St Cyril's Rehabilitation Unit

Quality Report

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

Overall summary

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

We undertook this focussed inspection due to concerns that had been identified through our routine monitoring of services, as well as concerns that had been raised externally with the CQC. We carried out the unannounced inspection on 12 and 13 March 2019.

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

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

- Following our last two inspections of March 2017 and May 2018, we had continued concerns that the service had not used safety monitoring results well. This was because information had not been submitted to NHS Safety Thermometer between January and March 2019. Additionally, we did not see any evidence of patient harms being discussed in minutes of governance meetings that we reviewed.
- The service had not always managed patient safety incidents well. This was because we found that 46 out of 145 incidents that had been reported between October 2018 and March 2019 had not yet been closed. Additionally, we sampled 18 incidents, finding that there was limited documented evidence that action had been taken to reduce the risk of similar incidents happening again.
- Staff had not always understood how to protect patients from abuse. This was because we identified one occasion when it had taken up to two weeks for a safeguarding concern to be raised with the hospital management team. This meant that an investigation into the incident had not been undertaken in a timely manner in order to protect patients from potential abuse.
- Although on most occasions the service had followed best practice when storing medicines, the service had not registered a controlled drugs accountable officer since the previous hospital manager had left in October 2018. This was not in line with the Controlled Drugs (Supervision of Management and Use) Regulations, 2013.
- Although the service had provided mandatory training to staff, records indicated that not all staff had completed this. Records indicated that there were areas of low compliance with training in other areas, include update training for key topics such as continence and catheter care (13%), as well as sepsis and national early warning score (39%).

Summary of findings

- Staff had not always kept detailed records of patient's care and treatment. We identified concerns during our last inspections of March 2017 and May 2018 that information was either difficult to find or was missing. On this inspection we sampled 11 patient records, finding that none had been fully completed.
- Staff had not always updated risk assessments for each patient. We sampled 11 patient records, finding that these had not been fully completed on any occasion.
- During our last inspection in May 2018, we identified concerns that patients would or would not be resuscitated appropriately in the event of an emergency. On this inspection, we identified continued concerns about the completion, review and storage of do not attempt cardiopulmonary resuscitation orders.
- The service had not always provided sufficient numbers of staff with the right qualifications, skills and training to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had not always operated effective recruitment processes to make sure that managers at all levels had the right skills and abilities to run a service providing high quality, sustainable care.
- The service did not always have workable plans identifying improvements that were needed or timeframes in which these were due to be completed. This meant that it was unclear how any required improvements would be implemented in a timely manner and how progress would be measured.
- The service had not used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Records indicated that governance meetings had not always taken place. For example, monthly hospital governance meetings had not taken place on three out of seven occasions between August 2018 and February 2019. This meant that it was unclear how issues were identified and improvements had been made during these periods.
- The service had not always operated an effective system to identify risks or planned to reduce or eliminate them. This was because records indicated that six out of seven risks that had been recognised had been overdue review since September 2018. Additionally, we found that current risks had not always been identified and managed on the risk management system.

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

- The service had suitable equipment which they had looked after well. We found that improvements had been made since our last inspection of May 2018 to how the hospital made sure that equipment had been serviced in a timely manner.
- The provider who ran the hospital had recruited a new director of nursing who was due to start their employment in April 2019. It was hoped that they would have a key role in providing clear clinical leadership for the service going forward.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. Due to the concerns that we had following the inspection, we issued enforcement action, telling the service that it had to make significant improvements. This is detailed at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services		Our rating of this service stayed the same. We rated it as requires improvement. We did not rate the service following this focused inspection as were following up on concerns that had been raised with us. A summary of our findings about the service appears in the overall summary.

Summary of findings

Contents

Summary of this inspection

Background to St Cyril's Rehabilitation Unit

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

St Cyril's has a total of 26 beds two of which are one bedroom bungalows. These are designed to help patients transition to a higher level of independence prior to discharge. All patients' bedrooms are single with ensuite bathrooms and fitted with ceiling hoists and a nurse call bell system.

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

The service provides a facility for patients with complex needs as a result of neurological impairment or physical disability. There are seven beds in use to meet the needs of patients with challenging behaviour as a result of neurological disability. These patients may or may not be detained under the Mental Health Act (1983, amended 2007). The unit has four separate care and bedroom areas and central communal facilities.

- The Cheshire Suite supports patients with complex physical needs, low awareness or continuing care needs.
- The Grosvenor Suite provides active short to medium rehabilitation with therapy services as required.
- The Westminster Suite offers specialist care to patients with challenging behaviour due to their neurological impairment.
- The Dee Unit supports patients along their rehabilitation programme towards a higher level of independence.

Services provided at the unit under a service level agreement include out of hours GP cover, consultant cover, diagnostics and other allied health professional services.

The hospital has a registered manager who has been registered with the CQC since February 2019. The nominated individual is the Chief Executive.

We carried out an unannounced inspection of St Cyril's Rehabilitation Unit on the 12 and 13 March 2019.

Our inspection team

The Inspection team was led by a CQC inspection manager, and included four CQC inspectors, one of whom specialised in safeguarding for adults and children.

Why we carried out this inspection

We undertook this focussed inspection due to concerns that had been identified through our routine monitoring of services, as well as concerns that had been raised externally with the CQC.

Some of the concerns identified or raised included poor staffing levels, delays when reporting safeguarding incidents as well as the potential of patients sustaining avoidable harm. In addition, we had concerns that previous improvements may not have been sustained.

In this inspection, we inspected parts of the 'safe' and 'well-led' key questions, making sure that the service was safe and that effective governance systems were in place to provide high quality, sustainable care.

Summary of this inspection

How we carried out this inspection

The inspection site visit took place on the 12 and 13 March and was unannounced.

We reviewed information before, during and after the inspection. This included patient records, care plans, medicines charts, staff rosters, and staff competency records.

We spoke with members of staff including medical staff, registered nurses, managers, therapy staff and rehabilitation co-therapists. We also spoke with members of the hospital management team, as well as members of the executive team.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this domain during this inspection. The rating from the previous inspection remained as requires improvement.

- Following our last two inspections of March 2017 and May 2018, we had continued concerns that the service had not used safety monitoring results well. This was because information had not been submitted to the NHS Safety Thermometer between January and March 2019. Additionally, we did not see any evidence of patient harms being discussed in minutes of governance meetings that we reviewed.
- The service had not always managed patient safety incidents well. This was because we found that 46 out of 145 incidents that had been reported between October 2018 and March 2019 had not yet been closed. Additionally, we sampled 18 incidents, finding that there was limited documented evidence that action had been taken to reduce the risk of similar incidents happening again.
- Staff had not always understood how to protect patients from abuse. This was because we identified one occasion when it had taken up to two weeks for a safeguarding concern to be raised with the hospital management team. This meant that an investigation into the incident had not been undertaken in a timely manner in order to protect patients from potential abuse.
- Although on most occasions the service had followed best practice when storing medicines, the service had not registered a controlled drugs accountable officer since the previous hospital manager had left in October 2018. This was not in line with the Controlled Drugs (Supervision of Management and Use) Regulations, 2013.
- Although the service had provided mandatory training to staff, records indicated that not all staff had completed this. Records indicated that there were areas of low compliance with training in other areas, include update training for key topics such as continence and catheter care (13%), as well as sepsis and national early warning score (39%).
- Staff had not always kept detailed records of patient's care and treatment. We identified concerns during our last inspections of March 2017 and May 2018 that information was either difficult to find or was missing. On this inspection we sampled 11 patient records, finding that none had been fully completed.

Summary of this inspection

- Staff had not always updated risk assessments for each patient. We sampled 11 patient records, finding that these had not been fully completed on any occasion.
- During our last inspection in May 2018, we identified concerns that patients would or would not be resuscitated appropriately in the event of an emergency. On this inspection, we identified continued concerns about the completion, review and storage of do not attempt cardiopulmonary resuscitation orders.
- The service had not always provided sufficient numbers of staff with the right qualifications, skills and training to keep people safe from avoidable harm and to provide the right care and treatment.

However,

- The service had suitable equipment which they had looked after well. We found that improvements had been made since our last inspection of May 2018 to how the hospital made sure that equipment had been serviced in a timely manner.

Are services well-led?

We did not rate this domain during this inspection. The rating from the previous inspection remained as requires improvement.

- The service had not always operated effective recruitment processes to make sure that managers at all levels had the right skills and abilities to run a service providing high quality, sustainable care.
- The service did not always have workable plans identifying improvements that were needed or timeframes in which these were due to be completed. This meant that it was unclear how any required improvements would be implemented in a timely manner and how progress would be measured.
- The service had not used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. Records indicated that governance meetings had not always taken place. For example, monthly hospital governance meetings had not taken place on three out of seven occasions between August 2018 and February 2019. This meant that it was unclear how issues were identified and improvements had been made during these periods.
- The service had not always operated an effective system to identify risks or planned to reduce or eliminate them. This was

Summary of this inspection

because records indicated that six out of seven risks that had been recognised had not been overdue review since September 2018. Additionally, we found that current risks had not always been identified and managed on the risk management system.

However,

- The provider who ran the service had recruited a new director of nursing who was due to start their employment in April 2019. It was hoped that they would have a key role in providing clear clinical leadership for the service going forward.

Community health inpatient services

Safe	
Well-led	

Are community health inpatient services safe?

Safety performance

- In our last inspection of May 2018, we found that the service had submitted information to NHS Safety Thermometer. However, during this inspection we found that the service had not submitted any information about patient harms between January and March 2019. The NHS Safety Thermometer provides a temperature check on harm that can be used alongside other measures of harm to measure local system progress in providing a care environment that is free from harm. This included falls, pressure ulcers and hospital acquired urinary infections.
- We had concerns that patient safety information was not being reviewed during our last two inspections of the service in March 2017 and May 2018. In this inspection, we did not see any evidence of patient harms being reviewed and discussed in monthly meetings that we reviewed. This meant that it was unclear how the service had used patient safety information to make further improvements where needed. Additionally, we did not see the number of patient harms displayed in the hospital for patients, relatives and staff members to see, which is good practice.
- During the inspection, we requested data about the total number of falls, pressure ulcers and hospital acquired urinary infections that had been reported between October 2018 and March 2019. The hospital management team had not collated this information and were unable to confirm how many incidents there had been.

Incident reporting, learning and improvement

- The hospital had an incident reporting policy which was available to staff electronically and it had been amended since our last inspection in May 2018. All staff had access to the hospitals electronic incident reporting system. Staff we spoke with could tell us how they would report an incident.
- Between October 2018 and March 2019, there had been a total of 145 incidents reported to the incident reporting system. However, we had concerns that these had not always been managed in line with policy or in a way that made sure that there had been learning to reduce the risk of similar incidents happening again.
- Out of 145 incidents that had been reported, records indicated that 46 had not yet been closed. 17 of these had been for incidents that had been reported in December 2018 and 18 had been for incidents that had been reported in January 2019. This meant that it was unclear if further action had been taken in a timely manner to reduce the risk of a similar incident happening again.
- Additionally, we sampled 18 out of 145 incidents, finding that there was no documented action that evidenced learning.
- Although we noted that the updated incident reporting policy included the need to document the level of harm that had been caused to patients, this had not been consistently followed. This was because records indicated that between October 2018 and March 2019, the level of patient harm had been recorded as 'not-applicable' on 23 out of 145 occasions, despite there being evidence that they related to patient safety concerns, such as safety checks not being completed in a timely manner or when a pressure ulcer had been identified.
- We had concerns about the management of incidents that related to one patient. Records indicated that there had been 34 reported incidents of the patient displaying challenging behaviour. Although we found that there were initial actions documented on each occasion, there was limited documented evidence of actions taken to reduce the risk of similar incidents happening again. For example, we reviewed 10 of these incidents, finding that 9 did not have documented actions.
- Additionally, on reviewing the patient's records, we also found that between 9 February and 13 March 2019, there had been 12 incidents of challenging behaviour that had not been reported to the incident reporting system. This meant that there was a risk that the management team would be unaware that these

incidents had occurred and that the patient's care plan would not be amended when required. We also found evidence that the patient's care plan had not been reviewed in line with the identified time period of every three months. For example, the care plan was reviewed in February 2018 and then again in December 2018.

- Between October 2018 and March 2019, the service had not reported any serious incidents, although we found that one incident had been investigated using a root cause analysis tool (a tool used to investigate incidents fully so that actions can be implemented to reduce the risk of a similar incident happening again).
- On reviewing this incident, we had concerns that the documented actions to make improvements had not covered all areas that had been identified as requiring improvement. This meant that it was unclear if improvements would be made in a way that reduced the risk of a similar incident happening again.
- The service had reported two patient deaths between October 2018 and March 2019. However, the service had not planned to undertake mortality reviews in a timely manner. Although a learning from deaths policy was in draft at the time of inspection, the service had not conducted reviews of cases for patients who had passed away in December 2018 and February 2019. Mortality reviews are important as they help identify any care issues that could potentially improve standards of care in the future.
- An up to date duty of candour policy was available and the management team understood when the duty of candour should be applied. The duty of candour is a legal duty on hospitals to inform and apologise to patients if there have been mistakes in their care that have led to a moderate level of harm or above. The duty of candour aims to help patients receive accurate truthful information from health providers.
- We had concerns that there was an increased risk that duty of candour would not always be applied when needed. This was because levels of patient harm had not always been recorded as some had been recorded as not applicable.

Safeguarding

- The service had an up to date policy for safeguarding adults and children which was available to all staff. However, we noted that the safeguarding policy for children did not cover all areas that related to the type of services that the hospital provided. This was because although the hospital held weekly sessions for parents and their children in the hydrotherapy pool, this had not been included, meaning that it was unclear what responsibilities staff had regarding this.
- During our last inspection in May 2018, we had concerns that not all safeguarding incidents had been reported in a timely manner. This was because we found that on one occasion a member of staff had failed to report a safeguarding incident immediately. On this inspection we found a further safeguarding incident had not been reported for up to two weeks after it had happened. This meant that an investigation into the incident had not been undertaken in a timely manner in order to protect patients from potential abuse.
- We reviewed all low-level safeguarding concerns that had been reported between September 2018 and March 2019, finding that it was unclear if they had been submitted to the local authority in a timely manner. For example, the submission for February 2019 was only made on the 21 March 2019. Additionally, there was no formal agreement between the service and the local authority outlining a time frame for this to be completed.
- We took time to review seven incidents that had happened between October 2018 and January 2019, which detailed when patients had sustained injuries but there had been no explanation for how these had been caused. In these cases, the service had failed to identify the likely cause of injury. This meant that it was unclear if patients had sustained avoidable harm.
- On reviewing incidents that had been reported between October 2018 and March 2019, we identified one occasion when it was unclear if a patient who had become agitated had been managed in a way that would prevent avoidable harm or was in line with their positive behavioural management strategy. This was because the incident report stated that the patient had been tilted back in their chair to prevent movement. Although we were provided with evidence that this had been considered as an interim measure in November 2018, there was no evidence that this had been reviewed since, or that the patient's behavioural management strategy had not been updated to reflect this.
- We had concerns that mental capacity assessments had not always been undertaken when needed. This was because we reviewed five Deprivation of Liberty safeguarding applications, finding that on three

occasions, there was no documented evidence that mental capacity assessments had been completed for these. This was important as legislation and best practice states that all mental capacity assessments should be specific to the decision that is being made.
- All staff were required to complete safeguarding training for adults as part of their induction as well as their ongoing mandatory training. Records indicated that 84% of staff were up to date with this at the time of inspection. This was an improvement from our last inspection in May 2018.
- In addition, staff were required to complete safeguarding level 2 for children. This was in line with the Intercollegiate Document, 2014. Records indicated that 51% staff were up to date with this.
- In addition, we found limited evidence that safeguarding concerns were discussed at governance meetings, at local or corporate level. This meant it was unclear how safeguarding information and concerns were being shared and escalated appropriately.

Medicines

- The service had a medicines management policy which was available to all staff. This included topics such as administration, storage and destruction of medicines. Staff we spoke with knew about this and how to access it if needed.
- Registered nurses and doctors were required to complete mandatory training for the administration of medicines through a percutaneous endoscopic gastronomy tube (a tube which enters directly into the stomach). Records indicated that 63% of staff were up to date with this.
- Medicines including controlled drugs (medicines that require special storage arrangements and record keeping because of their potential for misuse) were securely stored. We found that the number of controlled drugs tallied with the amount recorded and that they had been checked daily. In addition, we found that a member of staff had witnessed and countersigned all entries in the register. However, we found that daily checks of controlled drugs had not been completed on four occasions between February and March 2019.
- The temperature of the clinic rooms and refrigerators were monitored to ensure medicines were stored at the correct temperature. However, records indicated that daily fridge checks had not been completed on six occasions between 1 February and 12 March 2019.
- The service had not registered a controlled drugs accountable officer since the previous hospital manager had left in October 2018. This was not in line with the Controlled Drugs (Supervision of Management and Use) Regulations, 2013.

Environment and equipment

- Emergency resuscitation equipment was in place in the main lounge and pool area. A review of the records indicated that the equipment was checked daily. All equipment was within its use by date and appropriately sealed.
- We found that following our last inspection in May 2018, improvements had been made to the way that equipment was monitored and how the service made sure that equipment had been serviced in a timely manner. This meant that the risk of equipment becoming faulty whilst being used had been reduced.

Quality of records

- The hospital used a paper based records system. We found that all records were stored securely in locked areas. We also noted that records that we reviewed were signed and dated appropriately.
- We identified concerns during our last inspections of March 2017 and May 2018 that information was either difficult to find or was missing. On this inspection we sampled 11 patient records, finding that none had been fully completed.
- We found examples of when the most up to date documentation had not been used. For example, daily monitoring forms for percutaneous endoscopic gastronomy daily checks. This was important as changes had been made to the updated documentation to make sure that best practice guidance was followed.
- In our last inspection in May 2018, we found that a records review had been completed, however, we had concerns that actions had not been implemented to make improvements to shortfalls that had been identified. During this inspection we continued to have concerns that there was a lack of effective governance to make sure that records were completed and stored appropriately as well as being available for all staff.

- Although we noted that members of the management team had undertaken a records audit, we found that it was not always clear why shortfalls had been identified. In addition, we did not see any evidence of actions taken to make further improvements, despite the audits having been undertaken in January and February 2019.

Mandatory training

- A compliance target of 95% had been set for all mandatory training. However, records indicated that this had not been achieved.
- In our last inspection in May 2018, we found that records for mandatory training had not always been kept up to date, meaning that it was unclear if sufficient numbers of staff had undertaken the necessary training to undertake their roles. During this inspection we found that this had not improved.
- For example, we were provided with training records during the inspection that stated only three members of the registered nursing team had completed update training for tracheostomy care. We raised these concerns with the management team after the inspection and were provided with additional evidence that was different to that provided during the inspection.
- Records also indicated that there were areas of low compliance with training in other areas, including update training for key topics such as continence and catheter care (13%), as well as sepsis and national early warning score (39%).

Assessing and responding to patient risk

- During our last inspection in May 2018, we identified concerns that patients would or would not be resuscitated appropriately in the event of an emergency. On this inspection, we identified continued concerns about the completion and storage of do not attempt cardiopulmonary resuscitation orders.
- This was because on two occasions, the orders had been marked as not applicable for review. This was not in line with best practice guidance and there was a risk that if a patient's condition changed, they would not be resuscitated when needed.
- We also found that on two occasions, there was no documented evidence of a completed mental capacity assessment in relation to the do not attempt cardiopulmonary resuscitation orders. This was not in line with legislation, which states that all capacity assessments should be decision specific. This was important as a patient might have capacity to decide about one thing but not another.
- On a further occasion, it was unclear why the do not attempt cardiopulmonary resuscitation order had been implemented, This was because the section for 'resuscitation would be successful' was completed as well as the section for 'resuscitation would be unsuccessful'. This was not in line with guidance from the General Medical Council and meant there was a risk that a patient would not be resuscitated when needed.
- We also found that one do not attempt cardiopulmonary resuscitation order was not immediately available for staff and it took a member of the management team six hours to locate this during the inspection. This meant that in the event of an emergency, there was a risk that a patient would be resuscitated inappropriately.
- On sampling 11 sets of patient records, we found that patient risk assessments had not been consistently completed on any occasion, which was not in line with best practice guidance or policy. This included inconsistent completion of risk assessments for falls, pressure ulcers and bed rails, as well as the inconsistent completion of daily monitoring forms for percutaneous endoscopic gastronomy tubes (this is when a tube is inserted surgically into a patient's stomach and is used to administer food or medicines) and the malnutrition universal screening tool (which is used to determine if patients are at risk of malnutrition).
- Records also indicated that moisture lesion charts for five out of 11 patients had not been completed consistently. This was important as moisture lesion charts supported staff to check the condition of patient's skin on a daily basis as well as being able to document if improvements had been made when treatment had been administered.
- We found that for one patient when a pressure ulcer had been identified, the patient's wound chart had not been completed in line with the patient's care plan. This meant that it was unclear if the patient's pressure ulcer had been managed effectively.
- On another occasion, when a patient had a fall, their falls risk assessment had not been reviewed to reduce the risk of a similar incident happening again.
- The hospital used a national early warning score system to monitor patients' clinical condition and identify any

deterioration so that appropriate action could be taken. The national early warning score system had been designed to assign a score to each clinical observation, for example blood pressure and temperature, to indicate potential deterioration in patients' condition and prompt clinical action. The national early warning score document stipulated set actions to be taken when patients overall score reached a specified level.

- We found that patient's national early warning scores had been calculated correctly in most cases and escalated when needed on most occasions. However, records indicated that on one occasion, actions taken following an increased national early warning score had not been documented, meaning that it was unclear if the patient had been managed appropriately. In addition, we found occasions for three patients when observations had not been completed at all. This meant that there was an increased risk that a deteriorating patient would not be recognised in a timely manner.

Staffing levels and caseload

- Concerns had been raised with CQC prior to the inspection that there had not been sufficient numbers of staff to keep patient safe.
- We had concerns that the service had not planned to have sufficient numbers of staff on duty at all times. We were informed that the establishment of registered nurses and rehabilitation co-therapists had been reduced since our last inspection in May 2018.
- Although we were informed by the management team that the reduced staffing establishment had been based on the needs of current patients, we found that on reviewing incident reports between October 2018 and March 2019, records indicated that there had been occasions when there had not been sufficient numbers of staff. For example, on one occasion, an element of tracheostomy care for a patient was undertaken in the corridor and on another occasion, a patient had been left for one and a half hours after being incontinent.
- The hospital had planned to provide two registered nurses on all shifts, 24 hours a day, seven days a week. Rotas between 1 January and 17 March 2019 indicated that the planned number of registered nurses had not been achieved on 10 out of 61 occasions. On these occasions, there had been only one registered nurse on duty who was able to administer important treatments such as medicines.
- Staff who we spoke with during the inspection informed us that during these periods it had been difficult to make sure that medicines had been administered in a timely manner as well as undertaking their other responsibilities.
- Rotas for the same period indicated that the planned number of rehabilitation co-therapists had not been achieved on 8 out of 61 occasions. This was important as rehabilitation co-therapists were responsible for undertaking important roles such as providing 1:1 care to patients when needed. Because of these shortfalls, bank and agency staff had been used on most shifts. For example, between 1 January and 17 March 2019, staffing shortages had been filled using bank or agency staff for registered nurses on 39 out of 61 days. In addition, bank or agency staff had been used to fill shortfalls in rehabilitation co-therapists on 61 out of 61 days.
- We identified concerns in March 2017 that the hospital did not have a system in place to make sure that appropriate numbers of trained staff were on duty to provide care to patients with percutaneous endoscopic gastronomy tubes and tracheostomies. Although we found that improvements had been made with this during our last inspection in May 2018, we identified similar concerns during this inspection.
- We reviewed rotas between the 1 January and 17 March 2019, finding that there had been 15 out of 61 day shifts as well as five out of 61 night shifts when staff with competencies to provide care to patients with percutaneous endoscopic gastronomy tubes as well as those with tracheostomies had not been available.
- We raised our concerns about this with the provider following the inspection and we were informed that there had only been six day shifts when appropriately trained staff had not been on duty. However, it was unclear whether this had been the case as the records provided following the inspection were different to those provided during the inspection. Within the information provided post inspection, three weeks of nursing rotas were not provided.
- Following the inspection, we were also informed that rehabilitation co-therapists who had received training to provide important treatment to patients with percutaneous endoscopic gastronomy tubes and tracheostomies had been available during any periods when the planned number of registered nurses with sufficient training had not been achieved.

- However, records provided during the inspection indicated that only a small number of rehabilitation co-therapists were up to date with different elements of training, which provided further evidence that there had been insufficient numbers of suitably trained staff available at all times.
- For example, only 18% of rehabilitation co-therapists had received training to administer feeds to patients with a percutaneous endoscopic gastronomy tube. Additionally, only 18% had received training to replace a tracheostomy inner tube, 12% had received training to manage tracheostomy cuff pressures and 15% had received training to provide suction to patients who had a tracheostomy.
- Members of the management team informed us that there were currently vacancies for one registered nurse and 20 rehabilitation co-therapists. We were also informed that the hospital had faced challenges in recruiting new staff and that this was managed as a formal risk on the risk register. However, it was unclear on the risk register how this risk was being managed.
- We sampled induction records for 20 members agency staff, finding that there was no documented evidence that these had been completed on 14 occasions. This was important as it meant that there was an increased risk of the hospital's systems and processes not being followed.
- At our last inspection in May 2018, the service had employed a consultant in neuro-rehabilitation. However, we found that they had left the service two weeks prior to the inspection. The management team informed us that short term arrangements had been made for the service to access two consultants under a service level agreement and had planned for them to be available for four half day sessions a week. Although this meant that they were present to review patients, we were informed that there was no capacity for them to attend any multi-disciplinary meetings. This was important as patients' needs were reviewed in these meetings by the whole team.
- The service had also arranged out of hours GP cover which was provided under a service level agreement with another provider. In addition, locum daily on site GP cover was provided through an agency.

Are community health inpatient services well-led?

Leadership of this service

- In our inspection in March 2017, we had concerns that the hospital did not have a stable or effective leadership team. We found in our last inspection of May 2018 that the hospital had made improvements in this area. However, during this inspection we found that there had been several key changes at leadership level.
- Since our last inspection in May 2018, the group that owned the service had restructured, meaning that there had been key changes at provider level. In addition, the registered hospital manager, the clinical services manager and the consultant who specialised in neuro-rehabilitation had all left the service.
- The overall provider had appointed a new chief executive officer as well as a new full time hospital manager since our inspection in May 2018, who had recently been registered with the CQC.
- The hospital manager was supported by a newly appointed modern matron, who had been in post since November 2018. They were responsible for clinical leadership as well as supporting the hospital manager in the day to day running of the hospital. The hospital had also employed a head of quality assurance.
- However, records indicated that checks to assess whether members of the management team had the right competencies and ability to undertake their roles had not been completed on two occasions. On another occasion, it was unclear if a full recruitment process had been fully undertaken. This was because the personnel file provided after the inspection stated that an interview had taken place on the 12 September, but the job advert for the position had only been created on the 17 September.
- The hospital employed a team of band 6 nurses and had planned for them to be available 24 hours a day, seven days a week. They were responsible for the day to day management and leadership of the care staff whilst on shift. In addition, the hospital had a team of senior rehabilitation co-therapists.
- At the time of inspection, there was no clear medical leadership as the consultant who specialised in neuro-rehabilitation had recently left the service.

However, we noted that alternative arrangements had been made for two consultants to review patients which was managed under a service level agreement with an external provider.

- The roles and responsibilities of the leadership team were not always clear. This was because we did not see evidence of a job description for the hospital manager. This meant that there was an increased risk that leaders would not always understand their role fully and what they were accountable for.
- Some staff who we spoke with informed us that the current leadership team had not always been supportive, visible and approachable. Concerns were raised during the inspection that this had been the reason that several members of staff had recently left their employment with the hospital.

Service vision and strategy

- In our last inspection of May 2018, we had concerns that the vision and values for the service had not been reviewed for any amendments that had been needed. This was important as they had been implemented for the period between April 2013 and March 2018. More importantly, there was no evidence that they had been discussed in any minutes of meetings that we reviewed, at either hospital or corporate level. In addition, we did not see evidence of them being displayed in the hospital for patients, relatives or staff to see.
- During this inspection, we found that although a new vision had been partially drafted, there was no indication of when this was due to be completed. At the time of this inspection there were no workable plans in place on how this vision would be implemented. This meant that it was still unclear how any required improvements would be implemented in a timely manner and how progress would be measured.
- Following our last inspection of May 2018, an action plan had been implemented to make further improvements to meet the regulatory requirements and improve standards of care. However, during this inspection it was unclear how effective the action plan had been and we found evidence that improvements had not always been made in a timely way.
- The action plan had several overdue actions without extended completion dates or a revised timeframe for completion. For example, an action had been identified to improve compliance with staff training which had been due for completion in November 2018. At the time of inspection, this had not been completed and an extended completion date had not been agreed. This meant that it was unclear if this action would be completed in a timely manner.

Governance, risk management and quality measurement

- There was a governance structure in place that facilitated monthly governance meetings between the management team from the hospital and the executive team.
- However, records indicated that governance meetings had not always taken place. For example, monthly hospital governance meetings had not taken place on three out of seven occasions between August 2018 and February 2019. This meant that it was unclear how issues were identified and improvements made during these periods.
- We reviewed minutes of hospital governance meetings that had taken place during the same period, finding that a set agenda had been implemented since our last inspection in May 2018. This included key topics such as reported incidents, health and safety as well as staffing.
- On reviewing minutes of meetings held in December 2018 and February 2019, we found that some improvements had been made since our last inspection, as there were documented actions from the meeting and each action had an owner, with a timeframe for completion. Additionally, the minutes from the February 2019 meeting included a review of all documented actions from the previous meeting.
- However, we had concerns that all actions from the meeting had not been captured. For example, the minutes from a meeting held in December 2018 highlighted that although the CQC action plan required review, this had not been documented as an action to be monitored. Additionally, outstanding actions from the previous meeting had not been continued to be reviewed in the next meeting. This meant that it was unclear how these actions would be continually monitored and there was an increased risk that improvements would not be made in a timely manner.
- We identified concerns in our last inspection of May 2018, that improvements to areas of poor performance had not always been made in a timely way. For example, tracheostomy audits that had been completed between

July 2017 and March 2018 had identified continual poor compliance with the required standards and we had concerns that actions that had been implemented to make improvements had not been effective.

- Although we were not provided with additional information during or immediately after the inspection, we were provided with an audit in May 2019 which had been completed in July 2018, indicating that compliance had improved to 82%. However, there was no evidence that the management team had monitored compliance to make further improvements or to ensure any improvement had been sustained since July 2018.
- During this inspection, we found that no further audits had been completed, meaning that it was unclear how the hospital had monitored compliance against this and whether further improvements had been needed.
- We also identified continued concerns during this inspection that the hospital did not have effective systems to monitor compliance with the completion of patient records, including key documents such as do not attempt cardiopulmonary resuscitation orders as well as patient risk assessments. Although the service had recently implemented a records audit, it was unclear how this had been used to make further improvements. This was because although failures had been identified, there was no evidence that a plan to make improvements had been implemented.
- The hospital had a risk management system which was used to identify and manage key risks that the service faced. Each risk that had been identified had been rated and had actions to reduce the level of risk as much as practicably possible. However, we found that six out of seven risks had been due for review in September 2018 and that on some occasions, risks had not been recognised and actions had not been implemented to manage these. For example, registered nurses leaving the service had posed a risk that sufficient numbers of competent staff would not always be available.
- Following the inspection, we were provided with an updated risk register which stated that risks were due for review in March 2019. However, it was unclear if this had been reviewed appropriately. This was because the target dates were still set at August 2018.
- We had concerns in our inspection of March 2017 that the hospital did not have an effective system for monitoring the implementation of patient safety alerts. In our last inspection of May 2018, we found that the hospital had made some improvements. However, we identified concerns during this inspection that safety alerts had not been actioned between January and March 2019. This was because we found that only two out of 23 had been reviewed to make sure that actions had not been required. This meant that there was a potential risk that care was being delivered in an unsafe way.
- We also had continued concerns that the hospital had not made arrangements to review service level agreements for services provided with external organisations. This was because the service did not provide us with evidence of this when requested during the inspection. A number of services were provided through this type of agreement, including tissue viability nursing services, general practitioner services as well as pharmacy services. This was important as the quality of services provided was not measured and there was an increased risk that amendments would not be made when needed.

Innovation, improvement and sustainability

- The provider who ran the hospital had recruited a new director of nursing who was due to start their employment in April 2019. The provider told us that they would have a key role in providing clear clinical leadership for the service going forward.
- The management team informed us that they had planned to undertake additional incident review meetings from April 2019 onwards. We saw evidence that this had been documented on the revised governance structure that was provided during the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that do not attempt resuscitation orders are managed in line with best practice guidance and in a way that reduces the risk of patients being resuscitated or not resuscitated inappropriately. Regulation 11(1).
- The service must ensure that decision specific mental capacity assessments are completed and documented on all occasions when needed, particularly prior to the implementation of a Deprivation of Liberty safeguard or a do not attempt cardiopulmonary resuscitation order. Regulation 11(1).
- The service must ensure that patient risk assessments, including falls and pressure ulcers are completed in line with best practice guidance and service policy. Regulation 12(1).
- The service must ensure that moisture lesion charts are consistently completed and that when pressure areas have been identified, that this is managed in line with the patient's care plan. Regulation 12(1).
- The service must ensure that when incidents have been reported, they are managed in a timely way, that appropriate actions are taken to reduce the risk of similar incidents reoccurring and that patient harms are recorded and monitored appropriately. Regulation 17(1).
- The service must ensure that incidents are reported in line with service policy, particularly regarding patient's behaviour, so that appropriate learning is captured and care plans are amended when needed. Regulation 12(1).
- The service must ensure that all safeguarding incidents are reported in a timely manner, reducing the risk of patients suffering avoidable harm. Regulation 13(2).
- The service must ensure that on occasions when patients have sustained injuries of unknown origin, that an investigation is undertaken to identify how the injury has been sustained. Regulation 13(2).
- The service must ensure that all safeguarding incidents, including low level safeguarding incidents are reported to the local authority in a timely manner. Regulation 13(2).
- The service must ensure that all services provided are monitored effectively, and actions are taken in a timely manner, demonstrating that they are continuously learning to improve patient care. Regulation 17(1).
- The service must review service level agreements that are held with external providers so that they are monitored to make sure that they meet the needs of the service. Regulation 17(1).
- The service must ensure that all risks are managed on the risk management system when needed and that all risks that have been identified on the risk management system are reviewed in a timely manner. Regulation 17(1).
- The service must ensure that they register a controlled drugs accountable officer in line with the Controlled Drugs (Supervision and Management and Use) Regulations, 2013. Regulation 17(1).
- The service must ensure that there is an effective system to undertake mortality reviews following a patient's death, identifying any lapses in care so that further improvements can be made if needed. Regulation 17(1).
- The service must ensure that all patient records are fully completed and that the most recent documentation is used at all times, particularly for percutaneous endoscopic gastronomy tubes. Regulation 17(1).
- The service must ensure that there are sufficient numbers of suitably qualified staff on duty at all times. Regulation 18(2).
- The service must ensure that appropriate recruitment systems are operated to make sure that staff have sufficient ability and competency to undertake their role effectively. Regulation 19(1).

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
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met;** Decision specific mental capacity assessments had not always been completed for do not attempt cardiopulmonary resuscitation orders of Deprivation of Liberty safeguards. Do not attempt cardiopulmonary resuscitation orders had not always been completed in line with best practice guidance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met;** Do not attempt cardiopulmonary resuscitation orders had not always been available, meaning that there was an increased risk that a patient would be resuscitated inappropriately. We sampled 11 patient records, finding that patient risk assessments had not been consistently completed on any occasion. For one patient, we found that there had been 34 reported incidents when aggressive behaviour had been displayed. Although initial actions had been documented, there was limited documented evidence of actions taken to reduce the risk of similar incidents happening again. Additionally, incidents of aggressive behaviour had not always been reported to the incident reporting system.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met;** Safeguarding concerns had not always been reported in a timely manner. On occasions when patients had sustained injuries but there had been no explanation for how these had been caused, the service had failed to identify the likely cause of injury. Patients had not always been managed in a way that was in line with their care plan. On one occasion, a patient had been tilted back in their chair to prevent movement. It was unclear whether low level safeguarding concerns had always been reported to the local authority in a timely manner.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;** The service had not always effectively monitored the services that had been provided. The service had not always identified risks in a timely manner and when risks had been identified, they had not always been managed effectively. Reported incidents had not always been managed in a way that meant that the risk of a similar incident happening again was reduced as much as practicably possible. The service had not made arrangements to have a controlled drugs accountable officer, in line with the Controlled Drugs (Supervision of Management and Use) Regulations, 2013.

This section is primarily information for the provider

Enforcement actions

The service had not made plans to undertake mortality reviews in a timely manner.

We reviewed 11 patient records, finding that none had been fully completed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How the regulation was not being met;** Records indicated that compliance with training was low in key areas. Rotas indicated that there had not always been sufficient numbers of suitably qualified staff available at all times.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met;** The service had not always operated an effective system to make sure that leaders had the right skills and competencies to undertake their roles.