with motor neurone disease which was chaired by the MDT team local lead. Meetings included the consultant from Darent Valley Hospital, representatives from a local hospice, a dietician, a Speech and Language Therapist and volunteers from the Motor Neurone Disease Association.
- Occupational Therapists (OT's) had developed an upper limb booklet for stroke patients which had helped to reduce waiting times for therapy and provided a consistent programme.

Community inpatients:

- The service allowed families to occasionally bring in patients' dogs for emotional support, when patients were struggling to adjust to their often life altering circumstances. Staff told us this improved patients' motivation to actively engage in their therapy, gave them hope and provided them with a sense of familiarity.
- Staff told us that relatives were encouraged to take part in physiotherapy sessions, with the consent of the patient, to educate and maximise rehabilitation opportunities in a person-centred way.

Summary of this 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 service MUST take to improve:

Community adult services:

- The service must ensure that all staff are up to date with all their mandatory training and ensure they have systems to record completion of training accurately. (Regulation 12(2)(c): Safe care and treatment)

Community inpatients:

- The service must ensure that all staff are up to date with all their mandatory training and ensure they have system to record completion of training accurately.(Regulation 12(2)(c): Safe care and treatment).

Action the service SHOULD take to improve:

Community adults services:

- The service should ensure that care planning documentation is provided to patients which is easy for patients to recognise and understand.

Community inpatients:

- The service should ensure that the ward environment is dementia friendly so that patients who are admitted with a dementia diagnosis can orientate themselves.
- The service should ensure that managers record when staff receive clinical supervision, in line with their policy.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Good	Good
Community health inpatient services	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Community health services for adults

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

Are Community health services for adults safe?

Requires Improvement

This was the first time we rated this service. We rated safe as requires improvement.

Mandatory training

Overall the service provided a good level of mandatory training in key skills to all staff.

Staff received and kept up-to-date with most of their mandatory training. We found the training figures to be good with most teams based at the Gravesham hub running above the 85% target set by the organisation. Where there were deficits in training compliance this was where the training was delivered face to face. Training figures were found to be lower in fire training which was 50% for the majority of services. When we spoke to local managers, we were told this was due to the impact of the Covid 19 pandemic on face to face training. The organisation already had plans to address this as restrictions had been reduced in the months prior to the inspection and it was expected this would be back up to 85% within the next six months.

We raised awareness around the requirement of the organisation to provide learning disability and autism awareness training. The staff informed us that it had been commenced the week of the inspection and this was also reported in staff focus groups that were run after the inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. Two systems for recording training were being used and we found a discrepancy between these systems. Senior managers were aware of this and were taking steps to move over to one electronic system.

New staff joining the teams received a comprehensive induction training package, which was documented at each location. This included safeguarding, fire safety, and health and safety training.

Contracted agency staff were required to be trained to the same level as permanent staff.

Safeguarding

Good

Community health services for adults

Staff understood how to protect patients from abuse and the service 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.

Managers told us they discussed safeguarding incidents in monthly quality meetings and then this cascaded down to the local teams through their team meetings. Team meeting agendas had safeguarding as a standing agenda item, so this meant that information was shared effectively to the teams.

All staff received training specific to their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to identify safeguarding incidents and told us they would raise these with the service's safeguarding lead, or their manager, and record it as an incident on their incident reporting system. This electronic system automatically sent the safeguarding referral to the correct people within the organisation. The safeguarding lead was readily available to support and coordinate safeguarding referrals across all community teams.

Staff liaised with GPs and social work teams when patients were at risk of abuse. Staff knew how to make a safeguarding referral and told us they could discuss concerns with colleagues, managers and the safeguarding lead. Within the district nursing teams safeguarding referrals were also discussed three times a week at staff face to face handover meetings.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the community premises visibly clean.

Staff used infection prevention and control measures to protect patients, themselves and others from infection. Staff followed infection control principles including the use of personal protective equipment (PPE), regular hand washing and delivered care, bare below the elbows. Staff also had access to and wore face masks to reduce the risk of spreading COVID-19. While on visits we observed that staff cleaned equipment after each patient contact. Using PPE was mandatory training and all staff teams had 100% compliance.

Patients were happy that staff used safe infection control practices and told us they felt confident in the staff and were well informed of the recent changes in safe PPE requirements.

Staff told us that they had sufficient PPE and that there were always enough supplies for them during the height of the pandemic, despite national shortages. Staff were aware of the provider's infection prevention and control policies.

We observed that staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out safety checks of specialist equipment. The service had suitable facilities to meet the needs of patients and their families. Staff had access to suitable equipment to help them safely care for patients.

Staff kept equipment and the premises visibly clean. Systems were in place to ensure equipment was checked and cleaned. The upstairs offices were very warm with limited airflow and staff told us this could be particularly difficult during the summer months.

Staff could obtain specialist equipment for patients when they needed to, by ordering this through patients' GPs. We looked at the storage of the equipment available to the team, including doppler scanners, blood glucose machines, thermometers, pulse oximeter, syringe pumps, blood pressure machine and weighing scales. Equipment held by staff was serviced and calibrated twice a year.

Defibrillators and first aid equipment were available at Gravesham Community Hospital which was located downstairs. Checklists were in place to help staff monitor them.

Staff carried out fire drills every six months. Records were kept of any learning from the drills, such as delays in responding to the alarm and action plans to address any issues identified.

Staff managed clinical waste safely. Clinical waste was transported safely back to base and disposed of correctly.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient and removed or minimised risks and updated their assessments. Staff identified and quickly acted upon patients at risk of deterioration. Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately.

Staff completed risk assessments for each patient on referral, using an assessment tool on the online records system. They reviewed this regularly, including after an incident or if their health deteriorated. Staff knew about and dealt with any specific risk issues including risk of falling, sepsis, and pressure ulcers. A track and trigger system for escalating concerns about deteriorating patients was in place for leg ulcers.

Staff shared key information to keep patients safe when handing over their care to other teams. We observed detailed handover meetings between staff, which included all necessary key information to keep patients safe. All district nursing teams had daily telephone handover calls and face to face handover meetings.

Staff completed comprehensive risk assessments for all patients. Staff used a range of risk assessment tools which were built into the electronic notes system. These tools identified when to assess skin integrity to help the prevention of pressure ulcers. Staff recognised when patients were at higher risk of sepsis and when the patient needed to go to Gravesham Inpatient Hospital.

Staff had specific training in identifying and managing sepsis and left sepsis information leaflets in people's homes.

Patients considered to be at high risk of pressure ulcers were seen within the policy guidance. District nurses assessed risks using recognised tools, such as skin integrity assessments and frailty scores. Staff photographed patients' wounds

with their consent and shared the pictures with the team in handover and with the tissue viability team, to help track how pressure ulcers were healing. In addition, for leg ulcers, the organisation had implemented a lower limb leg ulcer pathway and an upper limb pathway, based on NICE guidance which supported the treatment and escalation of limb care.

District nurses sought support from others in the organisation about how best to treat individual patients and the interventions they should provide. For example, district nurses were able to seek support from the local mental health team. They also had experience in supporting adults with a learning disability to ensure they took the best approach to support the patient's individual needs. The staff were carrying this out without specific training however the organisation had arranged training in awareness of working with people with autism which was being started the week of the inspection.

There were clear guidelines to support staff who were lone working. Staff used an instant messaging application to enable a safe network that identified when staff had safely completed their visits.

Staffing

The service had enough 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, and gave bank, agency and locum staff a full induction.

There were nursing and support staff vacancies across all the multi-disciplinary teams. The teams were managing this with the support of long term contracted agency staff, some of whom had been in post for over three years. With these long term agency staff in place the service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.

Patients told us they were aware which staff were agency staff and were familiar with them. Patients felt the agency staff were as kind and competent as the permanent staff.

Team leaders regularly reviewed staffing levels and skill mix, and prepared staff rotas six months in advance to ensure all gaps were well covered.

Agency staff told us they were given a full induction when they started with the organisation and also received a local induction once they joined the team. They felt fully integrated and part of the teams.

Team leaders accurately calculated and reviewed the number and grade of registered and non-registered staff needed for each shift. The team leaders could adjust staffing levels daily according to the needs of patients.

An average of 23% of posts across adult community services were vacant in July 2022. There had been an increase in the amount of vacancies in the 12-months leading up to July and not all these positions had been recruited to. Leaders were managing the staffing challenges and this featured on the organisation's risk register. There were recruitment plans in place and overseas nurses were starting on the inpatient wards with a project group supporting their transition into the community teams.

The district nurses held manageable caseloads within their geographical areas which aligned with the primary care networks. This helped with continuity of care and ensured visits could be scheduled closer together and so cut down on the amount of travelling time between visits.

Other specialist teams such as the tissue viability team did not hold a caseload and saw patients on a referral basis. They supported the wards, care homes, people in their own homes and hospices.

District nurse visits were scheduled using an electronic system to aid prioritising of higher priority visits and to avoid overallocation of staff. The system took account of mileage and travel times when making allocations. On each shift the team leader or nominated deputy would manually adjust the schedule to ensure as many visits as possible could be carried out.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

District nurses completed care plans for each patient according to their needs. We were told these were printed out, uploaded on to the system and then the original left with the patients but this was not always the case. We found patients did not always have copies of care plans left with them. Care plans were always written up to a high standard but were in the patients notes and not always as a separate document.

All district nurses used tablet computers. This meant that staff could access records and test results in patient's homes and did not have to return to base to update care records.

All care records we reviewed were completed to a high standard. They were accurate, holistic and contained detailed information about visits/appointments, physical health checks, plans for dietary needs, health promotion, and support with self-management of conditions. Care records covered reviews of patients' social circumstances and psychological reviews.

There were no duplicate records systems which helped minimise the risk of clinical information being lost.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. Most medicines were prescribed by patient's GPs and stored in their own homes. Medication cards were stored in patient's homes and returned to the team base when completed so they could be uploaded to the records system.

Nurses who were Non-Medical Prescribers, were able to prescribe medicines in line with national guidance. When needed, nurses would prescribe medicines and dressings which meant they did not have to always wait for GP to prescribe some treatments.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff told us that where possible they attempted to arrange all syringe driver appointments to be undertaken by two nurses, to ensure the risk of errors was minimised.

Staff learned from safety alerts and incidents to improve practice, these safety alerts were reviewed at clinical governance and disseminated to the community teams.

Good

Community health services for adults

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses appropriately.

The organisation had an online incident reporting system.

Team leaders investigated incidents and shared lessons learned with the whole team and the wider service. Staff followed their duty of candour and apologised and gave patients honest information and suitable support when things went wrong.

Staff knew what incidents to report and how to report them, using the online system and in line with the provider's policy. Staff discussed recent incidents and what could be learnt from them at monthly team meetings, weekly multi-disciplinary team meetings and daily handover meetings.

The most common reported incidents were pressure ulcers, and staff were clear about which of these needed to be reported. When an incident report was completed regarding a pressure ulcer the severity was graded and tissue viability nurses and managers were automatically contacted to look at the incident. We reviewed four incident reports across the district nursing teams and we saw evidence that changes had been made because of feedback.

Team leaders investigated incidents thoroughly, looking for themes. Patients and their families were involved in these investigations. Team leaders supported staff after any serious incident and staff accessed debriefs after significant incidents including expected deaths.

Managers collected safety information and shared it with staff, this included information about pressure ulcers, venous thromboembolism, falls and urinary tract infections. Leaders continually monitored safety performance including frequency of pressure ulcers, staff harassment incidents, slips trips and falls, patients who had not been seen for a long time and completion of risk assessments.

Patient safety tools were being used and completed appropriately. For example, Waterlow scores which give an estimated risk for the development of a pressure sore in a given patient and falls assessments.

Are Community health services for adults effective?

Good

This was the first time we rated this service. We rated effective as good.

Good

Community health services for adults

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.

The organisation had processes in place to ensure protected characteristics under the Equality Act were considered when making care and treatment decisions.

Staff provided care and treatment based on national guidance and evidence-based practice. Managers told us they checked to make sure staff followed guidance through individual managerial supervision and organised peer group supervision.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies on the staff intranet.

The organisation had given staff tablets and laptop computers to enhance the delivery of effective care as staff were able to input records in patient's homes and check on the most up to date patient records and clinical tests.

Treatment of wounds was adapted on an individual basis as the wound healed. Pain assessments were carried out at every appointment by the tissue viability team.

District nursing teams were able to prescribe dressings in line with national guidance for nurse prescribers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff were aware of patients' specialist nutrition and hydration needs. They used special feeding and hydration techniques when necessary.

Specialist support from staff such as dietitians was available for patients who needed it. We saw evidence of food and fluid charts in use when we visited patient's homes and patient care records included references to checking on patients' food and fluid intake and recommending changes when needed.

Staff used the malnutrition universal screening tool (MUST) a nationally recognised screening tool to monitor patients at risk of malnutrition.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff supported patients with communication needs using suitable assessment tools and gave additional pain relief to ease pain.

Staff told us how they used non-verbal signs to monitor patients who could not verbally communicate. Patients received pain relief soon after it was identified that they needed it or when they requested it.

Some patients had access to syringe drivers for symptom control, specifically when patients were coming towards the end of life. Staff told us they would visit patients who were on syringe drivers daily. Pain relief was administered and recorded accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

The organisation had a comprehensive clinical governance framework with a clear focus on patient experience and engagement. The clinical governance team reviewed the results of recent friends and family tests (FFT) and patient reported experience measures (PREMS) to look for areas of positive change and learning opportunities. The FFT scores for the 12 months before the inspection averaged at 96% positive responses.

Patient outcomes were monitored via key performance indicators (KPIs). These included numbers of referrals, total numbers of patients on caseloads, total number of face-to-face contacts, patients with personal individualised care plans, the total number of did not attends appointments. This was then reviewed with team leaders in their individual managerial supervision. We could see that KPIs were routinely met and normally exceeded especially in the area of face to face contacts which was maintained and exceeded most notably through the covid-19 pandemic.

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.

Staff were competent for their roles. Team leaders appraised staff members work performance and held daily handovers to provide clinical support and team development.

Staff reported feeling well supported in their roles and staff described that they attended supervision sessions with their line managers to support their development and clinical practice. Staff discussed their individual training needs with their line manager and spoke positively about learning and development opportunities within the provider organisation. Staff were carrying out higher level training and specific clinical training outside of the organisation that would help improve and advance their clinical skills.

Staff were experienced, qualified, and had the right skills to meet the needs of patients. Staff had access to a wide range of statutory, mandatory and specialist training.

The organisation gave all new staff and agency staff a full induction tailored to their role when they started work and supported staff to develop through yearly, constructive appraisals of their work. Information provided by the organisation showed that appraisals were happening regularly and in line with the organisation's policy.

Good

Community health services for adults

Managers identified poor staff performance promptly and supported staff to improve. Managers made sure staff attended team meetings or had access to minutes when they could not attend.

Staff in all the teams felt able to raise any concerns or questions they had with the team leaders. Less experienced staff were supported to develop their skills, and staff said they were never asked to perform interventions that were beyond their limit of competence.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular effective weekly multidisciplinary meetings to discuss patients and improve their care, these meetings had a structured agenda and minutes were recorded and uploaded on to the electronic record system. Staff worked across health care disciplines and with other agencies when required to care for patients.

The intermediate care team met together weekly with the community geriatrician to discuss patients with more complex and challenging needs.

The district nurses described effective multidisciplinary and integrated team working. They referred patients on to other specialist teams as needed, and worked closely with first community podiatry team, sometimes carrying out joint visits to patients.

When people were discharged there were clear mechanisms for sharing information with the local GP in a timely way as referral letters to the GP and handover information used the same electronic system as the GP services.

The community neuro rehab team held a monthly multi-disciplinary team meeting (MDT) for patients with motor neurone disease which was chaired by the MDT team local lead. Meetings included the consultant from Darent Valley Hospital, representatives from a local hospice, a dietician, a Speech and Language Therapist and volunteers from the Motor Neurone Disease Association.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The organisation took steps to involve patients and carers in monitoring their own health and had implemented procedures to enable them to manage their health and wellbeing and maximise their independence. Each of the community teams had a set of health promotion literature which they took out on visits when required and discussed with patients in their appointments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Good

Community health services for adults

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interests, and they took into account the patient's wishes, culture and traditions, and recorded this in the electronic record. The district nursing teams also sought the support of the mental health team for guidance in these cases.

Mental Capacity Act training was not a statutory training requirement within this service but was covered within the equality and diversity training. Equality and diversity training was completed at an average of 96% across the community teams.

In addition, on every visit the staff recorded that consent was collected from the patient for them to carry out the schedule of care. The electronic record system had this as a standard action and had to be completed in order to move on within the record.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are Community health services for adults caring?

Good

This was the first time we rated this service. We rated caring as good.

Compassionate care

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

Staff treated patients with compassion and kindness and were passionate about delivering care to patients. Staff were discreet and responsive when caring for patients, respecting their privacy and dignity. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed home visits where district nurses spoke kindly and respectfully to patients in consultations at their homes.

We spoke with 10 patients following the inspection and all patients felt overwhelmingly positive with the care they had received. Staff took time to understand the personal, cultural, social and religious needs of the patients and took these into account when visiting the patients. Patients told us staff were very helpful, when they felt frightened of carrying out a task for themselves the district nurses taught them what to do and the visits did not feel rushed.

Good

Community health services for adults

Staff proactively obtained feedback about the experiences of people using the service. Patients had been regularly asked to give feedback. It was recognised that sometimes it was difficult for house bound patients to deliver the friends and family test as a posted document so the service had arranged for the administration team, who were independent to the clinical teams, to routinely gather feedback from each patient on the telephone.

The organisation used a system called the patient reported experience measures (PREM). A PREM is a measure of a patient's perception of their personal experience of the healthcare they have received. PREM was reviewed in the organisation's monthly clinical governance meetings and results were used to improve services and provide a patient view on these improvements.

Staff followed provider policies to keep patient care and treatment confidential. Staff told us consideration of people's privacy and dignity is embedded in everything that they do. They would only speak about patients care to carers and family members if patients gave consent.

At handover meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers. Carers assessments were completed when required. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff supported patient's relatives, particularly in understanding their complex health conditions. Staff emphasised that this support was incredibly important because many patients and relatives reported feeling isolated because of the Covid-19 pandemic.

Staff told us they took extra time to listen to patients and support their emotional wellbeing and this was reflected in the patient feedback.

Staff had access to training in breaking bad news and demonstrating empathy when having difficult conversations. Staff told us they also had training in having challenging conversations, which helped them to be confident in having difficult conversations with patients, especially around end of life care.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Good

Community health services for adults

Staff were able to access interpreters using the language phone line when required and all staff were aware of this system. When appropriate, staff used close family members to support with discussions about care plans and clinical interventions.

Staff recorded each patient's social circumstances and preferences so these could be taken into consideration when delivering care. For example, some patients liked the nursing staff to liaise with a neighbour or carer prior to visiting, or to use a particular door rather than the front door.

The feedback from people receiving care was that they felt listened to, respected and had their views considered.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The organisation used the friends and family test to receive information and this was reviewed as a standing agenda item at each clinical governance meeting.

Are Community health services for adults responsive?

Good

This was the first time we rated this service. We rated responsive as good.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Staff worked in collaboration with colleagues working for other providers and GPs in the local healthcare system to plan care. Every week the community matrons met as part of a multi-disciplinary team at the local acute hospital.

District nurse visits were scheduled using an electronic system that was colour coded to aid prioritising of high priority visits and to avoid overallocation of staff. The system took account of mileage and travel times when making allocations. On each shift the team leader or nominated deputy would manually adjust the schedule to ensure as many visits as possible could be carried out.

Staff adapted their approach during the Covid-19 pandemic and managed to maintain a consistent level of face to face visits as pre-pandemic. The staff were committed to providing their services to already isolated individuals. Alternative telephone and video conferencing appointments were made available to patients which helped reduce pressure on other parts of the healthcare system, such as inpatient services.

All services in the adult community pathways had clear admission criteria and well-presented and information leaflets which had gone through the communications team and patient representatives to ensure they were easy to understand.

District nursing teams and the urgent and intermediate care team had no waiting times and were able to provide the right care at the right time. Senior leaders reviewed the number of people waiting across all community teams, average waiting times and longest waiting time for all services. This was done using data that was exported from the patient record system and reviewed in clinical governance. This meant that leaders could act to resolve any issues leading to extended wait times in particular clinical areas.

Managers ensured that patients who did not attend appointments were contacted and this was audited to ensure it happened.

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. They coordinated care with other services and providers.

All services were easily accessible to people with mobility needs.

Patient's individual needs were recorded within their electronic care records. Records were person centred and holistic and included patients' wishes when appropriate.

Staff recorded the location where patients who were receiving end of life care wished to die and staff worked hard to ensure they met these wishes. Leaders observed a Key Performance Indicator (KPI) to ensure these wishes were captured for all appropriate patients.

Staff were aware of the Accessible Information Standard (AIS). The Standard sets out a consistent approach to identifying, recording, flagging and sharing the communication needs of patients. This was particularly important for patients living with a disability, impairment or sensory loss. All information for patients, such as leaflets, were reviewed by the provider's communication team to help ensure the information was easily accessible to all people.

Occupational Therapists completed a training programme to assist single-handed patients to enable them to provide training and guidance to the team, carers and family members on how to fit a sling under a patient with one person, as well as techniques for a single-handed person to provide personal care. This will also support by bringing double handed packages of care down to a single handed one where appropriate to do so.

The Speech and Language Therapy Team fully utilised and enhanced the virtual consultation approach with their patient group. This format enabled the team to continue to visually see their patients during the height of the pandemic and during the various lockdowns to ensure that patient assessment and intervention continued. On average, the service utilised this approach with 48 patients every week, it has remained an effective media for the service to use saving patients and staff travel time and costs, this has enabled patients more choice and flexibility around when and where they are seen. The team continue to complete video consultations with some of their patients with a consistent average contact of around 18 patients per week.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

There were systems in place for people using the services to give feedback and raise concerns about care received. All 10 patients and carers we spoke with said that they were comfortable doing this and had only positive feedback for the staff supporting them. They felt able to complain and that staff would address their concerns quickly.

A senior administrator was responsible for making follow up calls to patients to gather their feedback.

Good

Community health services for adults

Any learning from complaints was discussed with staff during team meetings.

When complaints were received directly to the services an incident report was completed using an incident reporting system. This meant that there was an audit trail which senior managers could oversee.

Staff could give examples of how they used patient feedback to improve daily practice. This ranged from small areas of care such as which door patients preferred for visiting staff to use, to more important areas of care such as using feedback from friends and family tests to raise awareness of emerging themes.

Are Community health services for adults well-led?

Good

This was the first time we rated this service. We rated well-led as good.

Leadership

Leaders had the skills required to effectively run the services. They understood and managed the priorities and issues the services faced.

Staff told us the senior leaders were always visible and were approachable for patients and staff.

Staff knew how to contact senior managers and gave examples of when they had done so. All staff were aware of the "ward to board" approach that the organisation had and staff regularly made contact with members of the senior leadership team. Staff told us about the drop in training sessions that were arranged by the Head of the Business Unit and how helpful they had found the speakers to be in improving practices in the community teams.

Senior managers had got involved during the periods of short staffing during the pandemic and supported the team to continue to deliver care. Some nursing had staff received a thank you package as a way of the organisation acknowledging their work; however this wasn't always shared across the lower bandings.

All feedback from staff was positive about the support and guidance they received from the leadership team.

The leadership team had supported staff member's professional development. We were able to meet with nurses who were being supported in their training to develop into the band six district nurse role. Staff felt that leaders supported their career development.

Senior managers we spoke with had developed an initiative to support the recruitment and retention of staff including registered nurses. The organisation had links with local universities to provide associate nurse apprenticeships and the organisation had members of staff in the process of completing the district nurse additional training.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

Good

Community health services for adults

The organisation's vision and strategy were focused on the sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff teams had been grown and developed to match the increase in requirements from the local commissioning teams and this had led to the appointment of seven new staff within the district nursing teams.

HCRG Care Services Limited had a clear vision which was to "care think and do, staff were aware of the vision and were able to discuss with the inspection team what this meant for each of their services.

Each service had a clear strategy which was aligned to the overall organisation strategic approach, which was "Change lives by transforming healthcare". We found this to be echoed in the literature and information leaflets for each of the community services we inspected.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

The service promoted equality and diversity in daily work and provided opportunities for career development.

All staff we interviewed both individually and in the four focus groups we held felt respected, listened to and valued. The staff felt that leaders treated them as equals and that there was an open culture and they felt able to approach members of the senior leadership team if they wanted to provide feedback.

Despite the pressures of the Covid-19 pandemic, we heard from most staff that the area they felt most proud of was the way they had continued to provide a high quality service and that morale remained high throughout.

No staff reported bullying or harassment at work and many staff had worked within the organisation for many years. Some staff had returned to the organisation because they felt the organisation was very supportive and that morale was high.

The organisation was taking steps to continuously recruit and offered many incentives such as opportunities for flexible working and membership of a reward hub which offered discounts and access to vouchers.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

Staff at all levels were clear about their roles and accountabilities and were aware of key performance indicators. The provider had developed dashboards, which gave clear information about service performance in line with these KPIs.

The organisation used a red/amber/green (RAG) rated clinical governance scorecard to show at a glance how all services were performing and this remained green throughout the 12 months prior to the inspection meaning that the organisation was meeting all of its compliance targets.

Good

Community health services for adults

Clinical governance minutes demonstrated that the senior management team had oversight of adult community services quality and performance measures such as complaints management and compliance with key performance indicators. The organisation had an audit committee which ensured that there was an effective internal audit function established by management that provided appropriate independent assurance to the Board.

Although all staff were able to access both individual and group supervision regularly, managers did not record locally whether managerial supervision had taken place in line with the organisation's policy. However, staff were all happy with the amount of supervision they were receiving and all received annual appraisals which was documented by the organisation.

The services held weekly multi-disciplinary team meetings where patients were discussed, and daily nursing handovers. This was structured with staff describing what actions were carried out for each patient, for example what referrals were made, and which observations were carried out. This was an opportunity for all staff to contribute in the care for each patient, these handovers were documented and the minutes were stored so they could be accessed by all relevant staff. The services also held regular monthly team meetings

A programme of annual audits was in place for all services. Staff used an online system based on four key areas, external audits, internal audits, service driven audits and clinically driven audits. Managers learnt from actions identified in audits and shared outcomes with their teams.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively.

The provider held locally managed service risk registers which were regularly reviewed and improvements made. These fed into a corporate risk register which covered all services

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The services held team meetings regularly and staff confirmed that there was good teamwork and engagement. We reviewed team meeting minutes for community matrons "SITREP" meetings which demonstrated that line managers updated their staff with information such as but not limited to, service updates, waiting lists, incident reports, audits, compliments and complaints and feedback from individual clinics.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Good

Community health services for adults

The service delivered learning events for all staff to provide a venue to support shared learning across the business unit. Staff told us these events were time protected for wider sharing of learning to take place from events and incidents, promoting good practices and lessons learnt.

Good

Community health inpatient services

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

Are Community health inpatient services safe?

Requires Improvement

This was the first time we rated this service. We rated safe as requires improvement.

Mandatory training

Staff did not always receive or keep up-to-date with their mandatory training.

At the time of the inspection, 82% of staff had completed their mandatory training, which fell slightly below the service's target of 85%. However, there were specific modules of safety training which fell significantly below the service's target. These were basic life support and anaphylaxis (40%), fire awareness and evacuation (45%) and moving and handling (60%). This was identified as a risk on the service's corporate risk register, however the impact of such low compliance meant that patients were likely being cared for by staff on shift who were not compliant in key safety modules. Managers and staff told us this training would usually be delivered face-to-face but had been paused during the Covid-19 pandemic to prioritise frontline duties in line with Government guidelines. Managers told us the service's training provider had recently cancelled scheduled face-to-face sessions at short notice and this was identified as a risk on the service's corporate risk register. The service had upskilled staff to deliver additional training locally and training events had been rescheduled to improve compliance.

We raised awareness around the requirement of the service to provide learning disability and autism training, in line with new legislation. Managers informed us this training had been added to the mandatory training requirements.

Managers had access to a training matrix to identify when training was due. Although, at the time of our inspection the service used two electronic systems which meant training compliance figures were not always accurate. Senior managers told us they were in the process of integrating the two systems and this featured on the service's corporate risk register.

The service had recently employed a practice development nurse who was focused on reviewing compliance and identifying gaps in staff training and learning.

Contracted agency or bank staff were trained to the same level as permanent staff.

Good

Community health inpatient services

Safeguarding

Staff understood how to protect patients from abuse and the service 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.

The service had a dedicated safeguarding lead that staff could access for advice.

Staff completed the appropriate safeguarding training for their role with a current average compliance rate of 95%. Staff said they felt confident raising safeguarding concerns and understood their role in the process. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Senior staff told us they discussed safeguarding incidents in monthly quality governance meetings and then this cascaded down to the team through their monthly team meetings and a safeguarding newsletter which was shared via email. Team meeting and staff briefing agendas had safeguarding as a standing agenda item, so this meant that information was shared effectively to staff.

Staff followed safe procedures for children visiting the ward. Children who visited their relatives in hospital could do so privately as patients had their own rooms.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date which demonstrated that all areas were cleaned regularly. Cleaning audits showed an average compliance rate of 97% for the period January to May 2022. Housekeeping staff were employed by the facilities management company who owned the building where the ward was located.

Staff knew how to prevent infection and had received training in infection prevention and control (IPC). Staff followed national guidance for allowing visitors on the ward and the use of Personal Protective Equipment (PPE), to reduce the risk of spreading Covid-19. We observed that staff cleaned equipment after use.

At the time of our inspection, the ward had one patient who had recently tested positive for Covid-19. Due to patients having their own bedrooms with en-suite facilities, staff were able to isolate the patient appropriately and we observed strict IPC practices being used by staff when caring for this patient.

The service had an infection control lead responsible for ensuring audits were completed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. All patients had their own rooms with en-suite facilities which maintained their privacy and dignity.

Patients could reach call bells and staff responded quickly when called.

The service had enough suitable equipment to help them safely care for patients, for example hoists, wheelchairs and pressure relieving mattresses. Equipment was stored safely in unused areas of the ward. Patients also had access to specialist equipment to aid their rehabilitation and meet their needs including use of a dedicated physiotherapy gym, patient kitchen and day room.

Staff carried out daily safety checks of specialist equipment. Staff had easy access to an emergency resuscitation trolley which had equipment including a defibrillator, oxygen and suction. The equipment was in date and checked regularly.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All four care records looked at showed appropriate use of risk assessment tools such as Waterlow scoring for pressure ulcer assessments and twice daily use of the National Early Warning Score (NEWS2).

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff assessed whether patients could easily use call bells to call for staff assistance.

Staff completed assessments to determine whether patients were at risk of falls, including bed rail assessments, kitchen assessments and moving and handling assessments. Patients at risk of slips, trips and falls were observed closely by staff and sensor mats alerted staff to respond to patients who had fallen.We observed a patient who had been assessed as a falls risk wearing anti-slip socks. The service used a wristband scheme to easily identify patients at risk of falls. Patients wearing red wristbands enabled staff to easily identify who required assistance to mobilise. A yellow wristband meant patients required supervision, and green wristbands meant that patients had been assessed as independent.

Staff knew about and dealt with any specific risk issues. Staff checked skin daily for patients identified with a pressure ulcer or deteriorating health. We saw that the SSKIN (Surface, Skin, Keep Moving, Incontinence, Nutrition) care bundle was completed for patients at risk of pressure ulcers.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe, including use of PPE, safeguarding concerns, ability to mobilise and falls risks. Staff received training and undertook thorough sepsis screening.

Staff referred patients for specialist mental health support and psychosocial assessments if they were concerned about a patient's mental health. The service had a service level agreement (SLA) in place with Kent Community Health NHS Foundation Trust, who provided access to a psychologist. This meant that patients accessing mental health support could continue receiving this support when transitioning into the community following discharge from the ward.

Good

Community health inpatient services

Staffing

The service had enough staff with the right qualifications, skills 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, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service used an electronic system which automated the staff roster in advance to ensure the ward had an appropriate mix of skilled staff on shift and gave a red/amber/green (RAG) rating to identify where compliance was not met. Leaders told us this was usually during periods of staff annual leave or unexpected staff sickness. The ward manager could then adjust staffing levels daily according to the needs of patients.

At the time of our inspection there were two whole time equivalent (WTE) registered nurse posts vacant. Managers told us that they had two international nurses undergoing their objective structured clinical examination (OSCE) who were due to fill these roles post-completion. There were two healthcare assistant posts which were in the process of being filled and one vacancy for a doctor. Managers limited their use of bank and agency staff and requested staff familiar with the service. All bank and agency staff had a full induction.

Staff sickness was 4.85% cumulative for the past 12-months.

Staff turnover rate for the ward was 15.3% cumulative for the past 12-months.

Medical staffing

The service had enough medical 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, and gave locum staff a full induction.

At the time of our inspection, the service had a vacancy for a General Practitioner (GP). The ward had medical cover by another GP covering multiple locations which meant they were not always present on the ward. Staff told us the GP was responsive and wrote prescriptions remotely to meet patient need when required. Out of hours staff could access medical support via 111. In an emergency, staff contacted the emergency services.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were up-to-date, stored securely and easily available to all staff providing care.

All records were stored securely in a locked trolley at reception. On the day of inspection we observed that the trolley was never left unlocked or unattended whilst in use. Patient risk assessments, routine patient observations, food and fluid charts and pressure care assessments were kept on paper, and staff could access them easily.

We looked at four patient care records which were comprehensive and person-centred.

Good

Community health inpatient services

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Medicines were supplied by a local independent community pharmacy. The service was supported by the organisation's lead pharmacist who worked across all four locations within the business unit.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. We saw evidence that the pharmacist completed a drug reconciliation process on admission of all patients.

Staff completed accurate medicines records which were stored safely and kept them up-to-date. The service kept a log of controlled drugs prescribed for individual patients which was double signed, and the recording of stock for controlled drugs was accurate. We saw evidence that this process was audited twice weekly and on an ad-hoc basis by senior staff.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Any medication omitted was documented and the reasons why recorded on a form within the Medication Administration Records (MAR).

Emergency drugs were stored in the clinic room and checked weekly.

The fridge and room temperature were checked daily to ensure medicines required to be kept at a certain temperature remained intact.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff told us the ward doctor would transfer medicines to the service's own drug chart on their next shift if a patient was admitted with a drug chart from the acute hospital. This was reflected in patient notes.

Staff learned from safety alerts and incidents to improve practice.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Staff monitored and recorded an appropriate range of safety performance indicators. These included recognising patients at risk of physical health deterioration and using a routine physical health monitoring tool.

The service displayed a safety thermometer board on the ward, which showed visitors the number of falls and pressure ulcers during the month. At the time of inspection, there had been no falls or pressure ulcers recorded for the month.

Falls and pressure injuries were reported on and reviewed at specified harm reduction groups where staff could identify any themes or trends. This information was fed back during monthly quality governance meetings.

Good

Community health inpatient services

The service made appropriate changes to care for patients with complex needs after identifying potential safety concerns. For example, one-to-one nursing and observations when required to help mitigate the risk of falls.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff we spoke with knew what incidents to report and how to report them in line with the service's policy. Falls were the most commonly reported incidents.

Senior managers attended monthly incident review panel meetings where specific incidents were discussed and lessons learnt identified which were then shared with the team during team meetings, daily safety huddles and handovers.

There was evidence that changes had been made as a result of feedback. For example, lessons learnt identified the need for improved physical health assessments after a patient was admitted to the unit with a dislocated shoulder which had not previously been noted on the referral paperwork. This resulted in an unwitnessed fall and swelling of the patient's hand requiring treatment at the acute hospital, at which time acute hospital staff raised a safeguarding referral. As a result, a more thorough admissions process was implemented, including improved communication with the referring team at the acute hospital.

Staff received feedback from investigation of incidents across community services and met to discuss the feedback and look at improvements to patient care through monthly 'learning events' which all staff could attend.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff told us that managers debriefed and supported them after any serious incident.

Are Community health inpatient services effective?

Good

This was the first time we rated this service. We rated effective as good.

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. Staff protected the rights of patients subject to the Mental Health Act 1983.

Good

Community health inpatient services

Staff kept up to date with and followed relevant National Institute for Health and Care Excellence (NICE) guidelines to plan and deliver quality care according to best practice.

Staff had access to policies on the staff intranet and knew where to find them. Leaders told us they checked to make sure staff followed guidance through individual supervision and team meetings.

The service discussed audit outcomes during monthly quality governance meetings. Staff included any identified risks on the corporate risk register.

At the time of our inspection, the service had no patients subject to detention under the Mental Health Act 1983.

Staff protected the rights of patients in their care and worked with patients to develop rehabilitation goals. These included increasing independence, improving mobility and activities of daily living. Occupational therapists and physiotherapists produced joint rehabilitation plans for patients.

The therapy team also completed home visits to ensure that patients' home environments were suitable to meet their needs once discharged, such as providing extra equipment.

At handover meetings and daily board rounds, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Leaders told us they could accommodate patients with percutaneous endoscopic gastrostomy (PEG) and radiologically inserted gastrostomy (RIG) feeds.

Staff used a Malnutrition Universal Screening Tool (MUST) in line with professional guidance to assess and improve nutritional care.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded patients' dietary requirements on a white board in the patient kitchen. Specific food and fluid requirements and any changes to these were discussed during handovers. Patients' weight was monitored and patients were referred to a dietitian or speech and language therapist if they needed support with their nutrition or hydration. We saw referrals that had been completed for patients who needed this additional treatment.

Staff provided patients with menus daily so that they could choose their meals in advance and alerted the catering team to any special needs as identified at initial assessment. For example, soft choice, energy dense, gluten free or diabetic menus. The food was supplied by the facilities management company who owned the building where the ward was located and brought to the ward.

Pain relief

Good

Community health inpatient services

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.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed that staff showed patients smiley and unhappy face cards so they could relate and explain their pain. Patients told us they received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Trained nurses were able to administer paracetamol without a doctor's prescription for temporary pain relief. Although, we saw in one care record that staff had not rechecked with the patient whether their pain relief had been effective.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits and repeated audits to check improvement over time.

Managers and staff used the results to improve patients' outcomes. For example, the service found that the escalation process was not always being following by healthcare assistants when carrying out NEWS2 observations leading to an increased risk of deterioration in patient's physical health. We saw lessons learnt and an action plan based on these findings. Additional training was provided for all nursing and HCA staff, and a new process of escalation introduced to improve patient outcomes.

Managers made sure staff understood information from the audits and this was shared in local teams meetings and on the staff intranet.

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.

Overall staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients, although some staff competencies were not up to date. Managers told us that staff were not authorised to carry out a procedure until their competency had been renewed. The service had identified this as a risk which featured on the risk register and the service had recently employed a practice development nurse (PDN) to support the learning and development needs of staff. At the time of our inspection, the PDN had developed a spreadsheet to identify all outstanding clinical competency requirements amongst the team and training dates were booked for the weeks following inspection.

Staff reported feeling well supported and described that they received informal supervision with their manager and colleagues to support their development and clinical practice, in line with their clinical policy. Although, managers did not always keep clear records of this. Staff told us they regularly undertook peer reviews to assess each other's clinical practice. We saw that clinical practice supervision groups had been set up across the business unit, although records showed inconsistent sessions having taken place as a result of the Covid-19 pandemic.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop through yearly appraisals. At the time of our inspection 98% of staff had received constructive appraisals of their work, although staff told us opportunities for career development were inconsistent amongst roles and some felt their professional development was hindered by a lack of funding.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Information was disseminated to the team via email, during daily shift handovers and posted on the intranet.

Managers identified poor staff performance promptly and supported staff to improve. Staff told us they felt able to raise any concerns or questions they had with their colleagues.

Multidisciplinary working and coordinated care pathways

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

All staff we spoke with felt that they worked well together as part of a multidisciplinary team (MDT). Staff described good opportunities for joint working, learning from each other and being able to challenge decisions constructively with colleagues.

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. Information and actions were recorded on a multidisciplinary communication sheet which was kept in patients' care records.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw that patients had been referred on to other specialist teams as needed.

Staff reported good working relationships with professionals visiting the ward and other community providers. Staff worked with colleagues in adult social care when planning a discharge package of care for patients. We saw evidence of joint home assessments carried out by professionals from different teams to plan patients' discharge and ensure appropriate equipment was in place to support them in the community.

Staff referred patients for mental health assessments when they showed signs of mental ill health. We saw evidence of referrals to the local mental health team being completed in care records.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the ward. Staff assessed each patient's health when admitted and identified who may need additional support due to frailty or cognitive issues.

Staff gave advice about health conditions, treatment and outcomes. The service had relevant information promoting healthy lifestyles and support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Community health inpatient services

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent and knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was covered within the mandatory adult safeguarding training. The safeguarding lead undertook additional training for staff to improve confidence in identifying concerns around mental capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering of their wishes, and recorded this in the patients' records.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. We observed discussion around patients' mental capacity during a daily board round meeting.

We found that 'do not attempt cardiopulmonary resuscitation' (DNACPR) records were appropriately maintained and easily accessible at the front of patient notes so that staff could find them quickly in an emergency.

Are Community health inpatient services caring?

Good

This was the first time we rated this service. We rated caring as good.

Compassionate care

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

Staff were passionate about delivering care and were discreet and responsive when caring for patients. We observed positive and compassionate interactions between staff and patients on the ward. For example, staff were supporting patients to dress appropriately to protect their privacy and dignity.

We spoke with six patients and carers during the inspection. All patients and carers spoken to felt happy with the care they or their loved one had received and told us staff treated them well and with kindness. One patient told us that staff were "very kind", and a relative told us the care provided by staff was "second to none".

The ward had several thank you cards displayed at reception from patients and relatives thanking them for their kindness and compassion during their stay.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us that staff promptly responded to their call bell when it was pressed including at night.

Managers told us that patients often struggled to adjust to their life altering circumstances and where appropriate, staff showed compassion by allowing families to bring in patients' dogs for emotional support. Staff told us this improved patients' motivation to actively engage in their therapy and provided a sense of familiarity for them.

Staff followed policy to keep patient care and treatment confidential. They understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. At handover meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers.

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients described staff as kind and caring and that they were always helpful. One patient told us that therapy staff would spend time with them throughout the day outside of therapy sessions, for company.

Staff supported patient's relatives, particularly in understanding their complex health conditions. Staff emphasised that this support was important because many patients and relatives reported feeling isolated as a result of the Covid-19 pandemic. Staff told us they took extra time to listen to patients to support their emotional wellbeing, particularly prior to discharge, and this was reflected in the patient feedback.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff supported and involved patients and those close to them to understand their condition and make decisions about their care and treatment. We saw that patients signed their care plans, which showed their involvement. Patients received a welcome booklet on admission which told them what to expect from their stay on the ward.

Family members were also involved in developing care plans and preparing plans for discharge. Staff told us that relatives were encouraged to take part in physiotherapy sessions, with the consent of the patient, to educate and maximise rehabilitation opportunities in a person-centred way.

Staff contacted relatives weekly as a minimum to update them on patient care. This was recorded in patient notes. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff provided phones for patients to use to keep in touch with their relatives when needed.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw a feedback box located at reception. Patients and carers were asked if they would like to complete the friends and family test (FFT) feedback form prior to discharge. All patients spoken to during our inspection gave positive feedback about the service, they told us they felt listened to, respected and had their views considered.

Good

Community health inpatient services

Are Community health inpatient services responsive?

Good

This was the first time we rated this service. We rated responsive as good.

Planning and delivering services that meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access mental health support for patients with mental health problems, learning disabilities and dementia.

The service was working closely with The Stroke Association who had recently started visiting the ward again following the Covid-19 pandemic, to support patients with their circumstances and enable a seamless transition into the community.

Therapy staff tailored patients' therapy sessions to meet their individual needs. For example, staff took patients out to a local shop to practice everyday tasks such as buying food and crossing the road. Staff also took time to understand patients' interests and incorporated these into their therapy sessions. For example, music or painting.

Staff discussed patients' progress at daily handover meetings. Discharge, pain management and physiotherapy goals were also discussed at weekly MDT meetings and we saw evidence of multi-agency working in patient care records, particularly around discharge planning.

We observed a safety huddle, where important information was discussed such as patient risks, mobility status and any actions required to work towards discharge. Staff supported patients to attend follow-up appointments at the acute hospital and we observed that transport had been arranged for this.

Meeting the needs of people in vulnerable circumstances

The service made reasonable adjustments to help patients access services and coordinated care with other services and providers.

The service did not exclude patients with a dementia diagnosis, although the ward had an admissions criteria which required patients to have a cognitive ability to retain and follow a rehabilitation programme. The service was committed to working with carers to meet the needs of patients requiring additional support. We observed clear signage on the toilet and bathroom doors, although there were no clear colours for different areas and little signposting so patients living with dementia could orientate themselves.

Good

Community health inpatient services

Staff used an alert system for patients with learning difficulties, which enabled staff looking at a patient's care record to easily identify what additional needs or adjustments were required to support patients living with dementia and learning disabilities. The service had forged links with Alzheimer's and Dementia Support Services (ADSS) who were involved in discharge planning for patients with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw that staff were supporting a patient who was visually challenged with bright colours in their bedroom for cues. For example, a block yellow sign was placed on the wall which told the patient she was entering the bathroom.

Staff had access to communication aids to help patients become partners in their care and treatment. For example, staff used picture boards with some patients who were unable to communicate their decisions verbally.

Patients were assessed for falls risks and knew what the coloured wristband system meant. One patient we spoke to told us this reminded them not to try and mobilise without staff present and another patient told us the wristband scheme empowered them when they progressed to a green wristband which meant they no longer required supervision when mobilising.

The service could provide patients with information leaflets in languages other than English, as well as some easy read versions. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were supported with their cultural and religious preferences, and the service welcomed religious leaders who visited some patients.

Staff facilitated contact with relatives for patients during Covid-19 outbreaks when visiting was restricted on the ward. Staff used mobile devices to set up video and telephone calls for patients and relatives.

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay for the last 12-months was 34 days for rehabilitation and 43 days for patients requiring neurorehabilitation.

Managers told us they often felt pressure from the acute hospital to admit patients and be flexible with their criteria for patients outside normal parameters, although they felt supported by the senior leadership team to manage this pressure. Senior ward staff told us this pressure had continued following the Covid-19 pandemic when they had been required to support the acute hospital with Covid-19 positive patients.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The service worked closely with adult social services for any required care packages which were sourced by an independent provider. Managers monitored the number of patients whose discharge was delayed and took action to reduce them.

The service moved patients only when there was a clear medical reason or in their best interest. For example, there were some instances where patients had been moved back to the acute hospital when their physical health had deteriorated.

Good

Community health inpatient services

Staff supported patients when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns and staff understood the policy on complaints and knew how to handle them.

The service clearly displayed information about how to raise a concern in patient areas. We observed that a feedback box was located on the reception desk and staff told us patients were asked if they would like to fill in the friends and family test (FFT) form prior to discharge to give their feedback. The service also displayed a 'you said we did' poster on the ward to encourage ideas and feedback from patients and relatives.

Patients and relatives said they would complain to the matron in the first instance but did know there were other ways to complain. They felt able to complain and that staff would address their concerns quickly.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw that complaints were routinely discussed as a standing agenda item during team meetings.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Are Community health inpatient services well-led?

Good

This was the first time we rated this service. We rated well-led as good.

Leadership

Leaders had the skills and abilities to run the service and understood and managed the priorities and issues the service faced.

Staff described an accessible and approachable ward manager who supported them on the ward with patient care as needed. The matron prioritised their time between two locations, and feedback from staff was that they were responsive and visible when on site.

Some staff we spoke to told us that it was not common to see members of the senior leadership team on site at Sapphire unit but they knew who they were.

Vision and Strategy

Good

Community health inpatient services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The North Kent business unit had a vision for what it wanted to achieve under HCRG Care Services Limited following the rebranding from Virgin Care in 2021, and a strategy to turn it into action developed with all relevant stakeholders.

The business unit's vision was focused on sustainability of services and aligned to local plans within the wider health economy. The strategic plan for 2022 to 2025 identified priorities to be delivered including meeting the expectations of people accessing care; being a responsive provider by driving quality outcomes for patients; investing in their employees to develop, attract and retain a high performing and sustainable workforce, adding social value to the communities they serve; and maintaining financial sustainability.

Whilst staff we spoke to were not always able to tell the inspection team what this meant for their service, they described wanting to do the best for patients and their colleagues, and a focus on providing high quality care. Staff knew where to access information about the rebranding and the majority of staff we spoke to felt happy with the amount of communication they received from senior staff about this.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we interviewed both individually and in the focus groups felt respected, supported and valued within the team. Staff felt able to approach their line manager if they wanted to provide feedback. The service had an open culture where patients, their families and staff felt able to raise concerns without fear. Staff were supported to learn lessons when things went wrong without being made to feel blamed.

The service promoted equality and diversity in daily work, although some staff told us opportunities for career development was inconsistent amongst roles.

Staff explained situations where their manager had been supportive and considerate of personal circumstances. Some adjustments in working arrangements were made to support staff when this was the case.

Staff were focused on the needs of patients receiving care. Despite the pressures of the Covid-19 pandemic, staff told us they felt most proud of the way they had continued to provide a quality service to patients and that morale remained high.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Good

Community health inpatient services

The service improved service quality with monthly quality governance meetings and monthly operational meetings attended by service managers. The service had action plans to address specific risks which were discussed during focused meetings, for example harm reduction meetings which monitored pressure ulcers and falls. The service held meetings twice weekly for clinical leads and service managers to share learning across teams and the senior leadership and quality team met weekly to discuss significant events.

The service had regular team meetings or briefings which were minuted.

Management of risk, issues and performance

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The organisation had an overall corporate risk register which applied across the business unit and a separate risk register which outlined specific risks for Sapphire unit. Leaders logged actions to reduce their impact and improve the service for patients, and each risk was assigned to an individual staff member. We saw evidence that this was regularly reviewed and updated.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The service collected reliable data and analysed it. Although, at the time of our inspection the service used two electronic systems to monitor performance, which meant training compliance figures were not always accurate.

Staff knew how to access key information such as policies on the Intranet.

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service held regular formal and informal team meetings which demonstrated that line managers updated their staff with information such as but not limited to, service updates, waiting lists, incident reports, audits and outcomes, compliments and complaints and lessons learnt. Staff were encouraged to attend monthly learning events and had opportunity to book one to one meetings with the head of the business unit to raise issues directly to the senior leadership team.

Overall staff told us that they were happy with the amount of communication received from the senior leadership team about the rebranding and knew where to access additional information if needed. Although, one member of staff told us that they did not know what was happening within the business until it happened.

Learning, continuous improvement and innovation

Good

Community health inpatient services

All staff were committed to continually learning and improving the service.

Staff in the therapy team were invested in building links with the stroke pathway at the local acute hospital and had accessed opportunities to spend time learning from staff in the community neuro-rehab team.

The service had recently employed a practice development nurse to focus on inducting new starters, training, competencies, and delivering teaching for all staff.

The service delivered learning events for all staff to provide a venue to support shared learning across the business unit. Staff told us these events were time protected for wider sharing of learning to take place from events and incidents, promoting good practices and lessons learnt.

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 service must ensure that all staff are up to date with all their mandatory training and ensure they have systems to record completion of training accurately (Regulation 12(2)(c): Safe care and treatment).