Villa Care Limited

# St. James Hospital Wards J30 & J31

## Inspection report

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

# Summary of findings

## Overall summary

We rated this service as overall requires improvement with safe rated as inadequate.

The reasons for the rating of requires improvement overall was as follows:

Risk assessments did not always capture key information and staff did not always follow risk management plans. This included risks such as falls, deterioration in physical health and pressure care.

We did not always find the environment and equipment was safe, clean or well managed.

People were not always encouraged to be as independent as possible and there was a lack of person-centred care being provided. For example, patients did not have access to sufficient levels of meaningful activities and were often bored. Also, patients were not encouraged to get dressed during the day or supported to use the toilet rather than a bedpan where this was possible.

We received mixed feedback from carers, some concerned at the deterioration in their relatives.

Records we reviewed did not always contain adequate information required to ensure safe and high-quality care was provided. For example, in some cases patients' weights were not adequately monitored and this was potentially unsafe if changes in weight were not addressed.

We received mixed feedback from stakeholders about the way the service operated.

Leaders and managers ensured quality assurance processes were in place however these were not always effective in addressing shortfalls in the quality of care provided.

However:

We did find that patients were not left for long periods of time when they required assistance, call bells were responded to efficiently by staff.

Staff who were employed by Villa Care spoke positively about the service and the relationships with other teams and professionals.

Staff were recruited safely.

We found managers worked closely within a network of other organisations to review and respond to pressures within the system.

Patients told us they felt safe and were mainly positive and complimentary about the care they received as well as the food choices available.

Leaders were visible and approachable, and staff felt they had the right support.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Community health inpatient services | Requires Improvement  | |

# Summary of findings

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# Summary of this inspection

## Background to St. James Hospital Wards J30 & J31

We last inspected this service in December 2018 in response to concerns. During the last inspection, the service was rated requires improvement in all areas with breaches to regulation identified.

This inspection was also prompted as a result of an increase of concerns CQC received in relation to the quality of care being provided. At this inspection we found limited improvements had been made and there were continued breaches to regulations.

St James Hospital Wards J30 & J31 located at the Beckett Wing are operated by Villa Care Limited who provide nursing care to patients under a service level agreement with a neighbouring trust.

Patients admitted to these wards are medically optimised for discharge from acute hospital wards. The provider works with the local Clinical Commissioning Group (CCG) to ensure patients receive and access care and treatment from a multi-disciplinary team of professionals, some of whom are employed by the trust such as therapy staff. Medical cover is provided by local General Practitioners (GPs) in accordance with agreed contracts.

Villa Care Limited operate ward J32 which acts as a winter pressure ward. We inspected this ward during this inspection as this was still open.

## How we carried out this inspection

- We inspected St James Hospital Wards J30, J31 and J32 located at the Beckett Wing over two days on 8 and 9 March.
- Our visits included an early morning, daytime and evening visits to all wards.
- We held further follow up calls to carers, key staff and stakeholders following our on-site activity between 14 and 17 March.
- We spoke with twenty-five members staff, these included health care assistants, nurses, therapy staff, leaders and managers, human resources and administrative staff.
- We spoke with sixteen patients and seven carers of patients.
- We spoke with stakeholders including General Practitioners (GPs), Therapy Manager and the Clinical Commissioning Group (CCG).
- We looked at nine medicine administration record (MAR) charts and observed two medication administration rounds.
- We looked at care records for thirteen patients, these included electronic and paper records.
- We conducted ward tours on all three wards and observed four handover meetings and safety huddles.
- We used the short observational framework for inspection tool (SOFI) to capture patients' experiences of care by observing patient interactions with staff.
- We looked at a range of policies, procedures and other documents relating to the running of the service.

## Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations.

**Action the service MUST take to improve:**

# Summary of this inspection

**Community health inpatient services**

- The provider must ensure that staff follow correct risk management processes when reviewing or escalating deteriorating patients. (Regulation 12)
- The provider must ensure ward environments and equipment is safe for patients, this includes ensuring hazardous chemicals are not stored in accessible patient areas, call bells are always accessible and ensure health monitoring equipment is charged and ready for use. (Regulation 12)
- The provider must ensure that staff follow infection, prevention and control procedures and ensure equipment is cleaned and labelled appropriately ready for next use. (Regulation 12)
- The provider must establish systems and processes to ensure clinical supplies are suitably disposed of when they have expired. (Regulation 12)
- The provider must ensure areas where medication, hazardous chemicals or clinical supplies are stored are secure without door codes being visible. (Regulation 12)
- The provider must ensure care records contain complete and accurate information that demonstrate patient involvement. (Regulation 9)
- The provider must ensure staff support patients to be independent as far as possible as part of their recovery and support patients achieve their goals. This includes supporting patients to get dressed during the day and supporting patients to use the toilet rather than a bed-pan where appropriate. (Regulation 9)
- The provider must ensure patients have access to regular and meaningful activity provision in accordance with their preferences and interests. (Regulation 9)
- The provider must ensure governance systems and processes fully assess, monitor and improve the quality and safety of care provided. (Regulation 17)

Action a service 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 SHOULD take to improve:**

**Community health inpatient services**

- The provider should consider improving how it engages and communicates with patients and their carers.
- The provider should consider how and what data they collect to evidence how the service meets patient outcomes in line with national guidance and evidence based practice.
- The provider should consider utilising the care record systems in place to their full potential to avoid information on other records containing inaccurate or incomplete information.
- The provider should consider improving how de-briefs and lessons learned are cascaded to all staff.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Community health inpatient services** | Inadequate | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |
| **Overall** | Inadequate | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |

Requires Improvement

# Community health inpatient services

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

## Are Community health inpatient services safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

**Mandatory Training**

**The service provided mandatory training to staff to ensure patients were cared for safely.**

Staff received and kept up to date with their mandatory training.

Staff we spoke with told us they completed their mandatory training as well as refresher courses when required. Some of the mandatory training completed by staff included confidentiality, data protection and equality and diversity training.

We reviewed the training data collected by the provider and found that 95% of staff completed infection, prevention and control training, 98% of staff completed mental capacity training, 97% of staff completed moving and handling training and 94% of staff completed safeguarding adults training.

Additional training was available to staff where the provider had identified this would meet the needs of the patients, this included a group of staff recently completing venepuncture training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

**Safeguarding**

**Most staff understood how to protect patients from abuse, the service also worked with other agencies to do so. Staff had received training on how to recognise and report abuse however three staff we spoke with could not describe how to apply this training in practice.**

The provider had a safeguarding policy and procedure in place for staff to follow when safeguarding concerns had been identified, this included escalation to the local safeguarding authority. Information about the reporting process was displayed and visible in staff areas.

The provider used an electronic incident reporting system to enable staff to report their concerns however; not all of the staff we spoke with told us they reported concerns in the system. This meant there was a risk concerning information may not be captured and escalated in a timely manner. Four staff members we spoke with told us they would not use the reporting system or, some staff did not have access to this and that they would just inform the nurse in charge. One nurse we spoke with told us they would report any safeguarding incidents to management via the providers incident reporting system. We spoke with staff who confirmed they had received safeguarding training however, three staff we spoke with could not describe how to apply this training in practice in identifying the signs of abuse.

We reviewed the providers safeguarding data from the last twelve months there had been nine safeguarding concerns raised.

During the last inspection we identified that statutory notifications about safeguarding incidents had not been reported to the Care Quality Commission (CQC). This is a requirement within Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. During this inspection we found further incidents that had not been reported. Since this inspection the provider has submitted retrospective notifications in relation to incidents however; we are still gathering and reviewing information in relation to this outside of the inspection process.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well, the premises were visibly clean. Staff did not always follow control measures to protect themselves and others from the risk of infection because staff did not always label equipment once it had been cleaned.**

Ward areas were clean and had suitable furnishings which were clean.

Staff had access to personal protective equipment (PPE) which was positioned in various accessible areas across the wards.

We observed staff following infection prevention and control guidance using appropriate PPE, this included face coverings, aprons, gloves and visors where required.

Visitors were encouraged to make an appointment prior to visiting to control and reduce the spread of infections. Upon arrival on wards visitors' temperatures were checked and they could access PPE and facilities to wash and sanitise hands.

During ward tours we found multiple items of equipment that had not been labelled as clean. In bathrooms, ward storage areas and on wards we found weighing scales, walking frames, wheelchairs, moving and handling equipment and health monitoring equipment without 'I am clean' labels in place.

Daily ward assurance checks were carried out by staff. Staff completing these ward assurance checks were checking that staff on shift were following appropriate infection control practices, that PPE was available and being worn appropriately, that touch point cleaning was being completed and that equipment was being cleaned and disinfected. The results of these checks were positive however, these checks did not identify the various amounts of unlabelled equipment we found.

Managers conducted monthly metrics audits to check on hand hygiene, infection control and the correct use of PPE.

**Environment and equipment**

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

We found wards were not always safe or well maintained.

We requested information from Villa Care Limited to demonstrate health and safety checks on the premises including electrical, water, fire and gas safety were up to date. We are aware that the neighbouring trust are responsible for the overall safety of premises and equipment however; Villa Care Limited were unable to provide any of their own assurances that premises and equipment were safe.

Patients had access to a large lounge area on J30 however this was also used for physiotherapy treatment and contained moving and handling equipment. We observed patients during our inspection and found patients spent most of their time in their beds or chairs within their bay or side rooms.

Equipment such as hoists, standing aids and health monitoring equipment had been serviced and tested. We found that health monitoring equipment was not always charged and ready for next use.

Daily checks were completed by staff on resus trollies that contained emergency equipment and emergency drugs. We checked resus trollies during our inspection we found that some items had expired, this included two sets of scissors, syringes and one tube. We raised this with staff who replaced these items straight away.

During ward tours we found hazardous cleaning chemicals stored in patient accessible areas, this included toilet gels and two boxes of chlorine tablets, this posed a risk to some patients as there were some patients who had a diagnosis of dementia. We raised this with staff who removed these items straight away.

We also found a cleaning storage cupboard on J31 which was not locked despite this containing cleaning chemicals and cleaning equipment. After the inspection, the provider told us they had taken action to ensure a lock was installed.

On J30 we found a storage room that contained three oxygen cylinders. There was no sign on the door to indicate oxygen was stored in this area. We reported this to management who ensured appropriate signage was displayed.

Storage areas that contained equipment and clinical supplies were untidy and unorganised. We found multiple items of clinical supplies that had expired and had not been disposed of, this included water injections which expired in August 2021, dressings expired in October 2020, nitrite examination gloves expired in September 2020, mouth swabs expired in December 2021 and intravenous packs expired in October 2020. The provider had no systems or processes in place to check and dispose of out of date items. Following the inspection, the provider told us that they took action to update their protocols and worked with the neighbouring trust to ensure items were checked and disposed of.

We found one patient's prescribed barrier cream stored within a linen cupboard, we also found dressing packs in this cupboard where seals had been broken and not disposed of. We informed staff of these findings and they were removed.

On ward J31 in the sluice room and an unoccupied side room on this ward we identified the cap and cove flooring was damaged and worn, this was coming away from the wall. This meant that the floors could not be cleaned effectively posing infection control risks. The provider submitted evidence after the inspection, following our visit of a request to have repair work carried out by the neighbouring trust.

Some of the storage rooms, including treatment rooms where medicines were stored were secured by a coded lock. Throughout the wards we found that these codes were often written on or around the door frames which meant rooms were not secure and anyone including patients and visitors could potentially enter restricted areas. Following the inspection, the provider told us they took immediate action to address this issue.

Patients had access to call bells at their bedsides as well as in bathrooms. We found in bathrooms call bells were frequently tied up and placed out of reach which meant patients could not always call for assistance when required. We raised this with staff who ensured call bells were accessible.

**Assessing and responding to patient risk**

**Staff completed risk assessments for each patient however, these did not always capture key information and staff did not always follow risk management plans.**

We reviewed care records for thirteen patients. Staff completed an initial nursing assessment on admission, where risks were identified such as falls risks and skin integrity risks, specific risk assessments were implemented.

Staff used an electronic version of the recognised National Early Warning Score (NEWS2) tool to monitor and identify clinical deterioration in patients. Staff knowledge on when to conduct NEWS2 reviews was inconsistent. In four of the care records we reviewed NEWS2 scores were recorded once daily. We spoke with three staff about this and were told this should be done twice daily. This was not happening consistently which meant there was a risk to patients not being escalated for further medical treatment in a timely manner. Following the inspection, the provider told us they had installed an app that alerted staff to when NEWS2 scoring was due.

Patients who were identified to have skin integrity risks and pressure damage were not always being supported in accordance with their risk management plans. We observed patients spending most of their time in bed or in chairs. In four of the care records we found patients should be repositioned and their skin integrity checked within four hours. We found gaps in these records where staff had not recorded repositioning checks within the set time periods.

Information in risk assessments was not always captured or consistent in other records. One patient was identified to be at risk of falls and had been admitted to hospital as a result of a fall. The patient was being cared for on the enhanced bay. Staff had completed the falls risk assessment form to state the patient had fallen twice or more within the last twelve months and that there was a continued risk of falls. We checked the patients falls risk management care plan and the record asks about history of falls, staff had selected there was no history of falls.

Handover meetings and safety huddles were completed on shift changeovers. We observed four of these across the wards during the day and night shift. We found not all staff attended these meetings, we observed some staff floating in and out of meetings therefore missing vital information about the patients in their care. We observed some of the handovers to be task based, not person-centred or recovery and rehabilitation focused. The provider told us they had taken action in response to this feedback and have now implemented bedside handovers.

**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 reviewed and adjusted staffing levels and skill mix, and gave agency staff a full induction.**

We reviewed staffing rotas for the last three months, the provider used agency staff where required to cover some shifts. The planned nursing staff for each ward was two per ward during day and on night shift. On weekdays there was also a Matron and Deputy Matron on shift who were supernumerary.

The planned health care assistant staffing was seventeen staff split across the three wards, this included some senior health care assistant posts. Other staff also employed included bed flow co-ordinators and a patient experience co-ordinator.

At the time of our inspection, J32 was in the process of closing as this ward was only used to support the city with winter pressures. Staff from J32 were re-deployed to other Villa Care wards. The provider had continued to have access to a consistent compliment of nurses despite national challenges. The provider was actively supporting nurse associate training and development.

Patients we spoke with told us they felt there were enough staff. We conducted observations and found that staff were responsive and able to support people in a timely manner when support and assistance was required.

Since our last inspection in 2018, the providers contract with the trust had changed which also meant there were some changes to how patients were supported by other staff including medical and therapy staff.

In accordance with the providers new contract with the local Clinical Commissioning Group (CCG), patients received care and treatment from local General Practitioners (GPs) who conducted regular visits and completed patient reviews. Systems and processes were in place that staff followed to seek input from GPs via the providers electronic system which was also accessed by the GP. GPs were part of regular Multi-Disciplinary Team (MDT) meetings that were held. In the event of an emergency out of hours, staff would access medical input by contacting NHS 111 or emergency services where patients may be transferred to Accident and Emergency.

Therapy staff were provided by the trust, patients could access support and input from occupational therapists, physiotherapists and speech and language therapists.

Managers conducted daily calls to monitor and review staffing levels, where required managers could adjust staffing levels and utilise support from their other wards where pressures or risks were identified.

**Records**

**Staff kept records of patients' care and treatment however these were not always detailed. Records were accessible and available to all staff providing care but not always stored securely.**

Patient records were stored in a combination of places, some were contained within a password protected computer system, paper-based care records were stored within bays and outside of side rooms. Other folders containing patient information were stored within nurses' stations, these were not always stored in lockable cabinets.

In all the care records we reviewed we found information was not consistent across all records, staff were not always completing documents fully or information captured was contradictory. In one patient record their expected date of discharge entered was the same day as their admission.

One patient was diabetic however their risk management plan did not have any reference to the patients recommended diet.

We found food and fluid record charts that did not always contain dates, some of the information recorded on these records was illegible and in some instances where patient's fluid intake was being monitored no target intake amount was set nor were totals being completed. The provider had identified this was an area that required further attention and had started to work with staff to improve knowledge and records in this area.

In other records we found hygiene care plans that did not include how much assistance a patient needed with these tasks. In bowel charts we found gaps in staff completing these, for one patient there was no record of a bowel movement for five days.

In the records we reviewed we could not locate any personal emergency evacuation plans (PEEPs). The provider followed the fire evacuation policy from the neighbouring trust where, at the time of our inspection, PEEPs had not yet been introduced. Villa Care did not have any further records to describe what support and equipment patients would require to safely evacuate in the event of an emergency.

Managers carried out audits as part of their ward metrics to review documentation compliance. In the data submitted by the provider compliance with documentation standards for ward J30 was 60%, ward J31 was 62% and J32 was 49%. The provider told us they had action plans in place to improve document compliance standards.

**Medicines**

**Systems and processes were not always followed to ensure the safe management and administration of medicines.**

Staff used an electronic Medication Administration Recording (MAR) system. Staff were completing medication reconciliation checks when patients were admitted to the wards.

Medicines were stored in locked cupboards within patient bays or side rooms, other medication was stored centrally within treatment rooms. Treatment rooms were not always secure as codes to enter these rooms on wards was written on or around the door which meant anyone could access these rooms. During our evening visit on the second day of inspection we continued to observe staff using codes displayed around the treatment room door to gain access. Following the inspection, the provider told us they had taken action to address this issue.

Staff ensured patients who were due for discharge had prescription medicines to take home. We found two instances where stocks of to take home medicines were left on benches within treatment rooms that not stored securely.

On J30 we identified a significant amount of return medicine that had not been returned to the pharmacy for destruction. We spoke with managers about this who explained that this was due to the change in contracts which meant this was not being collected as it would have previously. Managers did ensure this medicine was returned during our inspection.

Staff were completing relevant temperature checks within treatment rooms and in fridges. We also observed medication rounds and found nurses interacted positively with patents when offering medication.

We reviewed eight MAR charts and identified one concern. One patient was prescribed an anti-coagulant which was prescribed twice per day at specific times. We identified the patient had not had their morning dose until 11am when this was prescribed for 8am.

Staff reported medication incidents, we requested medication incident data for the last twelve months however, there had been changes to the way medication incidents were being captured following changes to the providers commissioning arrangements. The data submitted by the provider was based upon incidents between November 2021 and February 2022.

There had been eight reported incidents and the main theme identified was in relation to medication stock. Staff were not always pro-active in conducting checks to ensure patients had the correct amount of medication which meant this was only identified as the patient was about to run out. This meant last minute requests would need to be made to the GP for a further or emergency prescription. The provider was aware of issues in relation to medication management following the changes in commissioning arrangements. The provider was working with commissioners and local GPs to address these issues to improve systems and processes.

Patients were prescribed nutritional supplements and on our ward tours we identified significant amounts of these were stored in a general storage cupboard. Upon review of the manufactures storage instructions these should be stored in a cool dry place in a temperature-controlled environment that does not exceed 25 degrees. The provider had no recording mechanism in place to ensure the temperature of this room was being monitored to ensure the items were being stored as per the manufacture instructions. We raised this to staff who told us they would arrange for the supplements to be moved to a suitable storage area.

**Incidents**

**Staff recognised and reported incidents and near misses. Managers investigated incidents however not all staff could tell us about de-briefs or any specific lessons learned.**

Staff we spoke with understood the providers process for reporting safety incidents. The provider collected incident data through their electronic reporting system. There had been no near miss incidents on wards in the last twelve months.

There had been 149 incidents since September 2021, the provider referred to incidents as events. The events recorded varied and in the main included slips and falls, medication errors, pressure sores, staffing issues, safeguarding incidents, deaths as well as where patients had to be transferred to accident and emergency or another ward.

Requires Improvement

# Community health inpatient services

The highest event reported was patients being readmitted to accident and emergency with thirty-five instances of this happening followed by twenty-two falls events reported. The provider told us they were working with system partners to discuss improvements to the patient pathway with the aim of minimising avoidable admissions.

There had been one event within the last twelve months that met the duty of candour threshold, the investigation was ongoing however we saw evidence of the providers correspondence to the relative with an apology as well as the providers commitment in ensuring a full investigation is completed and that findings and learning from the investigation would be shared once this has concluded.

Staff could not always tell us about lessons learned or the de-brief process following an incident. We spoke with staff who told us, “I think managers investigate the reports but I am unsure about getting and feedback apart from being told if the report was closed”. Another staff member said, “we do not get any learning from incidents, I have reported a couple of things but had no feedback.

Managers reviewed incident event reports and conducted investigations.

Managers received specific training in understanding the duty of candour within healthcare settings and how to conduct root cause analysis investigations.

## Are Community health inpatient services effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement.

**Evidence-based care and treatment**

**The service was working towards providing care and treatment based on national guidance and evidence-based practice.**

Patients were medically optimised for discharge from acute wards and were admitted to these wards requiring assessment or rehabilitation. Therapy was provided to patients under a contract agreement between local commissioners and the neighbouring trust.

We reviewed some of the providers policies and these were all up to date, some had been recently reviewed.

Staff were completing care assessments in line with best practice guidance in areas such as pressure care, nutrition and hydration.

The provider was still developing their model under new commissioning arrangements.

Therapy staff were also developing tools and collecting data to monitor patient outcomes and assess how patients were reaching goals.

**Nutrition and hydration**

Requires Improvement

# Community health inpatient services

**Staff did not always ensure nutrition and hydration risks were escalated to ensure appropriate treatment was provided. Staff supported people with their meals however, records in relation to food and fluid intake were not always completed to a high standard.**

Patients were offered a choice of food and snacks. Patients we spoke with told us they enjoyed the food choices available. Food, drinks and snacks were provided to the wards by the neighbouring trust under the providers contract agreement. The provider told us that a dietician visited the wards and conducted ward rounds, poor intake of fluid and nutrition was discussed in MDT meetings.

Patients were supported with any specialist dietary requirements, this included the provision of high fat and fortified foods, texture modified diets and vegetarian or cultural alternatives.

Staff from the neighbouring trusts catering team supported wards with distributing meals at mealtimes. Catering staff used a colour coded tray system to ensure the correct patient got the correct meal in accordance with their dietary requirements.

Some of the carers we spoke with expressed concern about the deterioration and weight loss their loved ones had experienced since being admitted to these wards.

We followed up these concerns and reviewed a sample of care records. We found evidence that staff were not always using the Malnutrition Universal Screening Tool (MUST) correctly.

Staff weighed patients however in one patient record we found the patient was weighed in September 2021 but there was no indication of risk level recorded. In another patient record we found that a patient's height was not recorded or the estimated height recorded, weights were present however loss had been identified with no risk score present. In a further record we found weights were not being recorded consistently as there was a gap of two weeks and again no overall risk score present.

Staff did not follow a consistent escalation process. One staff member told us they would refer to a dietician if a patient lost more than 2kg in weight however; it was unclear over what timescale or if the patients' current weight and frailty was considered in this escalation decision.

Prior to our inspection, external stakeholders also conducted a quality visit and identified risks by ward teams, themes from this visit included the need to improve the quality of documentation being completed by staff. This was further corroborated within our findings. The provider did have plans to improve the quality of records and staff knowledge in this area.

**Pain relief**

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

Patients received pain relief soon after requesting it.

Staff followed as and when required protocols where pain relief was prescribed. Staff administered and recorded pain relief accurately.

We did not see any evidence of staff using a nationally recognised tool such as the Abbey Pain Scale, however there was a structured tool within the patient record system for staff to follow.

We spoke with one staff member to ask if a pain tool was used and were told “we do not use a tool, we do a visual assessment and rely on a patient’s verbal response".

**Patient outcomes**

**Staff did not always monitor the effectiveness of care and treatment.**

Therapy staff, who were employed by the neighbouring trust supported patients using the Modified Barthel Scale, this is an ordinal scale used to measure performance in activities of daily living.

At the time of our inspection, the provider and therapy manager were still implementing systems and processes to collect data in relation to therapy outcomes.

We did not always find staff were encouraging or supporting patients reach outcomes outside of therapy.

Patients had individual therapy plans in place however; we observed staff working in a task orientated way that was not always person-centred. We spoke with one patient who told us “I am supposed to use the hoist but they never do, I have to use the bed pan and its getting me down”, “being stuck in bed all day is not doing me any good”.

**Competent staff**

**The service made sure staff were competent for their roles. Managers held supervision meetings with staff to provide support and development.**

Managers provided staff with a full induction tailored to their role before they started work, this included inductions for agency staff.

Managers supported staff to develop through supervision and appraisal. We reviewed supervision and appraisal data and found twenty-seven staff did not have an appraisal within the last twelve months. The supervision data submitted was not categorised therefore it was not possible to identify if clinical staff received clinical supervisions in addition to routine managerial or group supervisions.

Managers supported staff access training and development opportunities. Health care assistants had completed the care certificate or were currently completing this. Some nurses completed the nurse leadership programme with the trust and managers had completed the lead to succeed programme.

Managers made sure staff competencies were up to date.

We reviewed meeting minutes that demonstrated some staff meetings had occurred.

**Multidisciplinary working**

Requires Improvement

# Community health inpatient services

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide care and communicated effectively with other agencies.**

Patients had their care pathway reviewed by relevant consultants on a weekly basis.

Staff attended regular and effective multidisciplinary meetings (MDTs) to discuss patients and improve their care, these meetings were held for each ward. Staff who attended these meetings included nurses, therapy staff, GPs, a consultant and occasionally a social worker.

The meetings discussed planning for patient discharge as well as review progress against goals.

We did not attend any MDT meetings during the inspection however we reviewed action plans following these meetings.

Staff we spoke with spoke positively about the MDT meetings.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff did not always support patients to make informed decisions about their care and treatment. Staff did not always follow national guidance to gain patients' consent. Some staff knew how to support patients who lacked capacity to make their own decisions or where the patient was experiencing mental ill health.**

Staff received mental capacity training and the training data we reviewed showed 98% of staff had completed this.

We asked staff about consent and mental capacity however three staff we spoke with did not demonstrate an understanding of their role in supporting patients who may lack capacity.

At the time of our inspection there were fifteen patients who had a cognitive impairment or a dementia diagnosis. One patient was subject to a Deprivation of Liberty authorisation and staff followed local processes to apply for these in line with guidance where it was appropriate.

In the care records we reviewed we found capacity assessments were not always completed correctly which demonstrated a further lack of understanding of consent and capacity. At the end of the inspection, we shared this feedback with the provider who told us they carried out an immediate audit of capacity assessments.

In one care record we found an assessment for mechanical restraint, staff had recorded in this assessment the patient had no mental disorder as the patient could understand and retain information. Staff had also stated the person did not have capacity however there was no evidence of best interest decision making.

In another care record a patient had a capacity assessment form for the use of bed rails, staff recorded that the patient had capacity however the record did not contain a date of when this was completed or who completed the form.

Managers completed audits on documentation however, the audits in place were not specific to consent or mental capacity. In the data submitted by the provider compliance with documentation standards for ward J30 was 60%, ward J31 was 62% and J32 was 49%.

Requires Improvement

# Community health inpatient services

## Are Community health inpatient services caring?

Requires Improvement

Our rating of caring stayed the same. We rated it as requires improvement.

**Compassionate care**

**Staff treated patients with compassion and kindness however did not always respect patient privacy and dignity.**

We spoke with sixteen patients and most patients spoke positively and were complimentary about staff. Patients told us "some of the staff are fantastic" and "staff are very pleasant and helpful" and "I think they are excellent".

Some patients told us staff respect their privacy and dignity, one patient told us "they always use the curtains when providing personal care".

Whilst observing on wards we identified a patient who was calling out for help, there was no staff present as they were in the other bay. The patient was naked and trying to cover themselves with a hospital gown, the patient asked our Inspector for assistance. Our Inspector brought this to the attention of staff.

We spoke with seven carers who were relatives of patients. The feedback received from carers was mixed. Carers consistently told us it was difficult to get in touch with the ward and that communication from the staff was not always good.

Some carers told us they felt their relatives were not getting better, one carer told us "mum has deteriorated since being on the ward, she is in a worse state than when she went in". Another carer said, "mobility has gone down since being here, prior to coming here [patient] was independent but now is significantly frail".

The provider captured feedback from patients, friends and family members. The provider shared the feedback comments collated between October 2021 and March 2022. There had been 139 responses, comments were mainly positive however there were some repeating themes of feedback including patients reporting they were often bored and staff could be more polite. The provider collated this feedback and presented this on 'you said, we did' posters to demonstrate the actions taken in response to feedback.

**Emotional support**

**Staff did not always provide emotional support to patients, families and carers to minimise their distress.**

Staff did not always take time to interact with patients and carers.

During the COVID-19 pandemic the provider followed national guidance and the local NHS trust policy to manage the number of visitors attending the wards in order to protect patients. This meant visits had to made by appointment only and were only permitted in exceptional circumstances. The provider recognised the importance of ensuring patients had visitors attend to support the emotional and social wellbeing of patients.

Requires Improvement

# Community health inpatient services

Whilst the provider continued to follow the local NHS trust policy, the provider was flexible in making decisions on a case by case basis. The provider displayed posters with their visiting guidelines. Carers we spoke with were mostly positive about this, however some carers told us messaging was inconsistent in relation to the number of visitors allowed at any one time.

We observed that staff were not always responsive to the emotional needs of patients. We saw staff moving in and out of patient bays without interacting with them. We observed a member of staff who did not take into account a patient's emotional needs when speaking with them.

We received feedback from relatives of patients who told us their interactions with staff were not always positive, one relative told us every time they visit "some staff are passive aggressive and rude".

**Understanding and involvement of patients and those close to them**

**Staff did not always involve patients, families and carers in relation to their care and treatment.**

Staff did not always ensure patients and those close to them understood their care and treatment.

Care records we reviewed did not demonstrate patients had been involved in developing risk assessments or care plans.

In one care record we found staff had said communication with this patient was good however in further notes staff had said they struggled to understand the patient. We found the patient's communication was impacted by their health condition. There was no evidence of how staff ensured the patient was supported in having discussions about their care or, obtained any support from other professionals such as a Speech and Language Therapist to support effective communication.

We spoke with patients to understand if they had been involved in care planning, patients told us "I have not seen a care plan", "I have not discussed my care with them [staff]", "a care plan has not been mentioned" and, I don't know anything about a care plan".

Some of the carers and relatives of patients we spoke with told us "staff do not interact much" and "the information we receive is basic", another relative said "staff are rude when they communicate with us".

The provider did have a leaflet available for patients and relatives which provided useful information on what to expect in relation to the care provided by Villa Care on these wards.

## Are Community health inpatient services responsive?

Requires Improvement

Our rating of responsive stayed the same. We rated it as requires improvement.

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

Requires Improvement

# Community health inpatient services

**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.**

The provider worked under a service level agreement with the local Clinical Commissioning Group (CCG). The provider worked with other stakeholder organisations within the local community.

Managers were involved in regular discussions with stakeholders to review and support the local system capacity pressures.

**Meeting people's individual needs**

**The service did not always support people's individual needs and preferences. The provider coordinated care with other services and providers.**

Wards were not designed to meet the needs of patients living with dementia and were not always dementia friendly. At the time of our inspection there were fifteen patients with a diagnosis of dementia or other cognitive impairment.

We found bathroom doors did have contrasting colours, signage was often misleading and some signs were damaged. The neighbouring trust is responsible for the premises. The provider and staff told us there were plans to improve the environment to make wards dementia friendly however, these plans had been postponed due to COVID-19.

In care records we reviewed we found no evidence of staff using 'This is me' documentation. 'This is me' documents help health and social care staff better understand who the person really is, which can help them deliver care that is tailored to the person's needs.

Staff did not always encourage patients to maintain or develop their independence. Most patients we observed were in their hospital gowns either in bed or chairs. Not all patients on wards were receiving rehabilitation, some patients were placed on these wards whilst awaiting or undergoing further assessment. We explored why patients were in hospital gowns and not their personal clothes. We were told this was because there were no laundry facilities which meant patients relied on relatives to bring clean clothes however visits had been restricted due to COVID-19.

Patients identified for rehabilitation received input from therapy staff twice per week, there were plans to increase this once further therapy staff were in post. Therapy managers reviewed therapeutic interactions.

Outside of structured therapy interactions, staff on wards were encouraged to support patients work towards meeting their goals. We found that some patients wanted to be more independent and, as part of their recovery would prefer to go to the bathroom. We observed and received feedback from patients that staff would often bring a bed pan rather than support the patient out of bed. One relative we spoke with told us "this service is not suitable rehab, the layout is not appropriate and the physio offered is to make a cup of tea".

The provider had recently introduced a new patient engagement facilitator role within the service to support patients engage in meaningful activities. We did not see any evidence of any planned or individual activities taking place. Some of the patients we spoke with told us they were often bored and that there was nothing to do. We observed most patients watching television however patients had no stimulating activity to engage in. In some of the bays there was only one television which was in the centre of the room, this meant not all patients could see or watch at the same time. The provider had identified this as an issue and had requested quotes for bedside televisions to be installed in the future.

Requires Improvement

# Community health inpatient services

Patients we spoke with told us “I enjoy doing crosswords and sudoku but spend time in bed doing nothing”, “there is nothing to do, if there is a day room I have never seen it”, other patients told us “I have not been shown a day room and no one has mentioned any activities”, “it gets boring sometimes but it’s a good job I have good neighbour in the next bed as we talk a lot”.

The wards contained various information leaflets and advice posters on display. The provider was able to provide and source leaflets in other languages or in other formats such as large print.

**Access and flow**

**People could access the service when they needed it and received the right care in a timely way.**

Patients admitted to wards were medically optimised and fit for discharge from acute settings. A team of bed flow co-ordinators led by a bed manager were employed to manage the admission process, the provider was in the process of appointing discharge co-ordinators. Staff followed access criteria before accepting patients.

Managers and co-ordinators attended daily pressures meetings within the local area with other stakeholders to review admission and discharge priorities.

We asked the provider to submit the data of the total of admissions within the last twelve months, we received data from 20 September 2021 to 10 March 2022, this was due to a change in commissioning arrangements. The data showed there had been 296 patent admissions to the service in this period. At the time of our inspection there were six patients within the local acute hospital waiting for a suitable bed within the service.

We reviewed the providers discharge data for the same period of time, this showed:

- 122 patients were discharged to their usual place of residence
- 11 patients were discharged to other hospitals
- 79 patients were discharged to a care home or hospice
- 65 patients were discharged to other NHS wards
- 9 patients were discharged to other temporary residence
- 10 patients had passed away.

We reviewed average length of stay data for the period 20 September 2021 to 10 March 2022 and this was 31 days, 135 patients spend more than 28 days on these wards with the longest being 111 days.

Information on display for staff within wards stated other wards sending patients St James Hospital Wards J30 & J31 should do so before 4:30pm. In the data we received we found that out of the 296 admissions, 97 of those patients were admitted after this time, with the latest admission time being 11pm.

Care records we reviewed reflected staff discussing patient discharge planning in weekly MDT meetings. Some of the care notes reviewed demonstrated evidence of therapy staff discussions with patients and their carers in preparation for discharge however; staff were not always capturing discharge information within the discharge planning section within the providers care record system. After the inspection, the provider told us this information was available within another section of the system.

**Learning from complaints and concerns**

Requires Improvement

# Community health inpatient services

**It was easy for people to give feedback and raise concerns about the care received. The service investigated complaints and shared lessons learned with all staff.**

Patients, relatives and carers knew how to complain and felt empowered to do so. One patient told us if they had a complaint "the staff would sort it out" another patient told us "I would have no problem approaching any of the staff".

We reviewed the providers complaints data. At the time of our inspection seven complaints had been raised. The complaints we reviewed demonstrated investigations had been carried out. The provider ensured apologies were provided acknowledging when things went wrong. There was also evidence of where the provider had identified learning opportunities to make improvements needed to prevent further complaints. The provider also ensured complainants knew their options for escalating complaints should they not be happy with the local resolution.

Feedback and learning from complaints was shared within the providers leadership and governance meetings and cascaded to staff through staff meetings and huddles, any urgent information was shared with staff via a secure instant messaging app.

## Are Community health inpatient services well-led?

Requires Improvement

Our rating of well-led stayed the same. We rated it as requires improvement.

**Leadership**

**Leaders had the skills to run the service. They understood the priorities and issues the service faced. Feedback about the visibility and accessibility of leaders from patients was mixed however staff felt leaders were approachable and accessible. Leaders supported staff to develop their skills and take on more senior roles.**

Directors maintained close oversight and involvement within the service and understood the organisational priorities.

Day to day management of the wards was overseen by a Matron and Deputy Matron as well as support from Service Managers who worked across the providers other locations.

Staff we spoke with told us they felt managers were visible and approachable.

Staff were supported in accessing development programmes and additional training to enhance skills in leadership and management.

We spoke with patients who told us they felt the service was well managed however they did not know who the managers were.

**Vision and Strategy**

Requires Improvement

# Community health inpatient services

**The provider has a vision, principles, values and a philosophy of care. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.**

Staff we spoke with could not always tell us about the providers vision and values however, the provider had developed and cascaded an interactive video of these to staff.

The providers values state that Villa Care Limited are committed to supporting all service users so that they can continue their lives with dignity and independence and be participating members with their own rehabilitation goals.

Villa Care Limited aim to provide high-quality care to the people that use their service, meeting individual needs in a safe, caring, effective and responsive environment by a well-led workforce with the skills, knowledge and resource to meet the highest standards.

Villa Care Limited has a value-based behavioural framework in place that applies to all staff who are employed.

Leaders reviewed performance against their values and behavioural framework with staff through observation, performance management and appraisals.

**Culture**

**Staff felt respected, supported and valued. Patients, their carers and staff could raise concerns without fear. The service was not always focused on ensuring the needs of patients were met.**

Staff we spoke with told us they felt valued and respected. Staff, including staff who supported the wards on behalf of the trust told us they felt part of the team. Staff we spoke with told us they could raise any concerns and could rely on support from managers.

Patients and carers also told us they would have no hesitation raising any concerns.

We observed that staff were not always focused on the holistic needs of patients. There was a culture of staff responding to tasks rather than a person-centred approach to care. In part we found that this was due to the complex pathways and responsibilities across different providers for differing aspects of patient care.

**Governance**

**Leaders did not always operate effective governance processes. Staff were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service**.

Governance systems were in place however these were not always effective.

Quality and compliance staff were in post and worked across the providers other services.

Managers held governance meetings which included representation from other stakeholders. We asked the provider to submit evidence of governance meeting minutes within the last twelve months however, only one set of minutes was submitted for November 2021. The meeting was structured and reflected discussions linked to CQC domains and key lines of enquiry.

Requires Improvement

# Community health inpatient services

Audit frameworks were in place and the provider monitored quality and compliance through ward metrics. The providers audit tools were electronic and managers were able to review compliance rate data in real time as well as produce multiple reports to support the analysis of performance. Managers conducted spot checks and visited wards out of hours to obtain assurances about the quality of care provided during the night.

Governance systems had not ensured appropriate and efficient action was taken in relation to the issues we identified during this inspection. Some of these included ensuring the environment and equipment across the service was safe. Care records were not always completed to the correct standard which meant information was often missing or contradictory. Managers were not always ensuring high quality, person-centred care was provided.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

Managers maintained a risk register and we found entries were reviewed and actions were taken to mitigate risks developing into issues.

The risk register contained twelve items all with risk rating scores to enable the provider to assess potential impact. The highest risk entry was in relation to blood sampling due to reduced access to the local trust's phlebotomy service. The provider took relevant actions to source and train several ward staff in this procedure to reduce the impact to patients.

The provider had various policies and procedures in place to cope with unexpected events.

**Information Management**

**The service utilised technology and systems to collect data. Staff could find information they needed. Information systems were secure and integrated to enable other stakeholders to review and share data. Notifications to CQC about incidents were not consistently reported.**

The provider invested in systems and technology to enhance care delivery. Systems were in place to collect and share data with staff and other stakeholders.

We identified in this inspection that notifiable incidents had not always been shared with CQC as they should have in accordance with regulatory requirements. We are following this up outside of the inspection process as this was also identified at the previous inspection in December 2018.

**Engagement**

**Leaders engaged and collaborated with patients, staff and local partner organisations to plan and manage services.**

Leaders and managers worked in partnership with multiple organisations.

Requires Improvement

# Community health inpatient services

The provider collected friends and family comments to understand patient experience. The provider shared and displayed 'you said, we did' comments. As a result of reviewing these comments the provider identified a common theme in relation to the discharge process not always being effective, the provider was able to source additional funding from the local CCG and were in the process of appointing a discharge co-ordinator.

During COVID-19 the provider had not conducted a staff survey however staff continued to have access and support from managers.

**Learning, continuous improvement and innovation**

**Leaders recognised the importance of continuous improvement. Staff across the service were encouraged to participate in sharing ideas to help improve the quality of the service.**

The organisation had undergone some changes within the last six months in relation to how the services were contracted which meant there were some changes to systems and processes.

At the time of our inspection the provider was still implementing and establishing new ways of working.

The provider had invested and implemented new systems and technology to improve communication and outcomes for patients. Staff were using a recognised secure NHS communication tool to share information about patients and escalate any key issues. During the COVID-19 pandemic patients were able to utilise the 'Just Talk' system to hold video calls between patients and their carers where visiting had been restricted.

The provider had also identified through their own assurance checks that the bereavement processes staff follow could be improved. The provider implemented new resources and materials to ensure processes were consistently followed by staff on all wards.

Managers worked with other organisations and stakeholders across the system. We received positive feedback about how the provider supported the city-wide pressures during the pandemic. This included opening ward J32 as a winter pressures ward to support the local system. The provider was working with local commissioners to review and improve the quality of the services provided. The provider had quality and compliance staff to oversee and support service improvements.

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<br><br>The provider did not ensure that staff followed correct risk management processes when reviewing or escalating deteriorating patients.<br><br>The provider did not ensure ward environments and equipment was safe for patients, hazardous chemicals were not stored securely, these were in accessible patient areas, call bells were not always accessible and health monitoring equipment was not always charged and ready for use.<br><br>The provider did not ensure staff followed infection, prevention and control procedures clean equipment was not always labelled appropriately ready for next use.<br><br>The provider did not have systems and processes in place to ensure clinical supplies were suitably disposed of when they had expired.<br><br>The provider did not ensure areas where medication, hazardous chemicals or clinical supplies were stored securely. |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The provider did not ensure care records contained complete and accurate information nor did they demonstrate patient involvement.<br><br>The provider did not always ensure staff supported patients to be independent as far as possible and did not |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The providers governance systems and processes did not always fully assess, monitor and ensure improvements were made to the quality and safety of care provided. |

support patients achieve their goals. This included supporting patients to get dressed during the day and supporting patients to use the toilet rather than a bed-pan where appropriate.

The provider did not ensure patients had access to regular and meaningful activity provision in accordance with their preferences and interests.