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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We undertook this focussed inspection due to concerns that had previously been identified during focussed inspections that were undertaken on the 12 and 13 March as well the 6 and 7 August 2019. We carried out the unannounced inspection on the 26 September 2019.

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

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

- The service had not always managed patient safety incidents well. Staff had not always recognised and reported incidents and near misses. This was because incidents of aggression had not always been reported to the incident reporting system so that improvements could be made when needed.
- Staff had not always understood how to protect patients from abuse. This was because there was not always documented evidence of actions that staff had taken before administering sedation to patient's who had displayed aggressive behaviour.
- Staff had not always followed national guidance to obtain patient's consent when needed. Additionally, the management team had not planned to check that this was being completed in line with national guidance and service policy.
- Staff had not consistently completed and updated risk assessments for each patient and removed or minimised risks. We found that falls, pressure ulcer and bed rails risk assessments had not been completed for three out of five patients.

However,

- The service had made improvements to their safeguarding policy, making it clearer for staff to follow when a safeguarding concern had been identified.

Following this inspection, we told the provider that it must take some actions to comply with the regulations.

Ann Ford
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 identified in a previous inspections. 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 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 26 September 2019. During this inspection there were only two areas being used to care for patients.

Our inspection team

The Inspection team was led by a CQC lead inspector, as well as an inspection manager.

Why we carried out this inspection

We undertook this focussed inspection due to concerns that had been identified during previous inspections that were undertaken on the 12 and 13 March as well as the 6 and 7 August 2019.

We inspected parts of the 'safe' key question, making sure that the service was safe and that effective governance systems were in place to provide high quality, sustainable care.

How we carried out this inspection

The inspection site visit took place on the 26 September 2019 and was unannounced.

Summary of this inspection

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 five members of staff including registered nurses 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.

- The service had not always managed patient safety incidents well. Staff had not always recognised and reported incidents and near misses. This was because incidents of aggression had not always been reported to the incident reporting system so that improvements could be made when needed.
- Staff had not always understood how to protect patients from abuse. This was because there was not always documented evidence of actions that staff had taken before administering sedation to patients who had displayed aggressive behaviour.
- Staff had not always followed national guidance to obtain patient's consent when needed. Additionally, the management team had not planned to check that this was being completed in line with national guidance and service policy.
- Staff had not consistently completed and updated risk assessments for each patient and removed or minimised risks. We found that falls, pressure ulcer and bed rails risk assessments had not been completed for three out of five patients.

However,

- The service had made improvements to their safeguarding policy, making it clearer for staff to follow when a safeguarding concern had been identified.

Community health inpatient services

Safe

Are community health inpatient services safe?

Incident reporting, learning and improvement

- **The service had not always managed patient safety incidents well. Staff had not always recognised and reported incidents and near misses. Managers had not always investigated incidents.**
- The hospital had an incident reporting policy which was available to staff electronically and all staff had access to this. Staff we spoke with could tell us how they would report an incident.
- Between 9 August and 26 September 2019, there had been a total of six incidents reported to the incident reporting system. During our last inspections of March 2019 and August 2019, 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. During this inspection, we reviewed all six incidents that had been reported, finding that there were no follow up actions documented on the electronic system on two occasions.
- The management team had introduced a weekly meeting which was held to discuss all clinical and non clinical incidents that had been reported to the incident reporting system. Members of the management team informed us that this had been introduced to make sure that all incidents were managed in a more timely manner.
- We reviewed a sample of minutes from these meetings, finding that they had taken place on all but one planned occasion between 9 August and 26 September 2019. On reviewing the minutes, we had continued concerns since our last inspection that there was not always documented evidence of learning or actions taken against each incident that had been discussed.
- During our last inspections of March 2019 and August 2019, we found that incidents of aggressive behaviour displayed by patients had not always been reported to the incident reporting system, in line with policy. We identified similar concerns during this inspection. One set of patient records indicated that 12 out of 13 incidents of aggressive behaviour had not been reported to the incident reporting system and another set of patient records indicated that although there had been five occasions when the patient had displayed aggressive behaviour, none had been reported to the incident reporting system. This meant that there was a continued 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.

Safeguarding

- **Although the service had made safeguarding processes clearer for staff to follow, staff had not always understood how to protect patients from abuse. In addition, staff had not always followed national guidance to obtain patient's consent when needed.**
- The service had an up to date policy for safeguarding adults and children which was available to all staff. During our inspection of August 2019, we found that the safeguarding policies for adults and children were not always applicable to the service that was being provided and did not always include up to date information for staff. The management team had updated this since our last inspection, making it clearer for staff to follow. In addition, staff who we spoke with were aware that the safeguarding policy had recently been updated.
- We reviewed one occasion when a potential safeguarding concern had been identified, it had been escalated to a member of the management team in a timely manner and a referral to the local authority had been made immediately.
- The management team had implemented an audit tool which had been designed to make sure that all safeguarding incidents had been recognised and reported in a timely manner. Managers informed us that they had planned to review a percentage of all patient records as well as reviewing all incidents on a weekly basis to check for this information.
- During our last inspection of August 2019, we identified concerns that a patient had been administered a sedative on occasions when they had displayed

aggressive behaviour without documented evidence of other strategies being considered before this. On reviewing incidents that had been reported between 9 August and 26 September 2019, we identified similar concerns. Records indicated that on 11 occasions when a sedative had been administered, there was no documented evidence indicating if staff had considered managing their behaviour in any other way.

- In addition, we found two occasions when sedatives had been administered, but had not been recorded correctly. For example, on one occasion this had been documented on the patient's prescription chart but not in their medical records.
- Since our last inspection, the management team had introduced a patient specific monitoring tool to help identify any areas that could be improved. However, this had not been fully effective. For example, it had not identified that the use of sedation had not always been documented appropriately.
- Although the patient's behavioural plan had been updated since our last inspection of August 2019 and had been made available to all staff, we found evidence that this had not always been followed. This was because it stated that during periods of agitation or aggressive behaviour, the patient should be assessed for pain prior to a sedative being administered. Records indicated that this had only been completed on one out of 11 occasions.
- During our last inspection of August 2019, we identified concerns that consent to care and treatment had not always been documented in line with best practice guidance when needed. On speaking to staff, we identified continued concerns that this would not always be completed. In addition, we found that decision specific Mental Capacity Assessments had not always been completed when needed. This was important as patients were sometimes able to make decisions regarding individual treatments despite them lacking the capacity to do so for others. This also meant that it was unclear when staff needed to obtain and document consent.
- We also had concerns that the management team did not have oversight of whether consent had been obtained or documented, in line with best practice guidance. This was because there were no planned audits to check compliance against this and meant that there was an increased risk that improvements would not be made when needed

Assessing and responding to patient risk

- **Staff had not consistently completed and updated risk assessments for each patient and removed or minimised risks.**
- On reviewing five sets of patient records which accounted for all patients at the unit, we found that risk assessments for three patients had not been consistently completed, which was not in line with best practice guidance or policy and was a continued concern since our last inspections of March and August 2019. This included risk assessments for falls, pressure ulcers and bed rails, meaning that there was an increased risk that patient's needs would not always be met or that care plans would not be updated when needed.
- We also noted that there was no specific part of the service's policy that indicated the timeframe when these risk assessments were to be completed. This was important as it meant that there was an increased risk that not all staff would understand their responsibilities in completing this.
- Although the management team had completed a records audit, this had not identified that patient risk assessments had not always been completed in a timely manner. This meant that actions had not been implemented to make improvements when needed.
- We also reviewed six patient end of bed records which included percutaneous endoscopic gastrostomy monitoring forms, tracheostomy care, gastric aspirate monitoring forms, fluid intake charts, national early warning scores, clinical observations and enhanced observation forms as well as repositioning forms. Although there had been some improvements in the completion of these, we found that repositioning charts and daily safety checks had not been consistently completed for all five patients.
- During our previous inspection we identified continued concerns around the completion of do not attempt cardiopulmonary resuscitation orders. On this inspection, we found that this had recently been reviewed, which was in line with best practice guidance. However, it was unclear when this was to be reviewed next. This meant that there was an increased risk that if the patient's condition changed, they would not be resuscitated inappropriately.

Community health inpatient services

- Following the inspection, the provider informed us that they had made improvements regarding this and that the review of do not attempt cardiopulmonary resuscitation orders had been added to the weekly medical reviews that were undertaken for all patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that all patient records are fully completed, up to date and legible, including risk assessments such as those for falls and pressure ulcers as well as end of bed monitoring charts. Regulation 12.
- 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 17.
- The service must ensure that consent is documented in line with best practice guidance on all occasions when needed. Regulation 17.
- 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 17.
- The service must ensure that on previous occasions when areas of poor performance has been identified, timely action is taken to make improvements to the service provided. Regulation 17.

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 **How the regulation was not being met;** We reviewed records for five patients, finding that risk assessments had not been completed consistently on three occasions. Daily safety checks had not been completed consistently for any patients, particularly those for repositioning. 12 (2)(a)

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 made plans to make sure that do not attempt cardiopulmonary resuscitation orders are reviewed in line with best practice guidance. Incidents of aggression had not always been reported to the electronic reporting system, in line with policy. 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. Consent had not always been documented in line with policy and best practice guidance. The service had not planned to check compliance against this. The service had not always made sure that improvements had been made in a timely manner on occasions when poor performance had been identified.

This section is primarily information for the provider

Requirement notices

Regulation 17 (2)(a)(b)