Royal Hospital for Neuro-Disability

Quality Report

West Hill
Putney
London
SW15 3SW
Tel: (020) 8780 4500
Website: http://www.rhn.org.uk/

Date of inspection visit: 19-20 & 22 November 2019
Date of publication: 26/02/2020

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

The Royal Hospital for Neuro-Disability (RHN) is an independent medical charity which provides neurological services to the entire adult population of England. The hospital specialises in the care and management of adults with a wide range of neurological problems, including those with highly dependent and complex care needs, people in a minimally aware state, people with challenging behaviour, and people needing mechanical ventilation.

At our last comprehensive inspection in March and April 2017, this provider was rated as Good overall. Safe was rated as Requires Improvement. All other key questions were rated as Good. We also conducted a focused inspection in July 2018.

This is a report of a focused inspection we carried out on 19-20, and 22 November 2019. We carried out this inspection in response to concerns about some incidents the provider had notified us of. The incidents took place

Summary of findings

on Chatsworth and Drapers Ward, and our concerns were about the safety and leadership of these wards. We also visited a sample of other wards. As this inspection was focused on specific areas of concern, we did not look at all aspects of all key questions, and we have not re-rated this service.

We found the following issues that the service provider needs to improve:

- We found examples of where the service did not make a safeguarding referral to the local authority in a timely manner. Not all staff had received safeguarding training which was tailored to the particular vulnerabilities and needs of the patient group they were caring for.
- The service did not consistently control infection risks on Chatsworth Ward. Staff on that ward did not always use control measures to protect patients, themselves and others from infection. Staff did not keep all equipment and ward areas clean.
- On Chatsworth Ward, we could not be assured that the design, maintenance and use of facilities, premises and equipment kept people safe. Staff did not manage waste well.
- Handover processes on Chatsworth Ward were not fully effective.
- Some staff expressed concerns on whether the service had enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep detailed records of patients' care and treatment. Records were not consistently clear or up-to-date on Chatsworth and Wellesley Wards.
- We found one example where staff did not escalate out of range medication fridge temperatures in a timely manner.
- The hospital did not always manage patient safety incidents well. Managers did not always robustly investigate incidents and there was limited evidence that lessons learned were shared with the whole team and the wider service.
- We were not assured that all local leaders understood and managed the priorities and issues the service faced, or always took timely action to address them.
- Families we spoke to did not always feel they could raise concerns without fear. We were also concerned that healthcare assistants on Chatsworth Ward did not have the training to cope with violence and aggression displayed by some patients.
- Managers we spoke to could not always identify relevant risks and issues, and therefore actions to reduce their impact.
- We found one example where a statutory notification was not submitted to CQC without delay.

However, we also found the following areas of good practice:

- We found good practice in relation to infection prevention, cleanliness, hygiene, environment and equipment on other wards at the hospital. We found an example of innovation in use of equipment on Drapers Ward.
- Staff identified and quickly acted upon patients at risk of deterioration.
- 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.
- The service used systems and processes to safely prescribe, administer and record medicines.
- Executive leaders were visible and approachable in the service for patients and staff.
- Staff consistently told us they could raise concerns without fear.
- The hospital demonstrated they had plans to cope with unexpected events, such as a major incident.

Following this inspection, we issued the provider with an urgent notice of decision to impose conditions on their registration, under Section 31 of the Health and Social Care Act 2008. Details are at the end of the report. Since then, the hospital has provided us with an action plan detailing how they have addressed, or are working

Summary of findings

towards resolving, the issues we identified. For some issues, we have seen or received evidence that these have been resolved, and where this is the case we have referenced this in the report below.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London & South)

Summary of findings

Contents

Royal Hospital for Neuro-Disability

Services we looked at
Long term conditions;

Summary of this inspection

Background to Royal Hospital for Neuro-Disability

The Royal Hospital for Neuro-Disability (RHN) is a residential independent hospital run by a charity. It is located in Putney, West London. Patients and residents come mainly from London and southern England, but some come from other parts of England. RHN has total of 237 beds. It provides acute assessment and rehabilitation for 48 patients with severe brain injuries or illness through the NHS England Specialist Rehabilitation Contract. The hospital provides specialist help to patients with a wide range of complex neurological disabilities caused by damage to the brain or other parts of the nervous system as a result of brain haemorrhage, traffic accidents or progressive neurological conditions. It includes people who are highly dependent and have complex care needs, people in a minimally aware state, people with complex behavioural needs, and people needing mechanical ventilation. RHN has a high dependency nursing home providing long term care for 121 residents who have become disabled following a brain injury.

RHN is registered to provide diagnostic and screening activities, treatment of disease, disorder or injury, accommodation for people needing nursing or personal care and transport, triage and medical advice provided remotely. The chief executive has been the registered manager since March 2018.

RHN employed 11 doctors on a mix of full time, part time and zero hours contracts, and 0.45 whole time equivalent (WTE) dentists. A Wandsworth-based GP provides medical services to residents of the specialist nursing home and to patients with Huntington's disease.

The hospital employed 55 WTE qualified allied health professionals (AHP) and 18 WTE support AHPs. Allied Health Professionals include physiotherapists, speech and language therapists and occupational therapists.

RHN employs 127 WTE registered nurses and 192 WTE healthcare assistants, as well as having its own bank staff to cover staffing shortfalls.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, an inspection manager, head of hospital inspection, and a modern matron specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

During the inspection, we visited the following wards; Drapers, Chatsworth, Wellesley, Evitt and Haberdashers House. It should be noted that we spent the most time on Chatsworth Ward during our inspection, as this is where our concerns were focused.

We spoke with approximately 30 members of staff including registered nurses, health care assistants, reception staff, medical staff, and senior leaders. We spoke with one patient and four relatives. During our inspection, we reviewed nine sets of patient records.

Long term conditions

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long term conditions services safe?

As this was a focused inspection, we did not rate safe.

Mandatory training

The service provided mandatory training in key skills but did not always make sure all staff completed it, as there were some areas of particularly low compliance.

Mandatory training was provided face to face and online. Face to face training included, manual handling, safeguarding levels one two and three, fire safety, Mental Capacity Act/Deprivation of Liberty Safeguards and cardio-pulmonary resuscitation. Online training included, drug calculation, intravenous training, equality diversity and human rights, use of the National Early Warning Score (NEWS2), Duty of candour, infection prevention and control, general data protection regulations, health and safety, and dysphagia (difficulty swallowing). Staff were given time off to complete training. Mandatory training updates were required annually, apart from safeguarding, which was required every three years.

Mandatory training compliance was monitored by the Learning and Development Department. A ward manager told us they received monthly updates on the mandatory training compliance rate for their ward. The hospital provided us with mandatory training compliance rates as of 6 December 2019, as part of their provider information request. This showed the overall percentage of staff who had completed mandatory training was 91%, below the hospital's target of 95%. There were some areas of particularly low compliance, such as Safeguarding Level 1A training for clinical staff at 68% and cardio-pulmonary resuscitation for non-clinical staff at 25%. However, it should be noted that these compliance rates relate to the whole hospital, and we only visited five of 13 wards on this inspection. Therefore, the evidence we collected was not sufficient to demonstrate a breach of regulation relating to mandatory training, and instead this will be looked in to in more detail during the next comprehensive inspection. Safeguarding training compliance is discussed in more detail under Safeguarding.

We saw staff could view the mandatory training records for an agency worker on an electronic system. We looked at a record for one agency worker on Chatsworth Ward and saw all their mandatory training was up to date, and they had undergone security checks.

Safeguarding

Staff understood how to protect patients from abuse. However, we found examples of where the service did not work with other agencies in a timely manner. Not all staff had received safeguarding training which was tailored to the particular vulnerabilities and needs of the patient group they were caring for.

Leaders confirmed that safeguarding concerns were raised through patient safety team who then raised the safeguarding referral with the local authority. The patient safety team led on safeguarding investigations, in partnership with the local authority and other external stakeholders such as clinical commissioning groups. Leaders confirmed all safeguarding cases were reviewed quarterly at the clinical risk and incident committee. Social workers were based in the hospital and covered various wards. One manager told us they felt confident staff would be able to identify a safeguarding concern.

We asked five non-managerial staff about their knowledge and understanding of safeguarding. All were able to describe how they would raise a safeguarding concern, which was line with the process described by leaders and managers.

We also asked four staff about warning signs they would look for that a patient was being abused. All four staff told us they would report any bruising and escalate this to a senior member of staff, and two told us they would also check to see if a patient appeared withdrawn. One member of staff told us it was difficult to find visible signs of maltreatment especially for patients who cannot communicate and told us they would seek family feedback on their relative's wellbeing.

Following our inspection, the provider sent us their updated Safeguarding Adults at Risk of Abuse Including Prevent policy. We saw this made reference to legislation such as the Care Act 2014 and the Mental Capacity Act 2005, and local protocols such as the Pan London Safeguarding Adults at risk from Abuse policy and procedures. The policy included arrangements for who staff should escalate concerns to both in and out of hours, and a procedure flowchart for staff to follow, illustrating this.

Compliance rates for Adult Safeguarding and Prevent Basic Awareness (Level 1 e-learning), were at 91.7% for clinical staff, and 93.81% for non-clinical staff, which was just short of the provider's target of 95%. The provider told us this level of training was in line with their contractual arrangements as agreed with their commissioners.

Healthcare assistants were trained to safeguarding level 1a. This was a face to face scenario-based training course. Leaders told us this was tailored to the type and needs of patients the hospital cared for. The provider told us this training was not required as part of their contractual arrangements but was introduced to embed the learning for staff on each ward specific to their patient groups and was completed in addition to the Level 1 e-learning. The hospital provided us with information on 6 December 2019 which showed amongst the 111 clinical staff eligible to attend safeguarding level 1a training, 35 had never attended training or their training compliance had expired. This resulted in a compliance rate of 68%. This did not meet the hospital's target of 95%. This meant the hospital could not be assured that all eligible staff had received training tailored to the type and needs of patients the hospital cared for, and the particular vulnerabilities of those patients. The hospital provided us with information following our inspection that additional training sessions had been arranged to improve compliance rates. At the time of writing the hospital provided evidence that an additional 14 staff had been trained, and training was planned for a further 11 staff. The hospital told us that as of 10 February 2020, compliance rates had improved from 68% to 74%. It should be noted that these compliance rates relate to the whole hospital, and we only visited five of 13 wards on this inspection. Furthermore, we also issued the provider with a notice of decision to impose conditions relating to safeguarding. Therefore, the evidence we collected was not sufficient to demonstrate a breach of regulation specifically relating to safeguarding training, and instead this will be looked in to in more detail during the next comprehensive inspection.

Safeguarding investigations were not consistently completed, thorough or timely. During our inspection on Tuesday 19 November 2019, we requested a list of incidents reported at the hospital for the last three months. On Wednesday 20 November 2019, we asked for investigation reports in relation to eight of those incidents. We found two of these incidents may have required a safeguarding concern to be raised with the local authority, but staff had not done so. In one case, we found the actions the hospital took were not in line with national safeguarding guidance and should have been reported to the police and to the local safeguarding authority at an earlier stage. In the other case, the investigation we reviewed was not in depth enough for us to establish if a safeguarding referral was required. Therefore, we could not be assured that the provider always escalated safeguarding concerns in an adequate and appropriate way.

Cleanliness, infection control and hygiene

The service did not consistently control infection risk on Chatsworth Ward. Staff on that ward did not always use control measures to protect patients, themselves and others from infection. Staff did not keep all equipment and ward areas clean. However, we found good practice on other wards at the hospital.

Infection control practices on Chatsworth Ward were not in line with best practice and were placing patients at increased risk of infection.

We did not see any checklists for cleaning displayed on the ward, including in patient toilets. The ward manager

told us the checklist for cleaning was held by domestic staff. However, when we asked a member of domestic staff, despite clarifying the question twice, they told us there was no checklist for cleaning of the ward and that they just remembered which patient rooms they had cleaned and which they had not.

Poor infection control practice meant patients were at increased risk of developing infections on Chatsworth Ward. We viewed four items of equipment (a blood pressure monitor, tympanic thermometer, ream hoist and a fan). None had an 'I am clean' sticker or equivalent to show they were clean, all were visibly dusty and one item (blood pressure monitor) had dirty gloves on it. We viewed five linen trolleys and saw two had a dirty clinical linen waste bag laid on top of the clean linen. In the main day room, we observed food debris and stains on one of the tables. We looked at three meal mats (a laminated document detailing patients specific needs and preferences for meals including positioning and food texture) which we found were stained with food debris and had not been cleaned. Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance.

We saw that three members of staff were not bare below the elbow on Chatsworth Ward by wearing long sleeves, or jewellery during our inspection. One of these staff gave clinical care to two service users whilst not bare below the elbow. This meant that staff who were not bare below elbow, were at risk of not being able to observe hand washing techniques in line with infection prevention and control, and the clothing on their arms could get contaminated. Therefore, in turn service users were at risk of cross-infection.

However, following our inspection, the hospital provided us with an action plan detailing steps they were taking to address poor infection control on the ward. This included a daily walkaround by senior nursing staff to check the cleanliness of the ward and introducing a hospital-wide bare below the elbow check at nursing handovers. We attended for a short visit on Chatsworth Ward on 12 December 2019 and both staff we spoke to were bare below the elbow. Staff told us they were now able to locate the cleaning checklist, although we did not view this.

On Drapers Ward, we saw good practice in relation to cleanliness, infection control and hygiene. The ward was visibly clean. Staff had enough personal, protective equipment to care for patients safely, including gloves and aprons. We saw patients who had infections were appropriately isolated in side rooms, in line with national guidance.

We also visited Wellesley Ward, Evitt Ward and Haberdashers House, and found these areas were visibly clean, and we did not identify any concerns with cleanliness, infection control or hygiene.

Environment and equipment

On Chatsworth Ward, we could not be assured that the design, maintenance and use of facilities, premises and equipment kept people safe. Staff did not manage waste well. However, on Drapers Ward we found good practice in relation to the environment and equipment.

Throughout our inspection, we saw Chatsworth Ward was cluttered and untidy. We noted the store and feeds room was cluttered with lots of empty boxes and further the room was overstocked with consumables. We checked the clinical room and the storage room, and they appeared unkempt and with litter on the floor. In the patient day room, we saw a food trolley with food waste that had not been cleared from the evening meal that was served a few hours before. We saw day rooms, used by patients and their families, were cluttered with inappropriate items on the floor, such as large sun umbrellas, crash mats and a broken piece of furniture. Premises should be properly maintained. This meant the ward premises were not always properly used and maintained in line with guidance.

During handovers on Chatsworth Ward at 7:45am on 20 November, we noted three service users had told staff they felt cold and requested heaters. We saw that by 3:30pm on 20 November 2019, these heaters had not been arranged. There was no facility to monitor the temperature in patient rooms. This meant there was a risk the low temperature could have an adverse effect on several service users on the ward who were unable to control their own body temperature, or other patients who were unable to communicate that they felt cold. We were not assured that staff made sure the temperature of patient's rooms was safe for them. There was the risk that patients could suffer the effects of hypothermia and this could endanger their lives.

Long term conditions

On Chatsworth Ward, we saw on 19 November 2019, on two occasions a fire exit door had been left open. During this time, we saw two service users were moving around the ward in self-propelling wheelchairs. This meant there was a risk that unauthorised persons could access the ward, or service users could leave the ward without the assistance of staff and potentially injure themselves whilst doing so. The hospital told us this was caused by a relative using the fire door inappropriately, despite the hospital requesting that the relative use the main entrance to the ward.

Since our inspection, the provider had made progress on improving the environment of the ward. The hospital provided us with an action plan which outlined steps taken to address the issues with environment and equipment on Chatsworth Ward. This included a regular review of the environment by senior staff, and the introduction of temperature monitoring. We attended for a short visit on Chatsworth Ward on 12 December 2019 and saw staff had removed all rubbish and inappropriate items, and the store and feeds rooms had been tidied. We also saw a new alarm had been installed on the fire exit door, with a sign reminding staff, patients and visitors that the door was for emergency use only.

We found the design, maintenance and use of facilities, premises and equipment kept people safe on Drapers Ward. Staff were trained to use them. Staff managed clinical waste well. On Drapers Ward we saw the environment, which had been recently refurbished, was modern and in line with best practice. For example, we saw there was a bespoke bedside hoist for each patient, which was innovative practice. Staff stored clinical waste in the sluice room and segregated waste by infected (orange), clinical (yellow), and medicine (blue). There was restricted access to the ward and patients at risk of absconding had alarms on them to alert staff.

We also asked three staff across the hospital whether they felt they had enough equipment to care for patients safely, and all confirmed this was the case. Staff we asked were able to describe steps they would take in the event of broken equipment, including informing the nurse in charge and escalating the problem to the maintenance team who could arrange replacement or repair.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. However, handover processes on Chatsworth Ward were not fully effective.

All staff we asked were aware of the arrangements, both in and out of hours, should a patient deteriorate. There was a nurse site manager whom staff could escalate to through a bleep, and staff told us they would also inform the duty doctor out of hours. Staff told us if the patient required transfer to the local acute hospital, the duty doctor would write a medical transfer letter.

On some wards, staff updated patients National Early Warning Scores (NEWS) electronically. Staff checked patients observations at a standard frequency of 12 hours, which were increased should the patient display any signs of deteriorating, such as vomiting. The GP on Chatsworth Ward told us that the electronic system, although new had improved the efficiency of the service. Nurses entered observations and doctors were able to pick this information up immediately, and request investigations such as blood tests in response. The GP confirmed that medical staff were always informed of deteriorating patients in a timely manner. Staff were able to give examples of situations in which patients might be at particular risk of deteriorating, such as if a patient was going through the process of weaning from a tracheostomy.

We observed the morning handover on both sections of Chatsworth Ward. These handovers were very detailed and contained lots of reminders for both tasks due to be done on the ward, and specific patient's needs. However, at both handovers, there was no handover sheet given, although the ward manager later told us a list of patient appointments was circulated. The members of staff chairing the handover had computers, but all other attendees either wrote in their own notebooks or did not write any notes. This meant staff did not have a shared written document which outlined the key information required to hand over care of patients to staff on the next shift. At the start of the handover in the main day room, there were 10 staff, and a further five attended at different stages throughout the meeting. During the handover in the Garden Room, one healthcare assistant was required to attend to a patient in distress several times throughout the handover, and one member of staff arrived at the handover halfway through discussions. We did not observe these staff receiving any assistance to catch up

on what they had missed from the member of staff chairing the handover. We asked the ward manager about this, who told us that staff who were coming and going from handovers were usually from the night team. However, we saw the staff who missed part of the handover working on the ward over the course of the day. Therefore, there was a risk that these staff missed key information relevant to assessing and responding to risks to patients on the ward. Despite our findings, following our inspection the hospital told us that the team on Chatsworth worked in pairs to support patients, and as such would staff receive handover from their partner colleague, if they had missed a handover.

Nurse staffing

During our inspection, nursing and support staffing met planned levels. The hospital used recognised tools to review and adjust staffing levels and skill mix. However, some staff expressed concerns on whether the service had enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Agency usage fluctuated, and sometimes exceeded 20%.

The hospital provided us with information which showed they used the updated National Quality Board Safe Staffing guidance and expectations for nursing staffing across the hospital and used the Safer Nursing Care Tool as a framework to decide on staffing numbers.

On Chatsworth Ward, there were six nurses and fourteen HCAs on shift during the day, and three nurses and four HCAs at night. At the time of our inspection, there were 34 patients resident on the ward. The ward was divided into 'blue' and 'yellow' areas. Staff told us that patients in the 'yellow' area had more complex needs such as tracheostomies, therefore the staffing was adjusted in this area to reflect this.

Nursing staff were allocated to specific tasks for the day including monitoring the use of meal mats, first aid leader, checks on the clinical and feeds room, and fire warden. There was also a nurse allocated to each corridor of the ward to provide support to healthcare assistants. HCAs were divided into four groups, and each group was responsible for caring for four or five patients.

During our inspection, on both our day and night visits, we saw the numbers of staff on the ward met planned levels. The ward manager told us there were vacancies for two registered nurses and four healthcare assistants on the ward, which were being filled by bank and agency staff. The charge nurse told us that patient acuity was fairly constant, and therefore there was no need to increase or reduce staff, and the ward maintained a consistent level of staffing

On Drapers Ward, each day shift was planned to have three registered nurses and seven healthcare assistants. Night shifts had two registered nurses and eight healthcare assistants. A senior nurse told us that the ward normally had the planned number of staff.

A nurse was allocated as bleep holder for the whole hospital. Nursing staff told us there was a rota for each nurse to act as bleep holder one day per month, and appropriate cover was arranged on the ward the nurse usually worked on. Staff told us in the event of staffing shortages, they could contact the bleep holder, who could allocate staff to assist from other areas of the hospital if possible. We saw staff recorded nurse and healthcare assistance staffing shortages as an incident, on the electronic reporting system.

We asked five staff on Chatsworth Ward, from a mixture of disciplines, on both our day and night visits, as to whether they felt they had enough nursing and support staff on the ward to care for patients safely. One staff member told us they felt "rushed off their feet" and would find it helpful to have one additional healthcare assistant to act as a floater on the ward. One member of staff also told us the presence of agency staff created additional pressure as they sometimes 'do not know what to do'. Another staff member told us shortages of healthcare assistants could sometimes impact on patients receiving a shower, and therefore attending appointments such as therapy sessions, and estimated this happened approximately once per month. We spoke to another two healthcare assistants who told us they found the workload "worrying" and they sometimes struggled to cope when the ward was busy. A patient we spoke to also told us that healthcare assistants were "too busy" and sometimes they had to wait a long time to be moved

from their bed to their wheelchair. We saw five out of 77 incidents reported on Chatsworth Ward between 19 August 2019 and 18 November 2019, referred to nurse shortages on the ward.

It should be noted that since our inspection, the hospital had changed the staffing arrangements for Chatsworth Ward, so that staff were allocated to care for patients on the same part of the ward. Previously, staff had been allocated to specific patients, who may have been in different areas of the ward. Leaders had also introduced a team leader healthcare assistant to support staff and ensure they took their breaks. We attended for a short visit to the ward on 12 December 2019 and the charge nurse commented that these changes had improved the effectiveness of staffing on the ward, and fostered a better team working atmosphere.

We viewed the agency usage across the hospital for nursing and support staff. This showed that from May 2019 to October 2019, use of agency healthcare assistants fluctuated between 23 and 25%. For nursing staff, this fluctuated between 17 and 22%. The hospital did not indicate whether they had a target for agency staff usage. The charge nurse on Chatsworth Ward told us each agency HCA worked alongside a permanent HCA, and it was typical to have up to five agency HCAs on a day shift. Staff across the wards we visited told us agency staff were usually those who had worked on the ward before, and they tried to block book particular staff to ensure this happened. This was because of the high level of care needed by the patients; therefore, it was more desirable if agency staff had cared for the patients before and were aware of their needs and care plan. The charge nurse told us use of agency staff increased over holiday periods.

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.

There was a medical director who worked three days a week and had been in post for three years. There were four full time consultants, who also covered the hospital at nights and weekends. There as one part time consultant who covered the ventilator unit.

There were seven attending consultants who had expertise in different specialisms such as palliative care, respiratory, neuro-psychiatry, urology and Huntingdon's disease. GPs provided care for patients in the specialist nursing care home. There were five junior doctors who covered the brain injury service during the day. They covered nights and weekends on-call from home.

The medical director told us he was satisfied with medical cover arrangements at the hospital, which had increased recently. Medical staff carried out 'near patient testing' when required and were able to see patient's test results online.

Nursing staff we spoke to across the hospital told us they felt the hospital had enough medical staff to provide safe care and treatment to patients, and they could easily access doctors for advice.

Records

Staff did not keep detailed records of patients' care and treatment. Records were not consistently clear or up-to-date on Chatsworth and Wellesley Wards.

On Chatsworth Ward, we saw record keeping was poor. We saw intentional rounding charts were incomplete in all eight patient records we reviewed, for one or more days. A CQC team member was sat in the nurses' station office facing out in to the day area where the service users were sat in their wheelchairs between the hours of 10:40am - 12:20pm, on 20 November 2019. For one patient, we saw staff had recorded they had carried out intentional rounding at 11:55am, but we witnessed that this had not taken place. This poor and inaccurate record keeping meant there was a risk of staff believing that a patient's care needs had been met and key clinical interventions had been carried out, when they in fact had not.

However, we noted there was a system on Chatsworth Ward to keep care plans up to date. This was displayed in the nursing office for staff to easily refer to. According to this chart, all care plans were up to date, and all had a date for review in 2020.

On Wellesley Ward, the body map chart from one of the patients on admission showed the presence of a 'grade four bed sore healing with scab'. Under the comments section, a staff member had written 'patient received with skin intact, old scars indicated.' We reviewed six repositioning charts for this patient and saw none of the charts had been completed, despite one of the six forms

recording that patient seating tolerance was five to six hours. It was not clear from the body map chart what, if any, ongoing skin management the patient needed. It was not clear if the patient still had a grade four bed sore, or this had improved to a lower grade or had completely healed on admission. We spoke to the nurse in charge about the poor record keeping. The nurse in charge told us that a tissue viability nurse had advised that this patient was mobile and so did not need to be repositioned. The nurse in charge said this advice was recorded on the electronic patient record. However, upon request to see this, the nurse searched, but discovered there was no record of this advice or assessment from the tissue viability nurse. The matron later confirmed that the note should have said a 'historic grade 4 bed sore' that was completely healed on admission. This inaccurate record keeping meant there was a risk of service users not having their care needs met, particularly by new or temporary staff who were not familiar with the patient. On our last focused inspection in July 2018, we told the provider that they must take action to improve the consistency of completion of documentation, particularly recording of key clinical interventions, including turning charts, and NEWs scores. The report was published in September 2018. We found similar concerns on this inspection.

Furthermore, we also checked seven fluid balance charts for the same patient on Wellesley Ward and found there were no balance calculations recorded. This meant staff could not be assured that this patient was receiving the required daily amount of fluid. On our last focused inspection in July 2018, we told the provider they should continue work to ensure that patients' fluid balances were monitored systematically by adding up fluid balances on charts.

Since our inspection, the hospital provided us with information which showed they had introduced nurse checks of documentation at the end of each shift, and daily spot checks by the ward manager and charge nurse. We also attended the hospital for an engagement visit on 14 January 2019, and noted the hospital were holding an event to relaunch documentation including intentional rounding charts, to make documentation more accessible, streamlined and holistic for staff, patients and relatives.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, we found one example where staff did not escalate out of medication range fridge temperatures in a timely manner.

On Chatsworth Ward, we saw staff wore 'do not disturb' aprons when completing drug rounds. We inspected the clinical room on Chatsworth Ward and found drug trolleys were locked and controlled drugs were stored in locked cabinets, in line with guidance. Staff divided medicine cupboards in to patient rooms and names. Staff told us they received support from pharmacists based at the hospital. Staff recorded drug fridge temperatures and the temperature of the clinical room. We saw staff had recorded these checks for every day during 1-22 November 2019, except the 21st.

The hospital had gradually introduced an intravenous antibiotics pathway. Chest, urinary tract and skin infections were common amongst patients at the hospital, and the aim of the pathway was to prevent admissions to acute hospital, which could be difficult and disruptive for patients with cognitive and physical disabilities. The pathway document was reviewed by a CQC pharmacist specialist and national professional advisor, who found it to be comprehensive and with no safety concerns.

However, we saw drug fridge temperatures were being recorded at Haberdashers House, but there were delays of more than six weeks in reporting where they were outside the recommended temperature range. This meant there was a risk staff did not always escalate out of range temperatures promptly. We spoke to the nurse in charge, who told us the fridge had been reviewed by a pharmacist and found to be faulty. The fridge was marked for replacing and the medicines in it quarantined from being used.

Incidents

The service did not always manage patient safety incidents well. Managers did not always robustly investigate incidents and there was limited evidence that lessons learned were shared with the whole team and the wider service. However, staff were able to describe how they would recognise and report incidents and near misses.

Long term conditions

All staff we spoke with were able to describe what they would do in the event of an incident, including reporting it on the electronic system. The Head of Patient Safety and Quality received an alert whenever an incident was reported on the electronic system, and shared regular updates with heads of nursing, matrons and ward managers for all areas of the hospital.

Incident investigations were not consistently completed, thorough or timely. During our inspection on Tuesday 19 November 2019, we requested a list of incidents reported at the hospital for the last three months. On Wednesday 20 November 2019, we asked for investigations and safeguarding reports in relation to eight of those incidents. None of the eight incidents we reviewed had associated investigation reports. It was not possible to assess the timeliness of the investigations due to the incomplete recording of the incidents and associated investigations. In four of the eight and there was no evidence of any actions or further learning. In the other four, learning points were limited to arranging further training for staff in the future. Therefore, this placed service users at risk of harm and we could not be assured that the provider conducted investigations and shared learning regarding safeguarding incidents in an adequate and appropriate way.

Learning from incidents was not robust or embedded in to practice on Chatsworth Ward. We asked five staff how they accessed learning from incidents. Staff told us they discussed learning from incidents in handover meetings, and the ward manager told us learning from incidents was discussed in clinical forums with the clinical psychologist. However, we attended both of these meetings during our inspection and found specific incidents, learning and root causes were not discussed. Instead, these meetings were focused on the day-to-day running of the ward, handing over patients, or how healthcare assistants could deal with challenging behaviour from patients.

Furthermore, two of the five staff we spoke to were not able to clearly articulate how they accessed learning from incidents and adverse events, despite prompting by inspectors.

Safety Thermometer (or equivalent)

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

The hospital performed well in the safety thermometer. In August, September and October 2019, the hospital overall showed a percentage of 99% harm free care, which was better than the national overall percentage of all submissions to the safety thermometer in those months of just over 93%. Safety thermometer results were shown in the Patient Safety and Quality Report which fed up through the hospital's governance structure to the board.

We saw safety thermometer results were displayed on the wards we visited for patients, their relatives and visitors to see.

Are long term conditions services effective?
(for example, treatment is effective)

This key question was not inspected.

Are long term conditions services caring?

This key question was not inspected.

Are long term conditions services responsive to people's needs?
(for example, to feedback?)

This key question was not inspected.

Are long term conditions services well-led?

As this was a focused inspection, we did not rate well led.

Leadership

We were not assured that all managers understood and managed the priorities and issues the service faced, or always took timely action to address them. However, executive leaders were visible and approachable in the service for patients and staff.

Long term conditions

We found the local leadership could not fully identify challenges to quality and sustainability faced by the service, and therefore were unable to articulate the actions needed to address them. The ward manager on Chatsworth Ward told us did not know the ratio of agency to permanent staff who were working on the ward on both days of our inspection. We felt this was key information relevant to the day-to-day running and safety of the ward which should have been easily accessible to the ward managers. Since our inspection, the hospital has advised us that new senior management on Chatsworth Ward had been instated.

Despite this, on Drapers Ward, we found the ward manager was knowledgeable about staff vacancies, numbers of agency staff and mandatory training compliance.

Four staff we spoke to talked positively of their managers and leaders. On Drapers Ward, one staff member told us "My matron worked hard to let the managers know the needs and demands of the ward." Matrons we spoke to told us support amongst colleagues and from heads of nursing was positive. For example, there was a cross-hospital senior nurse forum, led by heads of nursing, where staff could discuss concerns and best practice.

Furthermore, the executive team took steps to ensure they were visible and approachable in the service. Leaders visited the hospital at night. We visited Chatsworth Ward in the evening as part of our inspection and saw the CEO was present, conducting a routine night visit.

Vision and strategy

As this inspection was focused on urgent safety concerns, this aspect of this key question was not inspected.

Culture

Families we spoke to did not always feel they could raise concerns without fear. We were also concerned that healthcare assistants on Chatsworth Ward did not have the training to cope with violence and aggression displayed by some patients. However, staff consistently told us they could raise concerns without fear.

The charge nurse on Chatsworth Ward described the ward as a "a good place to work" and told us they felt they had "very supportive managers." We spoke with two other staff members who reported they were "happy" working at the hospital, and that their colleagues were "caring". Staff on Drapers Ward told us they now spent more time with patients than previously. One senior nurse told us they were proud to be working at the hospital

We asked six staff across different wards if they would feel comfortable to raise a concern and all confirmed they would be. Staff told us they would report any concerns to their manager, or to the matron responsible for the ward and complete an electronic incident form. One member of staff we asked told us they knew there were whistleblowing procedures they could follow. We noted that staff leading handovers allowed time for staff to raise any problems, issues or concerns.

We viewed the staff rotas for Chatsworth Ward and we saw that staff teams were always varied, and staff were not allocated to permanently work the same shifts with the same colleagues. Staff also worked across both the 'blue' and 'yellow' sides of the ward. The charge nurse told us that if they had more than one agency nurse, they would allocate them to different sides of the ward and they would always be working with permanent members of staff. Ensuring staff do not always work with the same colleagues all the time is important to help to prevent closed cultures developing in the workplace.

A senior nurse on Drapers Ward could give examples of debriefing processes that were initiated after a recent incident, to support patients and staff, including the chaplain and a psychologist also attended the ward to support staff and help them to process what had happened.

We viewed the communication book on Haberdashers House, where patients and their relatives could leave messages for staff. This showed staff listened to the requests patients and relatives and took action to meet them. For example, we saw a request for an additional piece of equipment for mealtimes was promptly arranged. We saw staff used positive and kind language to respond in the communication book

However, during and following our inspection, we spoke to three patient relatives, and received anonymous allegations from one further relative. All four relatives told

us they had concerns about how their relative was cared for, but they did not want to raise these with the hospital because they were worried about the impact this would have on their relationships with staff. It should be noted that the concerns raised by family members were aligned with the issues we identified during our inspections, and were not new concerns.

Healthcare assistants on Chatsworth Ward had not received Prevention and Management of Violence and Aggression (PMVA) training. The ward manager told us they had been trying to access PMVA training for their staff, due to the changing cognitive conditions of some patients, who were starting to display challenging behaviour as a result. The ward manager told us they had been trying to arrange this since March 2019, but this had only been confirmed at the time of our inspection. The ward manager told us the training had been arranged for eight staff on 28 November 2019 and four staff on 2 December 2019. It was expected all staff would have training during the next 12 months from the date of our inspection. This meant staff, particularly healthcare assistants, were reliant on individual techniques or management plans for individual patients as recommended by the clinical psychologist during clinical forums, which occurred once per month. We observed a clinical forum and saw the healthcare assistants expressed concerns about feeling "worn down" and that they were "battling against" frequent incidents of patients lashing out at them. We spoke to one member of staff who had been pinched by a patient during our inspection and was reporting as an incident. We saw 22 out of 77 incidents reported on Chatsworth Ward between 19 August 2019 and 18 November 2019 related to a patient hitting, punching, slapping or otherwise abusing a member of staff. We did not feel assured staff had received training to be able to cope with violence and aggression displayed by patients in a timely manner, and we were concerned about the impact this was having on staff wellbeing. The hospital also identified this as an issue. At the time of writing, the hospital had initiated an action plan and checklist of care for staff encountering violence and aggression. The hospital told us this had been discussed at the safeguarding assurance meeting and they had agreed that further work was required to embed this.

Governance

Leaders did not operate effective governance processes throughout the service.

On our last focused inspection in July 2018, we found there were effective structures and systems of accountability to support the delivery of good quality, sustainable services. On this inspection, we found these structures and systems remained the same, although we had concerns about governance processes on Chatsworth Ward. Each ward within the specialist nursing home was led by a ward manager, who was managed by the Specialist Nursing Home matron. Staff we spoke to on the wards were aware of what they were accountable for and to whom. The head of nursing oversaw the work and line management of the matrons. The director of nursing held executive responsibility for nursing. There were separate governance arrangements for allied health professionals and medical staff who covered the wards.

We found issues around the consistency of documentation of key clinical interventions on Chatsworth and Wellesley Wards, such as completion of fluid balance, repositioning and intentional rounding charts. We told the provider to take action to improve the consistency of completion of documentation, particularly recording of key clinical interventions, including turning charts, and NEWs scores, in our previous report, published in September 2018. This meant we could not be assured that all levels of governance and management functioned effectively or interacted with each other appropriately, as improvements to completion of repositioning charts had not been made in all areas of the hospital.

We found one example where the hospital did not submit a notification of alleged abuse to CQC without delay. This meant the hospital's arrangements to ensure that data or notifications were submitted to external bodies as required were not always effective.

There was an organisational improvement plan, which fed up from the wards to the board through weekly ward quality audits. These audits included specific targets or goals for each ward to achieve and involved a review of a sample of patient records. Leaders met monthly with ward staff, to ensure the ward was on track to meet the requirements of the audit. We reviewed a copy of the weekly ward audits from 3 June 2019 to 18 November 2019, which had an overview of compliance of weekly audits such as documentation, medication, completion

of National Early Warning Scores (NEWS) and hand hygiene, on a rotating four weekly basis. This mostly showed high levels of compliance of 85% and above. There was a tab for each ward to record the action plan of any audits which showed lower compliance. For example, the Jack Emerson Centre (ventilator unit) had scored 25% on a NEWS audit in September 2019, and Hunter Ward had scored 60% on a hand hygiene audit in November 2019, against the hospital target of 95%. We found the action plan tabs were all blank, apart from Drapers Ward. The hospital told us the action plan tabs were blank because the hospital was in the process of rolling out the new electronic paper records process, as such the audit was being captured by this system and the previous paper audit forms were no longer being used. However, the hospital did not provide us with evidence of these action plans, which meant we could not be assured of actions taken to address low compliance in audits which were key to ensuring patients received safe care.

Managing risks, issues and performance

We could not be assured that leaders and teams used systems to manage performance effectively. Managers we spoke to could not always identify relevant risks and issues, and therefore actions to reduce their impact. However, the hospital demonstrated they had plans to cope with unexpected events.

The ward manager on Chatsworth Ward and the matron that covered Haberdashers House and Wellesley Ward were unable to articulate the top three risks for their respective wards. We viewed the ward improvement plan for Chatsworth Ward which contained detailed areas for improvement surrounding clinical records, learning and development, and nutrition and hydration, but the ward manager did not articulate these as risks. This meant the ward manager could not demonstrate awareness and management of key issues and risks on their ward area. However, the evidence we collected was not sufficient to demonstrate a breach of regulation specifically relating to staff's knowledge of key risks, and instead this will be looked in to in more detail during the next comprehensive inspection.

Ward staff told us if there was a concern about member of staff, they would speak to managers and the human resources team. Ward managers encouraged staff to give feedback about agency workers. The agencies the hospital used had an electronic system, where staff could view details of each agency worker and give feedback on performance. If the agency worker was subject to a pending investigation, they could not be booked on to shifts.

Shortly before our inspection, there had been a major incident on one of the wards. Staff and leaders dealt with this in a systematic way, and very quickly put in short and long-term mitigations to minimise any ongoing risk to patients. Throughout this incident, leaders demonstrated co-operation and openness with external stakeholders.

Managing information

As this inspection was focused on urgent safety concerns, this aspect of this key question was not inspected.

Engagement

As this inspection was focused on urgent safety concerns, this aspect of this key question was not inspected.

Learning, continuous improvement and innovation

As this inspection was focused on urgent safety concerns, this aspect of this key question was not inspected.

Outstanding practice and areas for improvement

Outstanding practice

- Every patient on Drapers Ward had a bespoke hoist at their bedside, which was innovative practice.

Areas for improvement

Action the provider SHOULD take to improve

- Consider reviewing handover processes on Chatsworth Ward to ensure all staff receive information key to caring for patients.
- Continue work to ensure all staff caring for patients on Chatsworth Ward receive Prevention and Management of Violence and Aggression (PMVA) training.

This section is primarily information for the provider

Enforcement actions

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
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Section 31 of the Health and Social Care Act 2008 Urgent notice of decision to impose conditions on your registration as a service provider in respect of regulated activities 1. The registered provider must not admit any new service users at Chatsworth Ward at Royal Hospital for Neuro-Disability West Hill, Putney, London, SW15 3SW, without the written permission of the Care Quality Commission. 2. The registered provider must undertake a review of all notifiable specific incidents at Chatsworth Ward at Royal Hospital for Neuro-Disability between 26 November 2018 and 25 November 2019, and provide the Care Quality Commission with: a. details of an effective system and policy to identify and assess any potential safeguarding issues and the management of vulnerable adults; b. a weekly report on action taken or to be taken in respect of those incidents; and c. a weekly report on the learning and recommendations put in place following the review/investigation of those incidents. 3. The registered provider must undertake a review of all service users' medical records relating to their care and treatment and ensure they are individualised, detail specifically what level of care is required and ensure they are based on individual risk assessments, including mitigation of any risks identified. This must include but not limited to tissue viability assessments, and;

This section is primarily information for the provider

Enforcement actions

a. ensure there is clear documentation to inform staff of the current treatment plans of all service users this includes details of any changes to service users' treatment needs are clearly recorded and are easily accessible to relevant staff.

4. The registered provider must:

a. Ensure that there is an effective system to identify and mitigate environmental risks across the Chatsworth Ward premises at the Royal Hospital for Neuro-Disability and that this is implemented. This should include, but not limited to, monitoring and maintenance of room temperatures, so that they do not fall below 18 degrees Centigrade.

5. The registered provider must provide the Care Quality Commission with a report setting out the actions taken or to be taken in relation to conditions1-4 above by 29 November 2019 and every other Friday. The report must also include the following:

a. details of the system(s) and processes that are implemented to comply with the conditions,

b. details and confirmation of action taken to ensure the system(s) are being audited and monitored to improve the quality and safety of services.