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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

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

- Although the hospital had made improvements when managing patient records, we found continued examples of when important information was not available for all staff.
- Compliance with training updates, including mandatory training was low, this included important topics such as basic life support and safeguarding adults.
- Although improvements had been made in referring and investigating safeguarding concerns in a timely manner once concerns had been identified, we found an example of when a safeguarding incident had not reported by a member of staff for two months. This meant that there was a risk that patients were not always protected from abuse.
- The hospital had not always managed equipment well. It was not always clear how the hospital made sure that equipment had been tested for safety in a timely manner.
- We found occasions when do not attempt cardio-pulmonary resuscitation orders were incorrectly completed or not stored correctly. This meant that there was a risk that patients might be incorrectly resuscitated or not resuscitated in the event of an emergency.
- Staff did not regularly use a recognised pain assessment tool for patients unable to verbalise their pain.
- We observed several periods of neutral interactions between patients and staff where staff did not engage verbally or otherwise with patients.
- Although the management team reviewed the complaints policy at the time of inspection, there was no information available to complainants about how to take action if they were not satisfied with how the hospital managed or responded to complaints.
- Although the corporate provider had a clear vision and values for 2013 – 2018, this had not been reviewed. In addition, staff at the hospital were not aware of what these were. The hospital did not always have workable plans so that improvements, identified to us by senior managers, could be monitored for completion.
- Although the hospital showed some consideration to best practice guidance including from the National Institute for Health and Care Excellence, we found that all planned audits measuring compliance against this had not been completed. We had concerns that information from audits had not always been used in a way to make improvements to the service provided.
- The hospital did not have a system for monitoring service level agreements. We found that some of these had not been reviewed since they had been agreed in 2015. This meant that it was unclear how the quality of the services provided were being monitored.

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

- The hospital had strengthened the leadership team since our last inspection. The hospital had employed a manager who was registered with the CQC, a clinical services manager and a consultant in neuro-rehabilitation.
- Staff informed us that there had been an improvement to the leadership since our last inspection. They felt that members of the hospital management team were visible, open and supportive.
- We found that the hospital had made improvements to the way that national early warning scores were used when identifying a deteriorating patient. Most scores were calculated correctly and patients were escalated in line with hospital policy when needed.
- The hospital had made improvements with the management of medicines. This included the management of transdermal patches.
- Staff had good awareness of the Mental Health Act and their responsibilities within this.
- Personal care was provided in a way which maintained patient's privacy and dignity.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with six requirement notices. Details of these are at the end of the report.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services	Requires improvement 	• Although the hospital had made improvements when managing patient records, we found continued examples of when important information was not available for all staff. • Compliance with training updates, including mandatory training was low, this included important topics such as basic life support and safeguarding adults. • Although improvements had been made in referring and investigating safeguarding concerns in a timely manner once concerns had been identified, we found an example of when a safeguarding incident had not reported by a member of staff for two months. This meant that there was a risk that patients were not always protected from abuse. • The hospital had not always managed equipment well. It was not always clear how the hospital made sure that equipment had been tested for safety in a timely manner. • We found occasions when do not attempt cardio-pulmonary resuscitation orders were incorrectly completed or not stored correctly. This meant that there was a risk that patients might be incorrectly resuscitated or not resuscitated in the event of an emergency. • Staff did not regularly use a recognised pain assessment tool for patients unable to verbalise their pain. • We observed several periods of neutral interactions between patients and staff where staff did not engage verbally or otherwise with patients. • Although the management team reviewed the complaints policy at the time of inspection, there was no information available to complainants about how to take action if they were not satisfied with how the hospital managed or responded to complaints. • Although the corporate provider had a clear vision and values for 2013 – 2018, this had not

Summary of findings

been reviewed. In addition, staff at the hospital were not aware of what these were. The hospital did not have workable plans so that improvements could be monitored for completion.

- Although the hospital showed some consideration to best practice guidance including from the National Institute for Health and Care Excellence, we found that all planned audits measuring compliance against this had not been completed. We had concerns that information from audits had not always been used in a way to make improvements to the service provided.
- The hospital did not have a system for monitoring service level agreements. We found that some of these had not been reviewed since they had been agreed in 2015. This meant that it was unclear how the quality of the services provided were being monitored.

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

- The hospital had strengthened the leadership team since our last inspection. The hospital had employed a manager who was registered with the CQC, a clinical services manager and a consultant in neuro-rehabilitation.
- Staff informed us that there had been an improvement to the leadership since our last inspection. They felt that members of the hospital management team were visible, open and supportive.
- We found that the hospital had made improvements to the way that national early warning scores were used when identifying a deteriorating patient. Most scores were calculated correctly and patients were escalated in line with hospital policy when needed.
- The hospital had made improvements with the management of medicines. This included the management of transdermal patches.
- Staff had good awareness of the Mental Health Act and their responsibilities within this.

Summary of findings

- Personal care was provided in a way which maintained patient's privacy and dignity.

Summary of findings

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St Cyril's Rehabilitation Unit

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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.

The hospital has a registered manager who has been in post since October 2017. The nominated individual is the Chief Executive.

We carried out an unannounced inspection of St Cyril's Rehabilitation Unit on the 8 and 9 May 2018.

Our inspection team

The Inspection team was led by a CQC inspection manager, four CQC Inspectors, a CQC pharmacist and three specialist advisors with expertise in safeguarding, mental health and rehabilitation.

Why we carried out this inspection

We undertook this inspection to follow up concerns that had been raised in our previous full inspection of the hospital in March 2017, as well as further focussed inspections in June and August 2017.

Following the inspection in March 2017, we rated the service as inadequate overall and we issued enforcement action telling the service that they needed to make significant improvements in a number of different areas.

In this inspection, we inspected the whole service as well as making sure that specific improvements had been made in areas where enforcement action had been issued.

Summary of this inspection

How we carried out this inspection

The inspection site visit took place on the 8 and 9 May 2018 and was unannounced.

During the Inspection we observed care and treatment and spoke with seven patients and six relatives.

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

We also undertook nine periods of observation using the short observational framework for inspection. This is a way of observing care to help us understand the experience of people who could not talk with us. Our observations ranged from five to 40 minutes.

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?

Requires improvement 

We rated safe as requires improvement because;

- Although the hospital had made some improvements when managing patient records, we found continued examples of when important information was not available for all staff.
- Compliance with training updates, including mandatory training was low. This included important topics such as basic life support and safeguarding for adults.
- We found that staff knew when to report clinical and non-clinical incidents to the incident reporting system. However, we found on the system we reviewed, that up until May 2018, the level of patient harm was not always recorded, although when this was identified to the provider they took immediate action to address this. In addition, we found that learning from incidents was not always clearly documented.
- Although improvements had been made in referring and investigating safeguarding concerns in a timely manner once concerns had been identified, we found an example of when a safeguarding incident was not reported by a member of staff for two months. This meant that there was a risk that patients were not always protected from abuse.
- The hospital had not always managed equipment well. It was not always clear how the hospital made sure that equipment had been tested for safety in a timely manner.
- We found occasions when do not attempt cardio-pulmonary resuscitation orders were incorrectly completed or not stored correctly. This meant that there was a risk that patients would be incorrectly resuscitated or not resuscitated in the event of an emergency.
- The hospital had not always ensured that infection control was managed well. This was because we observed occasions when staff did not use personal protective equipment appropriately as well as occasions when staff were not compliant with bare 'below the elbow'.

However,

- We found that the hospital had made improvements to the way that national early warning scores were used when identifying a deteriorating patient. Most scores were calculated correctly and patients were escalated in line with hospital policy when needed.

Summary of this inspection

- We had concerns in our inspection in March 2017, that tracheostomy changes were undertaken without appropriately trained staff being available to manage any complications. Records indicated the hospital had made improvements and that this was done at appropriate times with appropriately trained staff present.
- The hospital had made improvements with the management of medicines. This included the management of transdermal patches.

Are services effective?

Requires improvement

We rated effective as requires improvement because;

- Although the hospital showed some consideration to best practice guidance including from the National Institute for Health and Care Excellence, we found that all planned audits measuring compliance against this had not been completed.
- Staff had not regularly used a recognised pain assessment tool for patients who were unable to verbalise their pain.
- Although goal setting meetings had been introduced, outcomes for patients and rehabilitation goals were not always included in an up to date overall treatment plan that staff were working towards.
- Malnutritional screening assessment tools were not always updated in line with best practice guidance.

However,

- The hospital had made improvements in making sure that staff were competent to carry out their roles. Competency books were kept for all staff for topics such as tracheostomy and percutaneous endoscopic gastronomy care.
- Staff had regular multi-disciplinary team meetings to discuss patient's care and treatment.
- Catering staff were knowledgeable of specialist diets and had made improvements to patient choice and preferences of food.
- Staff had good awareness of the Mental Capacity Act and the Mental Health Act and understood their responsibilities within this. Deprivation of Liberty safeguard applications were completed appropriately.

Are services caring?

Requires improvement

We rated caring as requires improvement because;

- We observed several periods of neutral interactions between patients and staff where staff did not engage verbally or otherwise with patients.

Summary of this inspection

- Staff observations of patient's emotional wellbeing were not always accurately documented. This meant patients wellbeing could not always be effectively monitored and promoted by staff.
- Relatives informed us that although they felt that staff were kind, they felt that care had not always been delivered in a caring and compassionate way.
- Accurate information about patient's emotional states were not always recorded accurately. This meant that information about patient's emotional wellbeing was not available to all staff.
- Staff did not always communicate effectively with patients before providing care and treatment.

However,

- Personal care was provided in a way which maintained patient's privacy and dignity.
- The service had been proactive in making patient documentation individualised. The hospital had introduced concise patient records which gave an overview of information about patients such as patient's personal preferences and choices.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because;

- Although the management team reviewed the complaints policy at the time of inspection, there was no information available to complainants about how to take action if they were not satisfied with how the hospital managed or responded to complaints.
- Although patients had rehabilitation goals and therapy plans, records indicated that therapy plans were not always reviewed regularly. In addition, it was not always clear how much contact patients should have with therapy services.
- Although the hospital had made improvements in making timely referrals to tissue viability services when needed, we did not always find evidence that these plans had been consistently transferred to the patient's current wound care plans.

However,

- The hospital had made external activities more accessible for patients since our last inspection in March 2017. For example, we saw that patients had recently visited a local zoo.
- The hospital had considered ways in which to meet the individual needs of patients. For example, sensory sessions were facilitated for patients with hearing or sight impairments.

Summary of this inspection

- Improvements had been made to make sure that timely referrals were made to tissue viability nurses when needed.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because;

- Although the corporate provider had clear vision and values for 2013 to 2018, this had not been reviewed. In addition, staff at the hospital were not aware of what these were. The hospital did not always have workable plans so that improvements, identified to us by senior managers, could be monitored for completion.
- The hospital had made improvements to the governance structure since our last inspection. However, we still had concerns that not all areas that required improvement were captured and subsequently, improvements were not always made in a timely manner.
- The hospital did not have a system for monitoring service level agreements. We found that some of these had not been reviewed since they had been agreed in 2015. This meant that it was unclear how the quality of the services provided were being monitored.
- Although the hospital had completed a number of audits, records indicated that the hospital had not always completed planned audits appropriately. We had concerns that information from audits had not always been used in a way to make improvements to the service provided.
- Although the hospital had introduced a carers forum to allow relatives to provide feedback, the hospital had not yet introduced a staff survey to help understand where improvements needed to be made.
- Staff informed us that there had been an improvement to the culture within the hospital. However, we observed that there was a notable difference between the two days of our inspection in the way that staff worked with each other as well as the way in which they interacted with patients.

However,

- The hospital had strengthened the leadership team since our last inspection. The hospital had employed a manager who was registered with the CQC, a clinical services manager and a consultant in neuro-rehabilitation.
- Staff informed us that there had been an improvement to the leadership since our last inspection. They felt that members of the hospital management team were visible, open and supportive.

Summary of this inspection

- The hospital used a risk management system to manage risks that the hospital faced. Members of the management team were aware of the key risks that the hospital faced and arrangements had been made to control these as much as practicably possible.
- The management team had worked with external organisations to make improvements to the service. For example, they had worked with the local safeguarding team who had delivered training to staff at the hospital.

Requires improvement

Community health inpatient services

Safe	Requires improvement
Effective	Requires improvement
Caring	Requires improvement
Responsive	Requires improvement
Well-led	Requires improvement

Are community health inpatient services safe?

Requires improvement

We rated safe as requires improvement because;

Safety performance

- The service submitted information about patient harms to the NHS safety thermometer. 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 fall, pressure ulcers and hospital catheter acquired urinary infections.
- At the last inspection of the service, we had concerns that patient safety information was not being reviewed. In this inspection, we did not see any evidence of results from the NHS safety thermometer being reviewed and discussed in monthly meetings. 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.
- We reviewed information that had been submitted to NHS patient safety thermometer between October 2017 and May 2018. Records indicated that during this period, there had been six hospital catheter acquired urinary tract infections, one hospital acquired pressure ulcer and no patient falls. Records also indicated that all patients had received a venous thromboembolism risk assessment on admission to the hospital. A venous thromboembolism is when a blood clot forms in a patient's vein.

Incident reporting, learning and improvement

- The hospital had access to an incident reporting policy. We reviewed the incident reporting policy, finding that although it had been reviewed at the time of inspection, it had not been made available for all staff. During the inspection period the hospital provided evidence that a further review of this policy had taken place.
- The incident reporting policy covered examples of incidents that required reporting. This included near misses, as well as incidents that had resulted in harm to a patient, relative or member of staff. Additionally, the policy also gave definitions of the different level of harm and indicated how all incidents should be reviewed, which was dependant on the severity of an incident.
- All staff had access to the hospitals electronic incident reporting system. Staff we spoke with were able to tell us how they would report an incident. Incident reporting was included in mandatory training and local induction.
- Staff who we spoke with were able to give us examples of the types of incidents that they would report. Examples of these included medication errors and pressure ulcers. We saw examples of staff reporting incidents appropriately during the inspection. However, on one occasion we had concerns that an incident had not been reported accurately. This meant that there was a risk of limited learning from this incident.
- Between October 2017 and May 2018, the management team had reported one serious incident. We found that this had been investigated using a root cause analysis. A root cause analysis is a tool used to investigate

incidents fully so that actions can be implemented to reduce the risk of a similar incident happening again. Following the investigation, an action plan had been implemented to make required improvements.

- During the same period a total of 158 incidents had been reported. However, it was unclear if all of these incidents had been investigated in line with the incident management policy. This was because documentation reviewed during the inspection identified that the level of patient harm for all incidents had not been recorded until May 2018. The management team provided a further document following the inspection which evidenced that the level of harm had been recorded for incidents that had been reported between March 2018 and the time of inspection.
- The senior management team informed us that they had identified this as an area for improvement. On reviewing incidents that had been reported in May 2018, there was evidence that the management team had started to include the level of patient harm on a more consistent basis when reviewing incidents.
- Records indicated that when incidents had been reported, they had been reviewed in a timely manner. This was an improvement from our previous inspection. We found that actions taken following the review of incidents had been documented on most occasions. However, full details of the investigation and learning to inform the actions from each incident were not always clearly documented.
- Most staff informed us that they had received feedback on incidents via email, the staff information folder which was available in the staff room and via weekly staff meetings and safety briefings. Minutes of these meetings showed that incidents were discussed but there was limited documented evidence of learning from incidents or that any changes to practice had been implemented.
- 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.
- Between June 2017 and May 2018, there had been one incident that had required the application of duty of candour. The management team provided evidence that this had been fully applied in line with policy. A verbal apology had been given within 48 hours following the incident and a formal letter of apology had been sent once the incident investigation had been completed, although this was over six months following the incident.
- 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.

Safeguarding

- The hospital had an up to date policy for safeguarding adults and children which was available to all staff. During our last inspection in March 2017, we raised concerns that the safeguarding policy did not list any types of abuse. We found that the service had taken action to rectify this. In addition, the hospital had a policy for managing patient finances. However, we found that this was overdue for review.
- All staff were required to complete safeguarding training for adults as part of their induction as well as their ongoing mandatory training. However, records indicated that only 56% of staff were up to date with this at the time of inspection.
- Most staff members we spoke with were aware of how to identify issues of potential abuse, neglect and access support. Staff were aware of formal reporting systems in place and informed us that they would verbally report concerns to their line manager.
- In addition, staff were required to complete safeguarding level 2 for children. This was in line with the Intercollegiate Document, 2014. Records indicated that 77% staff were up to date with this.
- There was a member of the management team who had completed safeguarding level 3 for children. However, no other members of staff had completed this. The management team had completed a risk assessment to control this risk. We reviewed the risk assessment which clearly stated that no one under the age of 18 would be admitted to the hospital due to a lack of appropriately trained staff available at all times.
- The hospital had identified a safeguarding lead for adults. However, although there was a named lead for safeguarding children, they were not compliant with the

Intercollegiate Document, 2014, which states that services should have access to someone with level 4 safeguarding for children if persons under the age of 18 were admitted to the hospital.

- We identified concerns in our last inspection in March 2017, that safeguarding referrals were not always being made to the local authority in a timely manner. We reviewed all safeguarding incidents between October 2017 and May 2018, finding that during this period there had been a total of 24 reported. We found that referrals to the local authority had been made appropriately and in a timely manner on most occasions.
- However, we found that on one occasion, a member of staff had failed to report a safeguarding incident immediately. Records indicated that the incident had only been reported one month after it had occurred. 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 found that although the management team had taken action in a timely manner when safeguarding concerns had been made, documentation of actions taken was not always clear. This was because there was limited information in the safeguarding spreadsheet provided to us on inspection which detailed 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 hospital 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 70% of staff were up to date with this. In addition, the management team informed us that they had planned to add the intravenous administration of medicines (where medicines are administered directly into a patient's blood stream) to the mandatory training schedule.
- At our inspection in August 2017, we found that some improvements had been made in medicines management but there were still occasions where policy was not followed in practice. For example, we found that there were some gaps in recording the administration of medicines and stock discrepancies were not appropriately reported or investigated.
- At this inspection, we found that the prescription charts were clearly presented to show the treatment people had received. However, as identified in the hospital's own audit (April 2018), we saw one record where a dose change had not been clearly made by the prescriber.
- Nurses completed additional records to demonstrate the application and removal of transdermal patches. Prescriptions included clear information about the use of 'when required' medicines supported by further information within patients notes.
- Qualified nurses administered all medicines, except creams for personal care. Rehabilitation co-therapists applied and recorded the use of personal care creams when needed. Records indicated that some rehabilitation co-therapists had received training in this and there was written guidance for staff to follow in individual's care plans. However, we reviewed five patient records and found that documentation had not been completed for this on four occasions.
- 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 amount of controlled drugs tallied with the amount recorded and that they had been checked on a daily basis. In addition, we found that a member of staff had witnessed and countersigned all entries in the register. This was in line with hospital policy.
- The temperature of the clinic rooms and refrigerators were monitored to ensure medicines were stored at the correct temperature. Oxygen safety signage was in place.
- The hospital had commissioned external technical and clinical pharmacy support for medicines supply, audit and prescription chart review. The pharmacy completed a six monthly clinical audit and weekly medicines stock reconciliation audits. The findings from these audits and from reported medicines incidents were included as

standing items on the hospitals governance committee meeting. The pharmacist also provided practical guidance, when medicines needed to be crushed prior to administration.

- When the external audits had found discrepancies the management team had taken steps to identify the cause. However, where reports were marked 'unresolved' the hospital did not take further action to try to identify the cause, and unresolved issues were not recorded as incidents. This was identified in the hospitals audit report (end April 2018). Similarly, we found that some medicines incident reports were closed without clearly recording the root cause and learning.
- The hospital manager was completing controlled drugs accountable officer as well as non-medical prescriber training. Non-medical prescribing can improve efficiency and access to medication in addition to existing medical support. There were plans to implement a separate medicines committee to facilitate sharing of learning across all then hospitals in the group.

Environment and equipment

- Most areas of the hospital had been kept tidy and free from hazards. However, we saw that there were a small number of occasions when equipment had not been stored appropriately in patient's bedrooms. For example, in one bedroom we observed a large number of splints stacked up at the side of the bed.
- We had concerns during our inspection in March 2017 that individualised moving and handling assessments had not been completed for patients. During this inspection, we found that the hospital had made improvements. We reviewed records for patients which showed that moving and handling assessments had been completed for all patients.
- 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.
- The hospital had a register to monitor all pieces of equipment, for example, wheelchairs and hoists. It was unclear if all equipment had been serviced and was fit for use. This was because records provided after the inspection indicated that equipment had only been serviced following the inspection. Additionally, there were a large number of pieces of equipment on the register where service dates were not indicated.
- We did note that a maintenance log had been kept for medical devices which were serviced by an external company. This indicated that these pieces of equipment had been serviced appropriately.
- The hospital had a contract with an external company to manage clinical waste. We observed that clinical waste was disposed of appropriately and sharps boxes were stored safely.
- The hospital had an on-site hydrotherapy pool which was used for patients at the hospital. The hydrotherapy pool was also used by external organisations. We found that staff were required to complete daily checks of the pool. Records indicated that checks had been completed appropriately.
- However, we observed that the hydrotherapy pool had not been refurbished. For example, there were a number of tiles missing from the pool area. We saw evidence that this had been risk assessed for safety and was managed on the risk register.
- Members of the management team informed us that there was a maintenance team who were available during normal working hours. In addition, there was on call cover provided by a member of the estates team 24 hours a day, seven days a week.

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 inspection in March 2017 that information was difficult to find as patient files were large and uncoordinated. On this inspection we found that although there had been some improvements in the way records were arranged, we continued to find examples when documentation was incomplete or missing. This meant that we had continued concerns that staff did not have access to the most up to date patient information.
- All patients also had a large file which contained documentation such as medical notes, appointments and other personal information. We had continued concerns that information was not always easy to find, was not always fully completed and in some cases was

not present. For example, on two occasions we found that emails regarding care planning by the speech and language therapist had not been added to the patient's files. This meant that there was a risk that all staff would not be supported to provide the correct level of care for the patients.

- We did note that the senior management team had recently completed a small number of informal record reviews to assess the quality of documentation. We reviewed these, finding that they had highlighted similar concerns to the ones that we identified during the inspection. For example, it was noted that patient records in one patient's file was located in the wrong sections. In another file it was noted that all medical notes and records from multidisciplinary team meetings had not been included.
- Although areas of poor compliance had been identified in these reviews, we did not see any evidence of actions being implemented to make the required improvements.
- In addition, all patients had three sets of paper records as well as a separate medication chart. The hospital had introduced a small, concise file which provided an overview of a patient's history as well as key elements of the care that they required, including personal preferences. We observed new staff being asked to read these files so that they had an awareness of the patients that they were working with.
- Patient's observations, such as blood pressure and pulse rate as well as patient risk assessments, including falls and pressure ulcers, were kept in records that were kept in patient's bedrooms. Rehabilitation co-therapists were responsible for completing these.

Cleanliness, infection control and hygiene

- The hospital had an infection control policy which was available for all staff. In addition, all staff were required to complete infection control training as part of their induction and mandatory training courses. Records indicated that 90% of staff were up to date with this at the time of inspection.
- Records indicated that between October 2017 and May 2018, there had been no reported cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA) or colostrum dificille (CDiff).
- All areas of the hospital were visibly clean. Housekeeping services were available in the hospital during normal working hours, seven days a week. Information was available to provide guidance on how often different areas needed to be cleaned and who was responsible for this. We saw evidence that checklists were completed when all areas of the hospital had been cleaned.
- Records indicated that environmental audits were part of the overall audit plan. We reviewed an audit which had been completed in November 2017, finding that overall compliance was only 68%. We noted that there were documented actions to make further improvements. We reviewed a further audit that was completed in February 2018, which had demonstrated an overall compliance of 80%.
- We sampled disposable equipment, finding that on most occasions equipment was appropriately stored in its packaging and was in date. However, we found one occasion when a piece of suction equipment had not been replaced following it being used. This item of equipment was contaminated with bodily fluids, meaning that there was an increased risk of infection being spread.
- In our inspection in March 2017, we identified concerns that although infection risk was discussed as part of staff handovers, no information was given to support staff in managing this. During this inspection we identified similar concerns, finding that this information was still not provided during staff handovers.
- Personal protective equipment was available for all staff to use. This included gloves and aprons. However, we observed two occasions when staff did not use personal protective equipment appropriately while delivering personal care to a patient. This meant that there was an increased risk of the spread of infection.
- We saw that there were hand wash sinks and gel dispensers available throughout the hospital. Hand gel dispensers were also available in communal areas and visitors to the hospital were encouraged to use these.
- The management team informed us that monthly hand hygiene audits were undertaken. We reviewed records for November 2017 which indicated 100% compliance. However, we observed three occasions during the inspection when staff did not wash their hands in between providing care to patients. In addition, we observed two members of staff wearing nail varnish and jewellery. This was not in line with best practice guidance or hospital policy.

- The hospital had a contract with an external company for the removal of clinical waste. We saw that there were systems in place to ensure that clinical waste and contaminated items were managed appropriately.

Mandatory training

- A compliance target of 95% had been set for all mandatory training. However, records indicated that this had not been achieved.
- All staff were required to complete four mandatory training days which included a range of topics. Day one included health and safety as well as fire safety, day two included dysphagia awareness as well as basic life support, day three included restraint, incident reporting and raising concerns. Day four included safeguarding training for adults, Mental Capacity Act and Menial Health Act training.
- Information provided following the inspection indicated that mandatory training compliance varied and that the mandatory training target had not been met in any area. Records indicated that compliance with day one was 66%, day two was 72%, day three was 90% and day four was 56%.
- Compliance with other training modules also varied. For example, compliance with restraint training was only 48%, however, compliance with immediate life support training was 82%.
- Records indicated that mandatory training compliance was discussed at local and corporate governance meetings. However, we noted that the mandatory training matrix held locally did not provide up to date training records for all staff at the hospital. In addition, compliance with other areas of training that staff were required to complete, such as basic life support were not discussed as part of the monthly governance meetings. This was particularly important for areas where compliance was poor and it was unclear what actions had been taken to make improvements.
- Members of the senior management team informed us that both induction and mandatory training was being revised for 2018/19.

Assessing and responding to patient risk

- We took time to review do not attempt cardio-pulmonary resuscitation orders that patients had in place. We had concerns that these had not always been completed or stored in a way that patients would or would not be resuscitated appropriately in the event of an emergency. For example, we found that on one occasion it was not clearly documented that a do not attempt cardio-pulmonary resuscitation order had been cancelled. This was because a line had not been put through the document. This was not in line with the hospital's policy. We also found that on another occasion, a member of staff had deleted some sections on the form incorrectly which meant that there was an increased risk of a patient being resuscitated in error.
- The hospital had introduced information about behavioural management for patients following our last inspection in March 2017. This had been introduced to support staff in recognising and managing individual behaviours. However, we found that patients behaviour had not always been documented consistently. For example, on two occasions we found that that although information about aggressive behaviour had been documented in individual patient's records, this information had not been transferred to a book that was used by staff to highlight such concerns. This meant that there was an increased risk that continuity of care would not be maintained.
- We attended two staff handovers, one for registered nurses and another for rehabilitation co-therapists. We found that all relevant clinical information was handed over in both meetings. A safety brief had been introduced for all patients to support staff in recognising patient risks. This included information about tracheostomy care, falls, pressure ulcers and do not attempt cardio-pulmonary resuscitation orders.
- However, we found that this information was not discussed clearly during the handover. This meant that there was an increased risk of staff not being fully aware of all patient risks. In addition, other important information such as dysphagia awareness was not included as part of the handover. This was important as some patients who had difficulty swallowing required different textures of food.
- We sampled patient records for tracheostomy and percutaneous endoscopic gastrostomy care (this is when a tube is inserted surgically into a patient's stomach and is used to administer food or medicines).
- Following our last inspection in March 2017, we raised concerns that tracheostomy changes were being undertaken at inappropriate times of the day,

particularly when there were no members of medical staff available in case of a complication. Records indicated that the hospital had taken action to rectify this.

- However, we found that documentation remained inconsistent following our previous inspection in August 2017. For example, the type of tracheostomy used and the reason for the use of suction was not always documented. In addition, records indicated that on one occasion a patient's tracheostomy had not been changed for over two months. This was not in line with manufacturer's guidance or hospital policy.
- The hospital had undertaken quarterly audits to monitor compliance with tracheostomy care. Results indicated that performance in this area had been continually poor. For example, overall compliance was only 67% between July and September 2017, 65% between October 2017 and December 2017 as well as 69% between January 2018 and March 2018.
- In addition, records for percutaneous endoscopic gastronomy care did not always include documentation of skin integrity or measurement of the length of the tube. This was important when determining if the tube was in the correct place before administering either food or medication. Guidance from the National Institute for Clinical Excellence (NICE CG32) states that this should be done on a daily basis to check whether the tube is correctly located.
- We were informed by the management team that an audit to measure compliance against percutaneous endoscopic gastronomy care had been introduced since our last inspection. However, the management team were unable to provide any evidence of this being completed.
- Records indicated that all patients had risk assessments completed on admission. This included assessments for falls, moving and handling as well as pressure ulcers. Records indicated that falls risk assessments had been completed correctly. However, we found that the completion of waterlow scores (a tool used to estimate the likelihood of patients developing pressure ulcers) was inconsistent. This meant that there was an increased risk that any such patients would not be managed appropriately.
- We found that the hospital had made improvements to the management of identified pressure ulcers since our last inspection in March 2017. This was because records indicated that referrals had been made to tissue viability nurses in a timely manner when needed and patients had a documented care plan for staff to follow.
- 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 improvements had been made with the documentation and use of the national early warning score system since our last inspection in March 2017. We sampled a number of patient records, finding that the national early warning score had been completed correctly on all occasions. We also found that there was evidence of patients having been escalated to a nurse in charge when needed. This was in line with the hospitals policy which stated that patients must be escalated to a nurse in charge if they had a national early warning score of between one and four.
- Weekly audits were undertaken to measure compliance with the calculation and use of the national early warning score. We reviewed all audits that had been undertaken in March 2018, finding that overall compliance was 95% during this period.
- All staff received training in the use of national early warning score. Staff who we spoke with were able to describe how to use the national early warning score and when escalation was required. However, training records indicated that only 35% of staff were up to date with this.
- In addition to the national early warning score system, staff were required to undertake separate observations, which were determined by the level of patient risk. We found that the frequency of observations was clearly documented in all records that we checked. Records also indicated that these had been completed appropriately on all but two occasions.
- The hospital had clear guidelines to support staff in the event of an emergency. All staff were able to inform us when they would dial 999.
- Dysphagia risk assessments had been completed for all patients. This was important as some patients had

difficulty swallowing and were at increased risk of choking if given certain textures of food. We also found that there was clear information available to the kitchen staff about the type of food texture that patients required.
- Staff were required to complete dysphagia awareness training on an annual basis. Records indicated that 72% of staff, including kitchen staff, were up to date with this.

Staffing levels and caseload

- We identified concerns in March 2017 that the hospital did not have a system in place to make sure that appropriate numbers of staff were on duty to maintain patient safety. We found that the service had made improvements in this area during a further inspection in August 2017. We found that these improvements had been sustained during this inspection.
- The hospital manager had reviewed the staffing establishment on a regular basis. We were informed that the establishment was adjusted in line with the number and needs of new admissions as well as the changing needs of current patients.
- The service employed registered nurses, learning disability nurses, as well as nursing assistants who were known as rehabilitation co-therapists. At the time of the inspection the hospital employed six band 6 nurses and four band 5 nurses. The registered nursing establishment had been set at three during the day and two at night. The hospital had planned to provide a senior band 6 nurse on all shifts, 24 hours a day, seven days a week.
- We reviewed rotas between March 2018 during the inspection, finding that it was unclear if the planned number of senior nurses had been met on 12 occasions. However, information was provided following the inspection period evidencing that the planned number of senior nurses had been met on all occasions.
- The hospital had been established to provide 15 rehabilitation co-therapists during the day and 13 rehabilitation co-therapists at night time up until the end of April 2018. The planned establishment had been increased at the end of April 2018 to 16 rehabilitation co-therapists during the day and 14 at night. This was due to an increased number of patients and a higher dependency in the hospital.
- We reviewed rotas between March 2018 during the inspection, finding that it was unclear if the planned number of senior nurses had been met on 12 occasions. However, information was provided following the inspection period evidencing that the planned number of senior nurses had been met on all occasions.
- The hospital also employed a physiotherapist, an occupational therapist and a speech and language therapist. Rotas indicated that between December 2017 and May 2018 the planned number of occupational therapists and speech and language therapists had not been achieved on a large number of occasions due to annual leave or sickness.
- Records indicated that there were currently vacancies for four registered nurses and nine rehabilitation co-therapists. The management team informed us 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.
- As a result of these shortfalls, bank and agency staff were used on most shifts. For example, in April 2018, staffing shortages had been filled for registered nurses on 37 occasions and rehabilitation co-therapists on 188 occasions.
- We reviewed induction records for agency staff, finding that induction checklists had been completed for all agency staff. This was important as it reduced the risk of the hospital's systems and processes not being followed. We also saw an example during the inspection of an agency member of staff being orientated to their role as it was their first shift working at the hospital.
- The hospital also employed a consultant who specialised in neuro rehabilitation and had been in post for six months prior to the inspection. The hospital had planned for the consultant to be available on site on Monday, Tuesday and Friday every week as well as being available by phone on a Wednesday and Thursday. This was an improvement from the last inspection.
- At times when the consultant was unavailable, the hospital had made arrangements for access to a second consultant and general practitioner services. These were both managed with external providers on service level agreements. However, these services were only available over the telephone. This was important as when the consultant who was employed by the hospital was unavailable, weekly patient reviews had not taken place.

Requires improvement

Community health inpatient services

Major incident awareness and training

- Fire awareness training had been included as part of the induction course that all new staff were required to attend. In addition, staff were required to complete fire awareness as part of their annual mandatory training update. Records indicated that 66% of staff were up to date with this.
- All patients had a personal emergency evacuation plan in place which provided information for staff about what actions should be taken in the event of an emergency. We found that these had been updated for all patients since our last inspection when we found that they had not been reviewed since patients had been admitted to the hospital.
- However, staff informed us that a 'stay put' policy had recently been implemented for all immobile patients. Although the fire policy had been amended to reflect this, we found that personal emergency evacuation plans had not. This meant that there was a potential risk that staff would not be aware of what action to take in the event of an emergency.
- The hospital undertook fire alarm testing once a week. This was important as it tested alarms throughout the hospital to make sure that they were in working order. However, we noted that the test was isolated to one area of the hospital.
- The hospital manager was in the process of making contingency arrangements with external providers. This was to make sure that appropriate arrangements were in place for patients in the event of a major incident.

Are community health inpatient services effective?

(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because;

Evidence based care and treatment

- The hospital demonstrated some consideration to best practice including guidance from the National Institute for Health and Care Excellence. We saw evidence of this being referenced in some clinical policies that we reviewed. However, it was unclear from minutes of governance meetings how best practice guidance had been reviewed to make sure that the most up to date information was available.
- The hospital undertook audits to measure compliance against best practice guidance. However, records indicated that between October 2017 and May 2018, the hospital had not carried out all audits that had been planned. For example, a planned audit to measure compliance with the care of patients who had a percutaneous endoscopic gastronomy had not been completed. In addition, the hospital had not completed planned audits to measure compliance against urinary catheter or pressure ulcer care between January 2018 to May 2018. This meant that there had been a potential missed opportunity to highlight areas where further improvements could be made.
- Results from audits that had been completed, measuring compliance against topics such as tracheostomy care and the use of the national early warning score system, were discussed in local audit meetings. Records indicated that results from these were mixed. In March 2018, compliance with the correct use of the national early warning system was 95%. However, the hospital's local audit for the period between October 2017 to December 2017 showed that compliance with the required standards for tracheostomy care ranged from only 54% to 69%.
- The hospital had introduced a tracheostomy focus group for staff to attend. The aim of this was to improve compliance against evidence based care and treatment. Minutes for this group showed that attendance by staff was less than five members of staff and while audit results and incidents were discussed there was no assurance of lessons learned being put into practice as a result of the focus groups.
- We found good compliance with Mental Health Act Code of Practice during our inspection. The Mental Health Act Code of Practice was readily available on the ward.
- There were effective systems and policies to support the adherence of the Mental Health Act and Mental Health Act Code of Practice including flagging systems to ensure renewals, medication reviews and consent to treatment.

Nutrition and hydration

- The use of a malnutrition screening tool screening tool is used to identify adults at risk of malnutrition and for

actions to be put in place to effectively monitor and reduce risk. We reviewed seven sets of patient notes for weekly malnutrition universal screening tool assessments. Five sets had fully completed weekly malnutrition screening tool assessments while two malnutrition screening tools had not been completed since 4 March 2018. This was not in line with National Institute for Health and Care Excellence standards which state that patients identified as at risk of malnutrition should be assessed weekly as a minimum standard.

- The hospital audited six sets of clinical patient notes in April 2018. The findings were that staff were not consistently assessing patients effectively for risk of malnutrition. For example two patients' malnutrition screening tools had not been completed since March 2018, one patient had an old version of the screening tool completed, one patient had no weight documented, and one patient had a weight loss documented with no action against it.
- Staff told us that they had been unable to weigh patients for three months as part of the malnutrition screening tools screening process due to the scales being out of order. This meant that staff were unable to monitor patient weight loss effectively.
- The hospital did not have a dietitian on site but could request advice and support, if required through a service level agreement with a local hospital's dietician service . We saw examples within patient records where dietitian advice had been sought and implemented. However, relatives we spoke with told us that they had found it difficult to speak with dieticians regarding patients.
- For some patients, the use of a thickening agent was prescribed for diet and fluids in order to prevent swallowing issues. These arrangements had been reviewed by the speech and language therapy team staff in order to ensure that the correct instructions were available for staff to follow. Records indicated that the correct amount of thickener was being used and recorded accurately in order to maintain the safety of patients.
- Staff in the catering team were knowledgeable of special dietary requirements such as pureed diet and diabetic diet.
- Improvements had been made since our last inspection in March 2017 regarding patient choice at mealtimes. Patients were offered a four weekly rotating menu and were able to request food not listed. Choices were displayed on both written and picture menu cards. Pureed food was available in moulds which improved the appearance for patients. Patients could also request food not listed on the menu as well as hot food available outside of set mealtimes. There were drinks and snacks available at any time to patients on request.

Pain relief

- During our previous inspection in March 2017, we found that patients pain was not being adequately assessed and documented by staff. During this inspection we reviewed seven sets of patient notes for assessment and treatment of patient's pain.
- The hospital provided us with the non-communicating patient pain checklist available for staff to use when assessing patients level of pain. However, none of the notes we reviewed for patients who were non verbal, had documented pain assessments completed using the pain assessment tool. In addition, there was no documented evidence that staff had used other methods of assessing pain prior to or after administering pain relief.
- We also observed pain relief being given to three patients who were able to communicate during our inspection. On all of these occasions, records indicated that staff had not completed an assessment of pain before or after administrating the medication.

Patient outcomes

- In March 2017 we identified concerns that patients at the hospital did not have clear rehabilitation goals.
- During our inspection we observed a goal setting group meeting which had been introduced. This was chaired by the clinical services manager with speech and language therapists, nurses, therapists, consultant and relatives in attendance. There was open discussion regarding patient progress, care plans were reviewed and rehabilitation plans amended appropriately.
- However, we did not always see evidence that the goals set during this meeting were recorded in patients care records. We looked at 23 goals set during the meeting. five of the 23 goals set had not then been included in the patients' clinical care notes. This meant there was a risk that staff did not always have access to the most recent aims for patients to help support them to achieve these goals.
- In addition, records indicated that care plans for two patients had not been updated or reviewed in their care

file for two months. The hospital had also completed a review of patient care plans in April 2018, which showed that one patient's seizure plan had not been reviewed since January 2018. This also showed that another patient's care plan had been reviewed monthly but updated goals for rehabilitation had not been updated since April 2017.

Competent staff

- During our last inspection in March 2017 we found that the hospital did not have adequate systems in place to make sure that staff only undertook tasks for which they were competent. For example, the hospital were unable to ensure that appropriately trained staff to deliver tracheostomy as well as percutaneous endoscopic gastronomy care were always available.
- Since our last inspection, the hospital had made improvements by ensuring that all registered nurses had completed appropriate training and that this was evidenced in competency records. However, records indicated that staff had not always completed training updates for the competencies that had been introduced. For example, only 62% of staff had completed tracheostomy care update training.
- We reviewed 52 staff competency workbooks for percutaneous endoscopic gastronomy care and 20 for tracheostomy care. The workbooks were a combination of observed practical skills by a mentor and theory questions. Best practice clinical guidelines were also included.
- Percutaneous endoscopic gastronomy care competency work books varied for nurses and rehabilitation co-therapists. Competencies included skin care, cleaning and administering liquid feeds and medication via a percutaneous endoscopically guided tube. Staff had varying levels of competency within these skills depending on their role. For example, registered nurses were responsible for administering medicines using this route.
- Tracheostomy competency workbooks also varied for nurses and rehabilitation co-therapy assistants. Competencies included skin care and dressing changes, cleaning equipment and routine and emergency tracheostomy changes. Staff had varying levels of competency required depending on their role.
- The hospital provided appraisal information for 87 staff members; some had been employed since 2007. Records indicated that only 26 members of staff had completed an appraisal in 2017. However, following the inspection the hospital provided records which indicated that 100% of staff had completed an appraisal in the previous 12 months.
- Staff who we spoke with confirmed that they had received annual appraisals. Senior nurses were responsible for completing appraisals for registered nurses and rehabilitation co-therapists. Records indicated that competencies and performance were monitored via staff appraisals.
- Records also indicated that the substantive consultant had completed their annual appraisal and all relevant mandatory training.
- Staff also told us they were able to undertake training in addition to core competencies that had been provided by the hospital. For example, one staff member had completed an academic module in tissue viability.

Multi-disciplinary working and coordinated care pathways

- We observed some examples of staff working well together. This included positive interactions between members of the leadership team, registered nurses, the substantive consultant and rehabilitation co-therapists.
- Members of the management team worked with commissioners, case managers and social workers when planning patient admissions and discharges. Members of the management team informed us that they sometimes faced challenges when managing care and treatment with external providers. We saw examples of when the management team had arranged multi-disciplinary meetings to overcome these challenges.
- During our inspection we observed a weekly multi-disciplinary team meeting**.** The consultant, registered nurse and therapists were in attendance, patients and relatives could attend this meeting. Care plans were reviewed, therapy goals reviewed and capacity assessment and best interests' decisions were discussed. We saw open discussion and contributions from all members of the multi-disciplinary team.
- The hospital had introduced a named nurse who was responsible for each patient's care since February 2016. However, it was unclear if the named nurses had attended the goal setting meeting for who they were responsible for. This meant that it was unclear how much involvement the named nurse had in the overall delivery of individual patient's care.

Requires improvement

Community health inpatient services

- The hospital had a standard operating procedure for admissions which stated that each patient would have a person centred plan of care which would be reviewed at regular intervals by the relevant members of the multi-disciplinary team. It also stated that patients must have a meaningful and individualised plan of care documented by the registered nurse who admitted the patient within four hours of their admission. We saw evidence of initial assessments, care plans and goals being set. However, on reviewing patients notes we did not see evidence that this was an ongoing process which was communicated to the whole team.
- We saw evidence of good multi-disciplinary team working between the speech and language therapy team and the catering team. Speech and language therapy had provided training to the kitchen staff on patients with dysphagia which is a difficulty in swallowing. We saw positive improvements to the menu choices for patient's and improved pureed food menus as a result of this training.
- We observed the nursing handover between the day and night shift of band 5 and band 6 nurses. We found that all staff required attended the handover which covered each patient including those who were currently in hospital. Although topics such as medication and pressure areas were discussed, patient preferences and choices or emotional state were not.
- We observed the handover between the band 6 nurse in charge and the rehabilitation co-therapists on the day shift. The Consultant was also present during the handover. All rehabilitation co-therapy staff attended the 60 minute handover which covered each patient including those who were in hospital. Staff discussed patient preferences and choices around food, drink, care and activities and were encouraged to look at each patient's "this is me file" for further details. Agency staff that were new to the hospital on that day were spoken to separately at the end of the meeting and encouraged to read the patients "this is me files".

Referral, transfer, discharge and transition

- The hospital had made arrangements to support patients in attending outpatient appointments with other services when required. We observed all patient appointments being documented in the hospital diary so that arrangements could be made to make sure that appointments were attended.
- In addition, staff were required to complete transfer of care documentation on occasions when patients required a period of hospital admission. We saw evidence of this being completed for patients who were in hospital at the time of inspection.
- Records also indicated that when patients had been discharged following a hospital admission, discharge summaries were added to patient records to support the continuity of patient care. However, we found that there had been one occasion when discharge information had not been shared appropriately between the two hospitals.
- The hospital had two bungalows which had been designed to help patients transition to a higher level of independence prior to discharge. During our inspection we attended a multi-disciplinary meeting where staff actively discussed transitioning a patient to one of the bungalows in the near future.
- However, for another patient, it was unclear if the discharge arrangements made would be fully effective. Although a documented discharge plan was in place, staff from the hospital had not always worked well with the external provider who were responsible for providing care to the patient once they had been discharged.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Mental Capacity Act and Mental Health Act training was mandatory for staff. Records indicated that 73 % of staff were up to date with this at the time of inspection.
- We saw examples of well completed capacity assessments and decisions made in line with the principles of the Mental Capacity Act. Capacity assessments were routinely completed for decisions relating to patients staying in hospital, receiving ongoing care and treatment, equipment used, safety restrictions placed on people such as using lap belts on wheelchairs and serious medical treatment such as decisions about fitting a percutaneous endoscopic gastrostomy tube, which was a procedure to fit a feeding tube into the stomach to aid nutrition.
- Staff completed detailed capacity assessments following the requirements of the Mental Capacity Act using the two stage test. Where patients were deemed to lack capacity, the decision was then considered in terms of whether it was in the patients' best interests.

- The hospital had a best interest checklist form which covered the legal requirements when looking at best interest. We found that this was consistently used and well completed. For example staff recorded details of how they had considered patients' past wishes and consultations with family members, court appointed deputies and independent mental capacity advocates where appropriate.
- Staff did not make assumptions about capacity. This was clearly shown on one file where the patient had several capacity assessments for specific decisions; for some decisions, the patient was deemed to have capacity and for other more complex decisions, the patient was deemed to lack capacity despite efforts to provide information in a format that was individual to the patient. This meant that where patients lacked capacity to make specific decisions, staff were keeping detailed records to show that the continuation of care or treatment was in the patients' best interests utilising the best interest checklist.
- We looked at four patients records who had a decision regarding resuscitation made when they lacked capacity. Decisions regarding resuscitation were documented on a form at the front of the patient's notes. Three of the four forms were completed accurately. One decision to not resuscitate a patient had been made in their best interest and not discussed with them as the patient had a low state of awareness.
- There were several patients subject to the Deprivation of Liberty Safeguards at the time of our inspection. Staff we spoke to were able to describe when the safeguards may be used and were aware of important case law around the safeguards. Patients' care plans reflected that they were on a standard authorisation, why this was in place and any conditions attached to the authorisation.
- Staff informed patients in writing of their right to support from an independent mental capacity advocate, their right to request a review of the deprivation and their right of appeal to the Court of Protection. Staff ensured that patients on a Deprivation of Liberty Safeguards had regular access to an independent mental capacity advocate and/or a paid relevant person's representative, to support them with their rights while under Deprivation of Liberty Safeguards. Staff recorded when paid relevant person representatives supported patients subject to a Deprivation of Liberty safeguards authorisation.
- Staff ensured that the relevant Deprivation of Liberty safeguard paperwork was in place. Where there were delays in the supervisory body starting an assessment or making a decision about standard authorisations, staff were chasing the supervisory body to receive updates. Staff had also notified the CQC of the Deprivation of Liberty Safeguards standard authorisation outcome as they were required to do.
- The corporate compliance manager kept a detailed list of patients who were subject to a Deprivation of Liberty safeguards authorisation. They also ensured that when the authorisation was due to end, staff were reminded to request a further standard authorisation in good time, if it was still required. This showed the provider had effective systems to support the adherence of the law around Deprivation of Liberty Safeguards and the Deprivation of Liberty Safeguards Code of Practice.
- We found that relevant staff had a good awareness of the Mental Health Act and their responsibilities.
- Prior to this inspection, we last carried out a Mental Health Act monitoring visit in March 2016. We found the provider had appropriate systems to support the Mental Health Act if required.
- We highlighted one area for improvement during the visit in March 2016, that informal patients were not informed of their right to leave the unit. The provider sent us an action statement telling us how they had addressed the issue we. On this inspection, we found staff had made improvements in evidencing that informal patients had been informed of their right to leave with both easy read information and more detailed signs available in the unit.
- During this inspection, we found that there were no patients detained under the Mental Health Act. We looked at two recent episodes of detention including one detained patient who was recently discharged and one patient who had been subject to short-term doctor's holding powers.
- We saw well-ordered separate legal files with evidence of the appropriate paperwork to support detention, evidence of patients' rights being given and patients being informed of their right to access the independent advocate.
- We observed that medication for mental disorder was given to the relevant detained patient supported by the appropriate legal certificate of consent (in the form of a T3 form).

Requires improvement

Community health inpatient services

- Appropriate records were kept to support decisions about approving patients leave from the hospital including leave risk assessments. There was an independent mental health advocacy service which detained patients had access to. Managers hearings were occurring in a timely manner and there were sufficient hospital managers to meet the hospital's responsibilities relating to appeals and renewals.
- However, in one case, the responsible clinician had not requested a second opinion doctor (to authorise treatment for mental disorder for an incapacitated detained patient) in a timely manner. This was because the request was made on the day before the end of the three months rule. However, the responsible clinician ensured that treatment was continuously authorised beyond three months using rules around urgent treatment (section 62). Had a second opinion appointed doctor been anticipated earlier as recommended by the Mental Health Act Code of Practice this may have been avoidable.

Are community health inpatient services caring?

Requires improvement

We rated caring as requires improvement because;

Compassionate care

- In March 2017 we highlighted that interactions between staff and patients less able to communicate were minimal. Interactions observed were conversations about tasks to be undertaken and not conversational in nature. While some improvements were observed during this inspection they remain in the minority and inconsistently shown by staff.
- We observed care between staff and patients using a short observational framework for inspection. The Short Observational Framework for Inspection tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive.
- We observed what happened to service users over a chosen observation period, making recordings at set intervals. In each time period we recorded the general mood of the patients, the type of activity or non-activity they were engaged with and the style and number of staff interactions with patients. In each time frame there may have been more than one type of engagement and multiple interactions with staff. Interactions with staff wee categorised as positive, neutral or poor.
- There were 36 staff interactions with patients observed and recorded. 84% of staff interactions were neutral, 8% were positive and 8% (three interactions) were poor. We carried out four group and five individual observations using the Short Observational Framework for Inspection method on 8 and 9 May 2018. Most of these observations were undertaken on 8 May.
- Overall, we observed mainly neutral interactions between staff and patients that were essential to giving care or treatment. We saw times when staff moved patients who were wheelchair users without explanation or communication. We also observed staff talking to each other in front of patients and across the room without acknowledging them. We observed one occasion where three patients sat in a line in front of the television which was on a radio channel with a static screen, during this time there was no interaction with any patient by any member of staff.
- We observed three poor interactions by staff. A rehabilitation co-therapist bumped a patient's chair into the table and did not acknowledge or apologise. When supporting a patient to eat rehabilitation co-therapists provided the next spoonful to them at too fast a rate (outpacing).
- Another example of outpacing was when a rehabilitation co-therapist became impatient whilst holding the door open for a patient saying' come on' in an irritated tone. We also observed one patient doing a jigsaw with a member of staff who did not speak to the patient during the observation period. During the observation we saw staff talking to each other and not acknowledging patient.
- We saw some positive examples of interactions, where staff actively engaged with or reassured patients. During the observations we saw patients supported to eat breakfast and to take medication.
- Examples of neutral staff interactions included discussing the activity plan for the day, encouraging a patient to swallow, asking before putting on the television and helping a patient to eat by lifting the fork to their mouth.
- We observed three positive interactions. One member of staff encouraged a patient to swallow their food then praised them saying 'perfect'. On another occasion a

member of staff showed genuine warmth and concern when a patient started to cough, stroking their back and saying 'good' when they started to eat again. We observed a staff member kneeling to talk to a patient in their wheelchair and offer a choice of films to watch.

- During our inspection we spoke with six relatives who overall felt that staff were kind and caring but expressed concerns around the consistency of compassionate care provided by all staff.
- Relatives told us about a birthday party staff had held for a patient at the hospital and a patient's hobby group had held an open day at the hospital also.
- We observed that when patient's personal care was being delivered by staff that doors were closed to maintain patient's privacy and dignity.

Understanding and involvement of patients and those close to them

- We observed a rehabilitation co-therapists handover where staff were encouraged to read the "this is me" document to help them communicate with patients and plan activities for the day. This document provided a concise overview of individual patients, including their likes and dislikes.
- Relatives were invited to a weekly goal setting meeting between the medical staff, nursing staff and patients. Staff told us that the hospital had open visiting times for relatives which had improved communication between relatives, patients and staff. Relatives we spoke with informed us that they preferred this and found it a positive way to improve their family life.
- However, some relatives we spoke with felt that their concerns were not always acted upon by senior managers and found communicating their concerns to be "frustrating". They described staff as approachable but sometimes defensive when they raised concerns about their relative's care.

Emotional support

- Staff monitored patient's emotions and behaviour with antecedents, behaviour and consequences recording process. We saw patient care plans detailing potential triggers for aggressive behaviour and the action staff should take to avoid or mange this behaviour and record this. This was mainly completed by the rehabilitation co-therapists when they provided emotional support to a patient following an episode of triggered behaviour.
- We reviewed five antecedent, behaviour and consequence documents. Three documents did not correspond with the documentation in the contemporaneous patient records. For example, the patient records said the patient had required an intervention for aggressive behaviour but the antecedents and behaviour document stated the patient had been settled all day. This meant that accurate information about the patient's emotional wellbeing was not available to all staff.
- A psychologist was available at the hospital one day per week and a psychology assistant three days per week. We saw evidence of patients being referred to and frequently using this service. Psychology care plans were individualised and up to date in the records we reviewed.

Are community health inpatient services responsive to people's needs?

(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because;

Planning and delivering services which meet people's needs

- The hospital was based on one level. This meant that there was easy access for patients who had limited mobility, such as those who used a wheelchair.
- There was a corporate admission standard operating procedure in place at the time of the inspection. This outlined that each patient should have a personalised care plan within six hours of admission and an assessment by each member of the multi-disciplinary team within the first 24hrs of admission. This had been completed within the seven sets of patients notes we reviewed.
- Patients had individualised activity plans. This included undertaking activities such as reading and watching television. Activity care plans were not consistently filled in by staff, meaning that it was unclear if patients had

completed these. Relatives we spoke with told us this happened regularly and no explanation was documented as to why a patient had not been involved in an activity.
- Each patient had an activities box which contained personal items such as favourite activities, photographs, music and books. Care plans were individualised and encouraged staff to use the activity boxes as part of each patient's daily activities.

Equality and diversity

- During the inspection we observed a patient whose first language was not English. We observed cue cards and words in the patient's first language in their room. The patients care plan stated the patient and their relatives understood little English and both required an interpreter. Staff told us they had not accessed an external translation service but had used a member of staff when they were on duty as a translator.
- The catering team were able to give details on how they would meet cultural needs within patient's diet.

Meeting the needs of people in vulnerable circumstances

- In March 2017 we had concerns that patients were not offered person centred activities and plans of care within or outside the hospital. The hospital had made some improvements. For example, details of external activities and trips were available to patients such as trips to the local zoo. However, we did not see evidence of any patients having attended these external activities within patient's records.
- The hospital employed an activities co-ordinator who worked 9am to 5pm four days a week.
- Some patients and relatives described taking part in internal activities such as gardening, bird watching and cooking. Relatives gave one example where staff had supported them to host a birthday party for a patient. We saw evidence of external clubs and groups being hosted at the hospital to meet individual patient's preferences. For example a patient who had a bike hobby the club met at the hospital.
- Patients who were living with dementia had a personalised care plan in place which included specific activities relating to their personal choices. We spoke with the speech and language therapists who had worked closely with one patient with dementia to develop an activity programme involving music and singing. However, the hospital did not have a dementia or learning disability strategy to make further improvements in supporting patients living with a cognitive impairment.
- We saw an innovative piece of equipment called a Tobi eye tracker which allowed patients to use eye pointing as a way to communicate their needs, preferences and choices to their relatives and staff. However, relatives and staff told us the speech and language therapist was the only person able to use the Tobi eye tracker and due to sickness and absence from the speech and language therapy team patients were unable to use this piece of equipment despite this being a preferred method of communication in their records.
- There was access to occupational therapy and psychology services for patients. Records indicated that the need for these services had been considered as part of each patients' rehabilitation goals and that patients had received contact with these services when needed.
- Multi-sensory activities were available for patients with sight or hearing impairments. These were to help patient's experience daily life in a meaningful way.
- British sign language awareness training was provided to staff during their induction training.
- Staff supported patients to make plans for end of life who were receiving palliative care. For example, financial decisions and funeral plans.

Access to the right care at the right time

- We reviewed staff rotas which showed physiotherapists and physiotherapy assistants were available Monday to Friday at the hospital. The physiotherapist was a locum and a permanent physiotherapist was due to start employment in May 2018.
- Relatives expressed concerns during our inspection over a lack of therapy and rehabilitation services available to patients. They told us about gaps when no physiotherapy was provided to patients and physiotherapy plans and goals were not regularly updated. During inspection, we reviewed three sets of patient notes where the physiotherapy care plans stated it should be reviewed every three months but were documented as last reviewed in January 2018. These care plans had not been reviewed at the time of our inspection.
- We reviewed the number of therapy contacts for all patients who required physiotherapy input between October 2017 and May 2018, finding that results were

mixed. Goal setting meetings indicated how much contact patients required with a physiotherapist. This audit indicated that these requirements had been met on most occasions.

- The hospital had completed a therapy audit in April 2018 to assess if patients who required therapies had received the amount of therapy contact that was needed. Records indicated that one patient did not have a physiotherapy plan in place, two patient's physiotherapy plans had not been reviewed for over three months, one patient's physiotherapy plan had not been reviewed since it was implemented in April 2017 and another plan had been reviewed by a nurse instead of a physiotherapist.
- There had been no arrangements made for staff in the hospital to deliver therapy sessions when the physiotherapist had been unavailable. This meant that there was a risk that patients would not receive physiotherapy sessions in line with their rehabilitation goals at times when a physiotherapist was unavailable.
- The hospital had planned for a speech and language therapist to be available four days per week. The hospital also employed a speech and language therapy assistant who was available five days a week.
- Relatives we spoke with informed us that patients had experienced limited speech and language therapy input in the last six months. Staff rotas provided by the hospital showed that out of a possible 90 working days since January 2018, the speech and language therapist had only been available for 31 days. This was due to annual leave and sickness. However, managers informed us that essential cover was provided by speech and language therapy assistants as well as a speech and language therapist from another hospital.
- We reviewed minutes of rehabilitation goal setting plans, finding that it was unclear how much contact patients should have with a speech and language therapist. In addition, records indicated that some patients had received an inconsistent number of contact hours between January and May 2018. This meant it was unclear if individual rehabilitation plans had been met at all times.
- We found that the hospital had made improvements in making timely referrals to the tissue viability service when needed since our last inspection in March 2017. The tissue viability nurse, assessed and planned patients care then emailed the information to hospital staff. Staff then transferred the information from the tissue viability nurses email to the patient's main care record. However, we did not find evidence that these plans were consistently transferred to the patient's current wound care plans. For example, we found that one patients wound care plan did not contain the most up to date tissue viability advice and had not been updated since February 2018.

Learning from complaints and concerns

- The hospital had a complaints policy which was out of date. However, the management team amended the complaints policy during the inspection.
- Staff informed us that if a patient or a relative wanted to make a complaint, they would be directed to a member of the management team.
- We sampled three concerns and complaints that had been made, finding that the hospital had responded to them in a timely manner, two of which had been responded to on the same day.
- We reviewed an audit of complaints that was completed for the period between April 2017 and June 2017. During this period the hospital had received one complaint. The audit showed that the actions taken were 82% in compliance with their policy. A full response was made to the complaint within 20 days in line with the policy. However, the complainant was not contacted within two days of making the complaint as in line with the policy. Additionally, the complaint had not been documented within the patient's clinical notes.
- The hospital had made no arrangements to advise patients or relatives to contact the parliamentary health service ombudsman or the independent sector complaints adjudication service. This was important as the ombudsman is an independent adjudicator who considers complaints when departments within the national health service have not acted properly, fairly or have provided a poor service. The independent sector adjudication service are responsible for considering complaints of patients who have received privately funded treatment.
- The hospital had posters in all communal areas advising patients, relatives and staff how to make a complaint which stated that written complaints could also be sent to the CQC to investigate. However, this is not the role of the CQC. This was highlighted to the management team who informed us they would remove them.
- We reviewed minutes of clinical governance meetings, finding the complaints and concerns had been

discussed. We saw evidence that lessons had been learned from complaints and that improvements had been made when needed. Complaints and concerns were also included in staff bulletins as well as being discussed in handovers.

Are community health inpatient services well-led?

Requires improvement

We rated well-led as requires improvement because;

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 that the hospital had made improvements in this area.
- The hospital had employed a full time hospital manager since our inspection in March 2017 and they had recently been registered with the CQC. The hospital manager also held an additional role (group head of nursing) at corporate level.
- The hospital manager was supported by a full time clinical services manager. They were responsible for clinical leadership as well as supporting the hospital manager in the day to day running of the hospital.
- 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 introduced a team of senior rehabilitation co-therapists. We attended a staff handover, finding that they had been given the opportunity to complete their own allocations for the team that they were leading.
- Medical leadership was provided by a substantive consultant in neuro rehabilitation. They were based on site three days per week as well as being available on the telephone two days per week for support and advice. The hospital had also made arrangements for access to an on call service and for periods when the substantive consultant was unavailable. However, we noted that cover arrangements were over the telephone advice only. This meant we had concerns that during periods of sickness or annual leave that there would be lack of on-site medical leadership and that patients would not receive weekly ward rounds so that care plans were reviewed and amended when required.
- We found that all leaders had clear roles and responsibilities. Individual members of the management team were aware able to articulate what their roles and responsibilities were.
- We saw evidence that the hospital had made management and leadership courses available for senior staff. This was important as they were responsible for the day to day management of the hospital. However, at the time of inspection, no members of the management team had completed this.
- Staff who we spoke with informed us that the leadership team were supportive, visible and approachable. The hospital management team were supported by a member of the corporate management team. We were informed that they had been visible at the hospital on a regular basis.

Service vision and strategy

- A clear set of vision and values were held at corporate level. The corporate vision was to provide high quality patient centred care and improving the quality of life for patients with brain injury. This was underpinned by five key values; delivering excellence, working together, respecting people, being ethical as well as providing strong leadership.
- However, we found that these vision and values had not yet been reviewed. This was important as they had been implemented for the period between April 2013 and March 2018. More importantly, the hospital management team and other hospital staff that we spoke with were not aware of the vision and values. There was no evidence that they were 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.
- We took time to review the corporate strategies that supported the vision and values, finding that there was limited evidence that most of these had been completed. For example, on reviewing the corporate strategy, we found there was no evidence that any actions had been completed, despite them having target completion dates between 2013 and 2014.

- In addition, we reviewed the corporate audit strategy that had been introduced following our last inspection in March 2017, finding that most actions were overdue. This was because completion dates had varied between March and September 2017 and had not been completed. We also found that the corporate clinical governance and information governance strategies were overdue for review that the hospital would follow.
- Although improvements had been made at hospital level, we found limited evidence that the hospital had promoted the corporate vision and values. Additionally, the hospital did not always have workable plans so that improvements, identified to us by senior managers, could be monitored for completion. This meant that it was unclear how these improvements would be implemented in a timely manner and how progress would be measured.

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. The hospital undertook a number of monthly meetings, including clinical governance, risk management as well as an audit focus group.
- We reviewed minutes of these meetings between October 2017 and April 2018, finding that most meetings had been well attended by hospital staff and members of the executive team. The management team had introduced a governance report which was populated and discussed at hospital clinical governance meetings. This report provided a variety of data including the number and type of incidents reported as well as staffing figures. However, we had concerns that areas of poor performance had not always been captured. For example, although data for mandatory training was provided, there were other areas of poor compliance with training updates that were not discussed, such as basic life support.
- We noted that each meeting did not follow a set agenda. This meant it was unclear how outstanding actions were followed up. For example, in the minutes from the hospital's clinical governance meeting which took place in February 2018, there was an outstanding action on the action log. We found that an update was not provided in the meeting that was held in March 2018. Additionally, timeframes indicating when actions should be completed by were not always included.
- Although improvements had been made in a number of areas across the hospital, we had continued concerns that improvements in all areas of poor performance had not always been made in a timely way. For example, results from tracheostomy audits had identified issues with continual poor compliance between July 2017 and March 2018. Although we found that actions had been implemented to make improvements, these had not been effective.
- In addition, we identified concerns about the completion of patient records as part of our previous inspection in March 2017. Prior to the inspection, the management team submitted an action plan which stated that regular case note audits were being undertaken to make improvements where needed. We found that there was limited evidence that this had been completed. This was because the hospital had only undertaken one informal review of patient records and no actions had been implemented to make improvements to areas that had been highlighted as requiring further improvement. During this inspection, we also identified continued issues with the completion of patient records.
- The hospital also held monthly risk management meetings. Topics discussed at these meetings included new risks that had been identified as well as health and safety issues. We also saw evidence of risks being discussed and closed appropriately.
- In addition, information about the hospital was also discussed at quarterly corporate clinical governance and risk management meetings. Records indicated that the hospital manager had attended these on a regular basis. Although we found that information such as incidents, safeguarding reports and medication errors were provided in the form of a governance report, we did not always see evidence recorded of all information being discussed. In addition, we did not always see evidence of shared learning between all hospitals within the corporate group and there was limited evidence in local hospital meeting minutes that information from corporate meetings had been disseminated.
- The hospital had access to a risk management strategy and held a risk register which highlighted a total of five risks. Hospital managers were able to tell us what the

main risks that the hospital currently faced were. Each risk had been rated, had been reviewed regularly and had some controls in place to reduce the level of risk as much as practicably possible. We also reviewed the corporate risk register and found that all risks had been escalated appropriately. This meant that members of the executive team were provided with oversight of the key risks that the hospital faced.

- We took time to review the corporate risk register. This listed a number of more significant risks that were applicable to the hospital and records indicated that timely actions had not always been implemented for some risks that affected the hospital. For example, a risk was added in February 2017 that 22 out of 25 human resource policies were due for review. We found that only a small number of these had been reviewed at the time of inspection. In addition, we found that there were a number of other policies that were due for review during the inspection. This meant there was an increased risk that the hospital were following policies and procedures that did not contain up to date evidenced based guidance.
- There was a corporate audit plan that the hospital were required to complete to measure compliance against national standards, legislation and best practice guidance. On reviewing minutes from the corporate clinical governance meeting in April 2018, we found that the hospital had only completed 73% of these between October and December 2017 as well as only 55% between January 2018 and March 2018. Records also indicated that the out of the audits completed, the hospital had only met 59% of the required standards between October and December 2017 as well as only 39% between January and March 2018.
- We did not see any discussion about corporate audits in local hospital minutes which meant it was unclear how improvements would be made. However, the senior management team had identified that the way audits were completed required improvement. In the minutes of the corporate clinical governance meeting held in April 2018, ways to encourage local hospital staff to take more ownership of audits had been discussed.
- The substantive consultant was a member of the corporate medical advisory committee. However, records indicated that the consultant had only attended one out of the last six monthly meetings. This was important as this was an opportunity for the consultant to discuss a variety of topics and share leaning across different hospital sites.
- We had concerns in our last inspection in March 2017 that the hospital did not have an effective system for monitoring the implementation of patient safety alerts. On this inspection, we found that the hospital had made some improvements. This was because all patient safety alerts were discussed in local clinical governance meetings and there was evidence that they had been implemented. However, we reviewed documentation that all staff were required to sign to say that they had read and understood the alerts, finding that not all staff had completed this. This meant that there was an increased risk that staff would not always provide care and treatment in line with all patient safety alerts.
- We had concerns that the hospital had not made arrangements to review service level agreements for services provided with external organisations. A number of services were provided through this type of agreement, including tissue viability nursing services, general practitioner services as well as pharmacy services. We found that some agreements had not been reviewed since the date that they had been implemented. 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.

Culture within this service

- Members of the management team and staff informed us that there had been an overall improvement to the culture within the hospital following our last inspection in March 2017.
- Most staff who we spoke with demonstrated an open and honest approach to the care and treatment that they provided. However, there had been one occasion when staff had not given an accurate account of an incident that had happened. This meant that there was an increased risk that all areas requiring improvement would not be identified.
- We observed a difference in culture during the days of our inspection. For example, on one of the days we observed limited interaction between staff and patients. On another day we observed an improvement to the way staff interacted with each other and with patients.

- A member of the senior management team had attended training to become a freedom to speak up guardian since our last inspection. This was important as it provided a forum for staff to raise concerns confidentially. We found that the whistleblowing policy had been amended to reflect these changes. However, not all staff we spike with were aware that they were able to raise concerns in this way.
- Since our last inspection, we reviewed records which indicated that the management team had taken actions in a timely manner to manage incidents of poor performance. We also observed one occasion during our inspection when the management team took immediate action following concerns being raised.
- Between June 2017 and the time of our inspection the hospital had received three formal concerns from staff members regarding colleagues. We saw evidence of how these were managed and acted upon by the provider.
- Staff who we spoke with informed us that they felt some improvements had been made since our last inspection. We were informed that changes to the leadership team had been positive. Members of the management team were committed to being open and honest with staff.
- Records indicated that staff sickness and absence rates had varied from 6% to 10% between April 2017 and February 2018. However, records indicated that sickness and absence had reduced (improved) to 4% in March 2018 and 3% in April 2018.

Public and staff engagement

- The hospital held weekly staff meetings which all staff were encouraged to attend Some staff who we spoke with confirmed that they had attended these. Staff meetings were used to disseminate information as well as encouraging staff to raise concerns or suggest potential improvements that could be made.
- The management team had planned to undertake a formal staff survey, although this had not yet been completed at the time of inspection. This had been planned to measure the satisfaction of all staff who were employed by the hospital. Staff surveys are important as they enable providers to know what is going as well as what requires further improvement.
- A carers forum had been introduced following our last inspection in March 2017. We reviewed minutes of these meetings, finding that they had been held on a monthly basis, although they had only been attended by a small number of relatives. The carers forum gave relatives an opportunity to suggest potential improvements that could be made.
- The hospital had completed a family and carers questionnaire in October 2017. The provider informed CQC that they planned to undertake a relative's survey later this year.
- The management team had planned to introduce a patient's survey, but at the time of inspection, the psychology team were still in the process of putting this together.

Innovation, improvement and sustainability

- The management team had worked with external organisations to make improvements to the service. For example, they had worked with the local safeguarding team who had delivered training to staff at the hospital. They had also worked with the local safeguarding team when investigating specific concerns that had been raised.
- The hospital had appointed a substantive consultant in neuro-rehabilitation and saw evidence that they had planned to introduce new equipment to the hospital to prevent unnecessary hospital admissions for patients. This included an ultrasound scanner (a scanner that uses high frequency sound waves to create an image of part of the inside of the body) and a humidifier for tracheostomy patients (this helps loosen mucous within the tracheostomy tube when suction becomes difficult).
- The management team had worked with headway (an organisation that supports patients who have suffered an acute brain injury as well as their families. We saw evidence in minutes of meetings that they had organised for headway to visit the unit as well as encouraging staff from within the unit to head a conference in order to promote the hospital as a place of care.
- The hospital manager was completing a non-medical prescriber course. Non-medical prescribing can improve efficiency and access to medication in addition to existing medical support.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospital must ensure that safeguarding incidents are reported by all staff in a timely manner so that immediate actions can be taken to protect patients from potential abuse.
- The hospital must ensure that there is an effective system to monitor the completion of patient records and must ensure that up to date, contemporaneous records are kept for all patients.
- The hospital must ensure that staff comply with best practice guidance when managing infection control. This includes wearing personal protective equipment and complying with 'bare below the elbow' standards.
- The hospital must ensure that all staff complete required training updates in a timely manner.
- The hospital must ensure that do not attempt cardio-pulmonary resuscitation orders are completed correctly and stored in a place that is clear to all staff.
- The hospital must ensure that staff are supported to engage in positive interaction with patients.
- The hospital must ensure that all policies are reviewed in a timely manner.
- The hospital must ensure that all audits are completed so that areas of poor performance are identified and improvements are made in a timely way.

Action the provider SHOULD take to improve

- The hospital should ensure that all incidents are reported accurately by staff so that learning can be shared in a timely manner.
- The hospital should ensure that all elements of the Duty of Candour requirement are applied in a timely manner when needed.
- The hospital should ensure that actions taken are clearly documented when safeguarding concerns are raised.
- The hospital should ensure that there are effective systems in place to monitor whether all equipment has been tested for safety.
- The hospital should ensure that care for patients with a tracheostomy as well as percutaneous endoscopic gastronomy tubes is undertaken in line with best practice guidance.
- The hospital should ensure that pressure ulcer risk assessments are completed consistently.
- The service should ensure that there are sufficient numbers of allied health professionals available at all times.
- The hospital should ensure that arrangements are made for patients to be reviewed in the absence of the substantive consultant.
- The hospital should ensure that there are workable plans in place to ensure that improvements are made in a timely manner.
- The hospital should ensure that malnutrition universal screening tool assessments are completed consistently.
- The hospital should ensure that effective systems are used in delivering pain management and that this is completed and documented in line with best practice guidance.
- The provider should ensure that patients emotional wellbeing is accurately reflected and recorded in their records.
- The hospital should ensure that care and treatment is only delivered with the patients' consent.
- The hospital should ensure that up to date and accurate information is available to complainants about how to take action if they are not satisfied with how the hospital manages or responds to complaints.
- The hospital should ensure that patients receive adequate contact with therapy services when needed.
- The hospital should consider ways in which to effectively monitor patient hams so that improvements can be made when required.
- The hospital should consider ways to make sure that staff are able to identify levels of patient harm when recording incidents correctly, in line with hospital policy.
- The hospital should consider ways in which to access to a member of staff who has completed level 4 safeguarding training, as outlined in the Intercollegiate Document, 2014 if persons under the age of 18 are admitted to the hospital.

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 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met;** During the inspection we observed occasions when there were periods of no or limited interaction between staff and patients. This was a breach of regulation 9 (1)

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 found examples of when do not attempt cardio-pulmonary resuscitation orders had not been completed or stored correctly. This was a breach of regulation 12 (2) (a) The hospital had not always ensured that staff managed infection control in line with best practice. This was a breach of regulation 12 (2) (h)

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;**

This section is primarily information for the provider

Requirement notices

We found that staff had not always reported safeguarding concerns in a timely manner.

This was a breach of regulation 13 (3)

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 hospital had not always operated effective systems for assessing, monitoring and improving care and treatment that was provided. The hospital did not operate an effective system to make sure that all policies were up to date, reflecting the most up to date guidance. This was a breach of regulation 17 (2) (a) The hospital had not always kept contemporaneous, up to date records for all patients. This was a breach of regulation 17 (2) (c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met;** The hospital had not always ensured that staff completed training courses in a timely manner. This was a breach of regulation 18 (2) (a)