Cestrian Court - Fresenius Kabi

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

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

Overall summary

There were two organisations registered with the Care Quality Commission under one parent organisation at the same address: Calea UK and the parent organisation Fresenius Kabi were registered as Cestrian Court. In practice this meant there was one board of directors and one senior management team shared across both organisations. The provider did not hold separate information for each organisation and therefore the information provided for the inspection covered both Calea UK and Fresenius Kabi. This included training statistics, policies and procedures, human resources information and governance and risk processes. Where the information is pertinent to Calea UK only this has been specified in the report.

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

Summary of findings

- There were systems in place for the reporting and investigation of safety incidents that were not fully understood by staff. The identification and recording of incidents was not clear as these were documented along with complaints.
- There was a lack of understanding and implementation of the duty of candour.
- The policies and procedures for safeguarding children were not robust.
- The majority of permanent staff and 42% of bank staff had completed safeguarding training for children; however this was to level two only and not the required level three.
- Patient records were completed both on paper and electronically. We observed and the provider's own audits had found that not all records were completed fully.
- Mandatory training rates were poor for bank staff at 54% completed.
- There was a lack of assessment and clarity of actions required for responding to patient risks.
- There was no audit programme in place.
- Policies and procedures were not always referenced and several key policies had been revised or come into effect immediately before the inspection.
- The clinical outcomes for patients were not measured.
- Not all staff had received an annual appraisal and there was no current formal supervision in place at the time of inspection.
- Not all staff competencies were consistently completed, therefore; we were not assured that staff had all the required skills.
- The six weekly field visits to assess staff competence were overdue for most staff.
- Patient's mental capacity was not formally documented and not all staff were aware of their responsibilities towards Mental Capacity Act and Deprivation of Liberty safeguards.
- Patients did not have individualised care plans relating to their clinical, social or emotional needs.
- There was a lack of robust governance processes.
- There were gaps in the controls for identified risks and the system for escalation of risks and forums for discussion were not clearly documented.
- The information obtained in order to appoint directors was not adequate to meet the fit and proper persons' regulation.
- If staff raised concerns they did not receive feedback.
- A staff survey showed some dissatisfaction with the communication within the organisation and nearly a third of staff did not feel valued by the organisation.

However we found the following areas of good practice:

- There was appropriate equipment to provide care and treatment for patients in their home.
- We observed staff following good hygiene practises when delivering care and treatment.
- The majority of permanent staff had completed mandatory training.
- There were vacancies across the service however bank staff were utilised to make staffing levels sufficient.
- Patients had access to a 24 hour helpline for support and guidance.
- Staff had access to information including protocols and care pathways.
- We observed that verbal consent was obtained prior to any care or treatment.
- Services were delivered by caring, committed and compassionate staff that treated people with dignity and respect.
- Patients were involved in decisions about their care and treatment and told us they were given adequate information before, during and after treatment.
- Staff provided emotional support to patients and recognised the importance of involving families or carers in their care.
- Staff assisted patients with a flexible service to ensure treatment was provided to include life events such as social outings and holidays.
- New patients were provided with a comprehensive welcome pack. This included a step by step guide of what to expect, frequently asked questions and useful contact details including the advice line.
- Patients had access to the helpline if they wished to raise a complaint.
- Staff of all levels were complimentary about their immediate line managers and the senior management team.
- We were told there was an open culture and staff were able to raise concerns freely.
- Procedures were in place to protect staff that were lone working.
- The results of an annual patient survey showed a high level of satisfaction.

Summary of findings

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 four requirement notices that affected Calea UK. Details are at the end of the report.

Summary of findings

Contents

Cestrian Court

Services we looked at

Community health services for adults (including reference to community health services for children and young people).

Summary of this inspection

Background to Cestrian Court - Fresenius Kabi

Fresenius Kabi Ltd. is a specialist community nursing service, which provides nursing training and clinical support to patients in their own homes in receipt of enteral nutritional therapies. They receive referrals from specialist clinicians and dieticians in NHS trusts and provide training for patients and/ or their carers either prior to discharge in hospital or following discharge in their own homes. They do not provide any additional nursing care or treatment to patients as where required this would be provided by NHS community nurses. They provide this service throughout England and Wales. For the purposes of this report, we have reviewed the service in England only, as our regulatory remit does not extend to Wales.

There are two organisations registered at the same address. Fresenius Kabi and Calea UK have been registered with the Care Quality Commission as Cestrian Court since 2 September 2011. There have been two inspections carried out at this service. The most recent inspection was carried out on 24 July 2013 (inspection report published 21 August 2013).

On the same day as we inspected Fresenius Kabi, a team of CQC inspectors inspected Calea UK. A separate report has been produced for that organisation.

Our inspection team

The team that inspected the service comprised one inspection manager, five CQC inspectors and one specialist advisor for governance.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive inspection programme for independent healthcare services.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection visit, the inspection team carried out visits to six patients' homes with two community nurses; we spoke with four patients face to face. At the head office we interviewed a range of managers, including one clinical account manager; one clinical business manager; one human resource manager; one senior professional development manager, who was also the advice line manager, a team leader and an administrator. We interviewed the nurse leadership team and we had a telephone interview with the Managing Director.

We observed how staff were caring for patients and carers during field visits and observed one discharge planning assessment at an NHS trust.

Summary of this inspection

We reviewed a range of policies, procedures, patient records, personnel records and other documents related to the running of the service. We also reviewed data and information provided by the organisation.

We have not provided ratings for this service. We have not rated this service, because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

What people who use the service say

During the inspection, we spoke with four patients and four relatives/carers, who were all positive about the care and treatment they had received from Fresenius Kabi services and staff. Patients told us the nurse visits helped them to feel safe and they described how nursing staff maintained good hygiene practises when delivering care. Patients felt support was readily available if they had any concerns; nurses were respectful and protected their dignity during care. Patients and their relatives felt informed and involved in choices about care.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- There were systems in place for the reporting and investigation of safety incidents that were not fully understood by staff. The identification and recording of incidents was not clear as these were documented along with complaints.
- There was a lack of understanding and implementation of the duty of candour. Since the inspection the provider has told us that duty of candour training and a clear process were implemented, through e-learning, to all field based nurses. However, they did not provide evidence of this for us to review.
- The policies and procedures for safeguarding children were not robust.
- Safeguarding training for permanent staff was at 96% completed for safeguarding adults training to level two and 94% safeguarding children to the same level. However, of the 117 bank nurses employed, only 52% had completed safeguarding adults training and 42% safeguarding children, both to level two.Following the inspection the provider has told us that additional safeguarding leads have been appointed and trained to level 4 for children. Level 3 safeguarding training was implemented for all staff. Bank nurses were suspended within 10 days of the inspection if the training was not completed. However, they did not provide the evidence for us to review
- Staff who delivered support to children had not completed paediatric life support training.
- Mandatory training rates were poor for ad hoc nursing staff at 53% completed. Following the inspection the provider told us that 64% of bank nurses had completed the training. The remaining 36% were suspended as they had not completed this training. The reduction of the bank nurse availability had not had not had any impact on the delivery of the service.
- There was a lack of assessment and clarity of actions required for responding to patient risks. Following the inspection the provider told us a risk assessment tool had been introduced and training was being implemented. However, they did not provide the evidence for us to review.

However;

Summary of this inspection

- There was appropriate equipment to provide care and treatment for patients in their home. The equipment was well maintained and tested to ensure its safety and effectiveness.
- We observed staff following good hygiene practises when delivering care and treatment.
- The majority of permanent staff had completed mandatory training.
- There were vacancies across the service however bank staff were utilised to make staffing levels sufficient.

Are services effective?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- Patients weight was documented however it was unclear as to where and when the weight had been performed. This meant it was difficult to assess whether patients had gained or lost weight accurately and therefore the effectiveness of the treatment provided.
- Not all staff had received their annual appraisal and there was no current formal supervision in place at the time of inspection. On average 71% of staff were up to date with their annual appraisal.
- The six weekly field visits to assess staff competence were overdue for most staff.
- Not all competencies for staff were consistently completed therefore we were not assured that they had all of the required skills or knowledge to complete their duties.
- Patient's mental capacity was not formally documented and not all staff were aware of their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS).

However

- Staff were able to access policies and procedures using their electronic hand held devices.
- Patients had access to a 24hour help line for support and guidance.
- Staff worked closely with the dietetics service and attended fortnightly meetings to discuss patients.
- We observed staff obtain verbal consent prior to care and treatment.

Summary of this inspection

Are services caring?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- Services were delivered by caring, committed and compassionate staff that treated people with dignity and respect.
- Patients were involved in decisions about their care and treatment and told us they were given adequate information before, during and after treatment.
- Staff provided emotional support to patients and recognised the importance of involving families or carers in their care.

Are services responsive?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- There were good working relationships with local hospitals to help understand the future needs for the service.
- Nurses we spoke with understood the need to consider any reasonable adjustments which may be required to accommodate a patient's needs.
- Nurses made every effort to visit within the agreed time for the patient and ensured the patient was informed if this was not possible.
- Patients spoke highly of the arrangements for the delivery of feeds which was efficient.
- Examples were shared of when staff had responded to a patient's individual need.
- Patients had access to information about how to complain and they could use the help line.

However

- Patients did not have individualised care plans relating to their clinical, social or emotional needs.

Are services well-led?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

- Staff other than senior managers were not aware of the vision and strategy for the service.

Summary of this inspection

- There was a lack of robust governance processes. This included a lack of reviews of policy standards, no discussion of quality or risk in the management team meetings and a lack of clarity of governance processes within the nursing services.
- There were gaps in the controls for identified risks and the system for escalation of risks and forums for discussion were not clearly documented.
- The information obtained in order to appoint directors was not adequate to meet the fit and proper persons' regulation.
- If staff raised concerns they did not receive feedback.
- A staff survey showed some dissatisfaction with the communication within the organisation and nearly a third of staff did not feel valued by the organisation.

However:

- There was a governance structure for the parent organisation of which Calea UK nursing services were a part.
- Staff of all levels were complimentary about their immediate line managers and the senior management team.
- We were told there was an open culture and staff were able to raise concerns freely.
- Procedures were in place to protect staff that were lone working.

Community health services for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health services for adults safe?

We have not provided ratings for this service. We have not rated this service, because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Safety performance

- Safety information, such as venous thromboembolisms and pressure ulcers, was not monitored by this provider. Other care providers, such as district nurses and home-care providers within the multi-disciplinary team, had the responsibility to obtain and monitor this information where it was applicable to the individual patient.

Incident reporting, learning and improvement

- Staff we spoke with told us any incidents were reported by the relevant NHS dietitian for that patient. For example, this included one case where a patient had not received their feed for three days. There was no documentation of this sharing of information, no feedback for the Fresenius Kabi nurses and no learning from these incidents.
- The provider had a policy which was titled: "Handling customer complaints". In this policy it was stated that the complaints officer should identify the appropriate complaint category, one of which was an incident. Reference was made to another policy for the management of incident reports which were received directly from an NHS trust. There was no procedure for the notification and management of incidents identified internally, unless they were raised as a complaint.
- There was no direction for staff as to what should be reported as an incident. Staff we spoke with told us they would report any change to the routine care and treatment a patient would receive via the internal helpline; however, they did not recognise this as reporting incidents. This included administration of enteral feeds which did not meet the prescription and incomplete administration of feeds.
- On requesting information from the provider about incidents, a database of information, which contained complaints, was provided. All entries on the database had a "complaint" number and a "complaint" description. Examples of these included medication errors, patient feeds not going through correctly and missed visits. As clinical incidents and complaints were recorded together on the same database, it was difficult to determine the difference in how complaints and incidents were managed. Nurses told us they would report such occurrences to their line manager or the community dietician, who would generate a report.
- There were no never events reported in the 12 months prior to the inspection. A 'never event' is a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers.
- There had been no serious incidents reported in the 12 months prior to this inspection.
- A draft process for triage of advice line reports was reviewed. This was a flow chart for the reporting and management of clinical incidents and complaints. This had been developed by the provider during the inspection.
- Staff told us they received emails which told them about changes to practice or reminded them about aspects of best practice. However, they were not always clear if this information had been generated as a result of learning from incidents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- We were provided with a policy relating to duty of candour, which was effective from the first day of our inspection: 27 March 2017. Although this was version two, the previous version had never been in circulation, as it was the same policy with a slight change to an appendix. This meant prior to the inspection there had been no policy in place for staff to refer to and ensure that the duty of candour was followed. The duty of candour regulation was introduced into legislation for providers of independent healthcare in April 2015 and there had been no measures put into place to attempt to meet this regulation for almost two years.
- In reviewing the duty of candour policy, we noted that it did not reference the complaints policy and vice versa. As a result, staff may be unable to correctly identify instances that would meet the threshold for the duty of candour and review the policy to ensure that the regulatory responsibility is discharged appropriately.
- Nurses we spoke with were not aware of the duty of candour policy or their role within its implementation.
- One complaint we reviewed had been classified as major. There was no evidence that duty of candour had been followed in the management of this complaint/ incident.

Safeguarding

- Safeguarding training for children was in place and provided for all staff, but it was provided to level two only. This included nurses working with children and managers who provided advice and support to other staff in the organisation. This was discussed with the registered manager during the inspection and immediate action was taken to provide staff with advice and support from an appropriately trained person from a nearby NHS trust. Additional training to level three for staff who provided care to adults and children was also identified and booked to be completed by the end of May 2017
- As of February 2017, 96% of permanent nursing staff had completed safeguarding adults training to level two and 94% safeguarding children to the same level. However, of the 117 bank nurses employed, only 52% had completed safeguarding adults training and 42% safeguarding children, both to level two.
- Whilst most nurses we spoke with were aware of how to identify a potential safeguarding concern, some were not clear about all issues they could encounter during their home visits, such as child sexual exploitation.
- Nurses told us they would report any concerns they had to the internal advice line and rely on them to pass the information to the necessary authorities. We saw examples where staff at the advice line had taken appropriate action to protect patients identified as being at risk, this included a concern raised by nursing staff regarding a patient with a mental health disorder, where follow up contact was made with the multi-agency safeguarding team. Appropriate procedures were followed to ensure patient safety.
- When nurses did inform the helpline about any concerns, they did not keep their own records of information provided and did not receive feedback about the actions taken. There was no record on the information we saw about how this information was passed to nurses making subsequent visits to the patient. This included concerns about a partner of a patient who refused entry for the nurses to complete the patient's care.
- The safeguarding policy we reviewed had become effective on the day of the inspection. We reviewed the previous policy. This policy, which came into effect on 27 March 2017, was identified as being the first issue of Standard Operating Procedure (SOP) Safeguarding Vulnerable Children. The policy included guidance for Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE). This previous policy had not contained the information required in the intercollegiate guidance "safeguarding children and young people: roles and competences for healthcare staff" (third edition March 2014).
- A generic service level agreement document we reviewed stated: "paediatric nurses will have had level 1 safeguarding training for children". This did not meet the intercollegiate guidance.
- At the announced inspection we raised a concern with the provider regarding staff working alone to provide visits to a vulnerable child, when they did not have the knowledge and skills to carry out this visit. During the inspection changes to these visits were made, which included introducing a multi-disciplinary approach.
- The safeguarding lead for the organisation was in the process of being changed at the time of the inspection. The safeguarding lead at the time reported to the head

of nursing and not directly to the organisations board. There was a board member appointed as the lead for safeguarding at that level; however, there was no mechanism for providing assurance to the board that safeguarding policies were being followed.

Medicines

- Nurses who provided the service for Fresenuis Kabi patients did not administer medicines to those patients.
- We saw during our inspection that staff documented and reviewed current medication taken by the patient.

Environment and equipment

- The equipment required to administer the feeds was delivered to the patient via an automatic stock checking system. This meant it was not reliant on nurses completing order forms and reduced the risk of human error.
- Following initial delivery, patients ordered their own products, for example feeds and tubing, and these were delivered at a convenient time. Patients spoke highly of the system for delivery of their nutritional feeds.
- Should there be any emergency situation, for example when feeds were required at short notice, there was then capacity to have them delivered the following day.
- Equipment had stickers present with dates for maintenance and all the equipment we saw was up to date at the time of the inspection, which indicated that it had been maintained as required. We saw this information was also documented within the five electronic records we reviewed.
- All equipment we saw, including pumps, were visibly clean. The pumps used had backup batteries in case of a power cut.
- The risk assessment process for the home environment was completed at the initial home visit and involved a tick box completion, which included pets, smokers within the home and whether the patient lived alone. We saw that this was not a thorough risk assessment process, as not all potential risks were identified, such as, the general cleanliness of the environment or personal safety of the staff.

Quality of records

- All records for patients were documented on internal electronic systems which were accessible to Fresenius Kabi nurses only. There were two systems running together, as a new system was introduced. For these patients there were no paper documents, therefore if the electronic system was not working, the nurses were then unable to record their visit contemporaneously or have access to information.
- There was one staff member in the office that supported nurses that used the new electronic system. They advised nurses and assisted them with any issues or concerns they had.
- Although records from other visiting professionals, such as district nurses, were present in the patient's home, these were not routinely reviewed by nurses from the provider on the visits we observed.
- Nurses relied on emails to contact each other about specific patients' care, including changes to visit times or patients' personal circumstances. These emails were shared using a secure network; however they were not copied to any manager and no record of them was kept. Nurses used this informal communication to pass on vital information, for which there was then no audit trail.

Cleanliness, infection control and hygiene

- Data provided showed that 83.7% of permanent staff had completed all aspects of infection control training, whereas; only 33.3% of bank nurses had completed the same training.
- Nurses were observed to follow the appropriate hand-washing technique in patients' homes and use hand gel appropriately.
- We observed that Personal Protective Equipment (PPE), such as sterile gloves and disposable aprons, were used as per protocol. Staff adhered to the 'arms bare below the elbow' protocol.

Mandatory training

- All mandatory training was delivered via e-learning and permanent staff had protected time to complete it.
- Mandatory training included key areas, such as: adult basic life support, consent and the mental capacity act, anaphylaxis management and personal safety. However, there were some areas not covered. For example, paediatric life support was not included, despite a service being provided to children. Also, there was no training for safe moving and handling. Managers told us that nurses did not move and handle patients, but we found that they may need to assist patients to be in the correct position for their treatment and thus had to move equipment around.

- Standard Operating Procedures were provided for adult and paediatric resuscitation, however; the paediatric document was in draft form only.
- Information provided showed that 95% of permanent staff across the Cestrian Court umbrella organisation had completed their mandatory training at the time of the inspection. However, only 53% of bank staff were up to date. Managers discussed the issues they had with bank staff completing this training and had introduced incentives to try and encourage them to complete it. Further strategies were being introduced, such as payment for their time spent completing this training.
- The lowest rates of completion of mandatory training for bank staff were for the subject of consent and mental capacity at 47%, adult basic life support at 60% and anaphylaxis management at 51%. This meant staff may not have up-to-date skills and knowledge in several key areas.
- Details of mandatory training for 16 registered agency nurses were provided. Records showed that three nurses had not completed medicines management training, four had not completed pharmacovigilance training and two had not completed either module. We were told that all nurses who were not going to be fully compliant by 10 April 2017 would not be offered further work.

Assessing and responding to patient risk

- There were a limited range of risk assessments completed by nurses from the service for patients in their care, which were focussed on environmental risks in patients' homes, rather than clinical issues. Nurses relied on other professionals from a multi-disciplinary approach to provide these and keep them informed. This included risks, such as: venous thrombo-embolism (VTE), pressure ulcers and risk of falls. Staff told us these risk assessments may be kept within the district nurse's notes in a patient's home; however, we saw that nurses did not always review these notes on arriving at the patient's home.
- Fresenius Kabi enteral nurses told us they would discuss any change or deterioration in a patient's condition with the patient's GP and the hospital dietitian or enteral nurse specialist at the hospital.
- There was no procedure for staff to follow should a patient's condition deteriorate. Nurses told us that a new system for assessing and responding to patient risk was currently being introduced. This was a traffic light system which would guide the nurse on the actions they should take.
- Nurses did not carry any equipment to monitor the condition of a patient, for example, to check their blood pressure. This meant they based their decision on whether or not to escalate a patient for review by the emergency services using their clinical judgement.

Staffing levels and caseload

- All nurses who provided visits for Fresenius Kabi and Calea patients were employed by Fresenius Kabi as the overarching company. This was stated in their contract of employment and the organisation was unable to separate the staff for each entity. Therefore we cannot state how many nurses worked for each registered provider. On 12 April 2017, there were 208 nurses employed, which included 21 vacancies. There were six nurses due to start employment in May 2017. In February 2017, there were 117 bank nurses employed.
- On 15 February 2017, there were 10,331 registered enteral homecare patients within the five regional directorates in the UK.
- A weekly capacity report was generated which provided information on the total number of patient visits made and the allocation of permanent, bank or agency nurses to those visits. Managers used this report to identify trends in any increased use of agency or bank staff and to inform the recruitment processes in each geographic directorate.
- Fresenius Kabi enteral nurses worked in small teams in geographic areas. One example was the North directorate, which had two full time and two part time nurses to cover Leeds and some patients who had a GP with a Leeds postcode.
- Nurses undertaking visits for Fresenius Kabi had a caseload which meant they completed four visits per day to provide enteral feeds. Nurses told us they managed their own caseload between them, arranging their own visits and communicating by email to arrange their work and their caseloads were manageable and they usually finished work on time and had their breaks from work during the day.
- There was no management oversight of this arrangement and therefore the nurses arranged their own work without a manager being aware of how this was done.

Community health services for adults

- Fresenius Kabi nurses worked in teams of four nurses who rotated between hospital and the community. These nurses rotated every four weeks, which meant patients had more continuity and the nurses could keep their skills and knowledge up-to-date whilst working in the hospitals.
- The nurses told us they would assist district nurses to change enteral feeding tubes. They worked flexibly with these nurses and had open communication to ensure this was done in a timely way.
- The resource planners were kept up-to-date with any changes to a patient's care by the visiting nurse or the helpline. This included changes to the visit times and they managed this when planning the schedule of visits for each individual nurse.

Managing anticipated risks

- There was a nursing contingency plan, which defined specific actions to be implemented in the event of an incident which may cause major disruption to patient's treatment. This included road closures, major epidemics and severe weather. This planning included discussions with the patient and carers to change infusion times and duration, alter a nurse's work pattern or refer to the discharging hospital to ensure patients received their prescribed nutrition.
- The risk of not being able to meet a growth in demand for patient visits was recognised by managers we spoke with. Actions to reduce this risk included the continued recruitment of permanent staff and the employment of bank staff to provide a large, flexible workforce.
- There was a policy statement in the employee handbook about lone working. This set out the nurses' and managers' responsibilities and the methods to summon help in an emergency and escalate any health and safety concerns.
- Lone worker devices were issued and staff told us and we saw that the system was efficient. Staff said it helped them to feel more protected in their working environment.

Are community health services for adults effective?

(for example, treatment is effective)

We have not provided ratings for this service. We have not rated this service, because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Evidence based care and treatment

- There were a range of standard operating procedures, which supported the nursing team. We reviewed some of these procedures and saw that the first issue was recent. One example was the infection prevention procedure which had been issued in August 2016. There was no record that before that date any other infection prevention procedure had been in place.
- Standard operating procedures were not in place for all required practices, such as escalation of a deteriorating patient or management of sepsis.
- The service was registered with the British Association for Parental and Enteral Nutrition. The managers told us they used guidance from this association for their procedures; however we saw no evidence of this on those we reviewed.
- There was no audit programme for Fresenius Kabi Ltd. No audits had been completed for this service. Following the inspection evidence was provided that an audit cycle had been put in place. This included audits with varying time cycles and several clinical and non-clinical subjects.
- In one area the nurses told us that they were working with other professionals from the local NHS trust, including dieticians, to develop a booklet of information for patients.

Pain relief

- Nurses did not provide pain relief to patients, but told us they would discuss with the patient how to get advice about appropriate management of pain.
- We observed nurses asked patients about their general wellbeing during visits and this included if they were experiencing pain.

Nutrition and hydration

- When patients attended outpatient clinics or dietitian appointments and their weight was checked, this was not recorded in the Fresenius Kabi patients' notes. Therefore, there was no record of whether the nutrition provided was effective for weight gain or maintenance.
- Nurses told us they did not weigh patients, as this was performed by the dietician and this was discussed with patients; however, this was not documented in the patients' records.
- When a weight was recorded on the Fresenius Kabi nursing record, this had been copied from other records, such as those from a hospital appointment. There was no record of when this was done, for example before the service was provided, or whilst the patient was still in hospital.

Technology and telemedicine

- The organisation provided a 24 hour advice line, which was for both patients and nurses. Either could ring with any queries about feeds, prescriptions, visits or changes in a patient's condition.
- Information was provided about advice line activity for January and February 2017. This showed that most calls were made in the early evening between 5pm and 6pm with the greatest number of calls about rota queries.
- The highest number of queries for the enteral service were related to accidental tube removal, followed by broken or damaged feeding tubes.
- The organisation was considering the possibility of phone consultations and use of smart phone technologies for patients in remote areas to promote flexibility and independence for patients, however; this was in the planning stages at the time of the inspection.

Patient outcomes

- Key performance indicators were not focused on the clinical outcomes for patients. The indicators recorded were around staffing capacity.
- There was no process to assess and monitor the clinical outcome of the service provided for the patient. The effect of the nutrition provided on the patient's nutritional status was not measured.
- There had been no delays in starting a patient's treatment in the community which had been caused by the provider in the last 12 months. This did not include delayed discharges from hospital that could change a patient's start date for treatment, as this was outside of their control.

Competent staff

- Annual appraisal rates for permanent staff indicated that on average 71% of staff were compliant across the business. The North region reported the highest compliance, with appraisals at 78.6%; in the South East, 82.5% of staff were compliant; the South West was 64.5% and the Midlands had the lowest compliance rate of 43.6%.
- The field visits, which included competence assessments, were not completed within the provider's timescale of six weeks for most staff. Information we reviewed, showed that in one geographical area there was no completion date of the next visit when the previous one was dated over 12 months ago. In another area, 20 visits of 28 were overdue. These visits should be completed by either their line manager or a practice development manager.
- Staff told us formal clinical supervision groups were due to start in April 2017.
- Two nurses we spoke with told us that they met as a team, which provided informal group supervision.
- We reviewed the competency assessment documentation for 10 nurses, which consisted of a total of 64 competency sheets. Of these, 11 were not signed by the trainee; however, all were signed by the trainer. Nine competency sheets were dated 2015. A total of 11 records were signed to indicate that the nurse was competent overall; however, for these nurses not all individual competencies were signed or documented as not applicable and some had been left blank. Some of these records had comments next to the specific task as not observed, but the nurse was still signed off as competent.
- One of the implications for nurses deemed to be competent in specific practices was that the electronic rota system allowed visits to then be allocated to those nurses. The rota planners told us that these nurses could be allocated to carry out practices, for which they had not been assessed as competent, to complete if they were deemed to be competent overall.
- We received the 10 most recent field visit check records. These included assessment of whether nurses were deemed competent, had development needs or if there were any shortfalls in the skills. Any improvements or changes from previous visits were also documented.
- For paediatric patients, a project focus group, made up of a clinical excellence manager, a paediatric team

leader, professional development managers and paediatric nurse advisors, met monthly. A paediatric study day was organised by the group in October 2016, that included specialist guest speakers, such as a paediatric gastroenterology consultant, dietician and pharmacist. The day also included workshops for dressing and pump competencies.

Multi-disciplinary working and coordinated care pathways

- The enteral nurses met with the lead dietician at the local NHS trust twice weekly. This provided a good opportunity for them to communicate informally and keep up to date with a specific patient's care and more general practice updates.
- Patients who were to receive enteral nutrition at home would be seen by the Fresenius Kabi nurse on their first visit. However, because these nurses worked in small teams with them caring for patients in hospital as well as their own homes, they were familiar with the patient's needs. They also worked closely with the dietitian at the hospital, who provided the information they required prior to their visits.
- One member of staff told us they attended an enteral and parenteral nutrition group six times per year.
- Nurses told us they attended fortnightly meetings with the dietitian at the hospital to review all the patients who received an enteral service in their own home.
- In the four patient electronic records we reviewed there was no documentation of communication with other health professionals, such as district nurses, dietitians or hospital specialists. However, staff had access to documentation completed by dieticians following review of enteral patients.
- During our visits with nurses we did not see them review patient's district nurse notes, even when these were present in the home. However, these patients were well known to the visiting nurse and were able to communicate any changes in their own care.

Referral, transfer, discharge and transition

- Patients were referred directly to the service by hospital specialists and dieticians.
- For enteral patients, the visits on the electronic patient record for the referring trust showed the patient consented verbally that information could be passed from the hospital to the provider.
- Prior to discharge of a paediatric patient, a multi-disciplinary team meeting took place at the referring NHS trust. The clinical account manager and paediatric nurse were part of the planning stage prior to discharge.
- We reviewed data provided by the organisation showing details of referral to treatment times. Forty four records confirmed there were no delays for patients commencing their treatment after they had been accepted by the service. Thirty three of these records indicated delay in referral to treatment as a result of hospital delay.
- We reviewed four service level agreements with NHS trusts. These contained details of the agreed referral and assessment procedures, but not information about discharge from the service or transition to another service.

Access to information

- The organisation's advice line was available to provide support, help and guidance to patients 24 hours per day. Patients were given the telephone number in their patient advice pack.
- Staff told us the main source of information for nurses was via emails and this included information about changes in a patient's condition and changes to visits. This was an informal system and did not have manager oversight and no central storage system for this information, some of which was about risk management.
- The provider's electronic system had the facility to flag certain important information about a patient. This could be clinical, social or environmental information, which all visiting nurses and resource planners needed to be aware of.
- There was no access to hospital medical records on the electronic patient records system. This included the patient's weight and blood results.
- The nurses were responsible for recording the information onto the electronic record and keeping these up to date. We observed that the most up to date information was not always on the electronic patient record and we observed one nurse had to document a patient's medication, as this had not been done at previous visits.
- Nurses were unable to access the policies and procedures for the organisation via their tablet computers. A project was ongoing to provide an IT

solution for them to access this information via an application. This was expected to be achieved by the end of April 2017. Following the inspection the provider told us this had been implemented.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training on the Mental Capacity Act as part of their mandatory training. Records provided showed that at the time of the inspection 82% of permanent staff had completed this training. However for bank nurses it was 39%.
- The consent form was electronic and stated that nurses would obtain verbal consent prior to each procedure, implied consent was defined and the right of the patient to refuse treatment was included.
- During our inspection we observed that verbal consent was obtained from all patients.
- There was inconsistent knowledge of the mental capacity act and their role within it from the nurses we spoke to. Some knew the basic concept of the act; however, none were aware of their role in assessing a patient's capacity if this was required. Following the inspection the provider told us mental capacity act training was added to the mandatory e-learning. However, no evidence was provided for us to review.
- Where patients had refused treatment there was no assessment of their mental capacity to understand the implications of their actions. Nurses and managers confirmed they did not assess or record a patient's capacity in such circumstances.

Are community health services for adults caring?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Compassionate care

- We observed that nurses were respectful to patients, carers and their families and understood the need to respect any wishes they may have about how care was delivered. Staff always knocked on the patient's internal doors to obtain consent for access.
- Nurses were compassionate and paid attention to the patient's comfort throughout procedures.
- Patients told us all the nurses who visited them were very friendly, caring and approachable.
- Although some patients had several nurses visiting them, they told us they were a "lovely team of nurses" and all were caring and patient.
- We saw that staff spoke to patients in a kind and caring manner, encouraging them positively to do what they could for themselves.
- There had been no patient survey for the patients receiving a service from Fresenius Kabi.

Understanding and involvement of patients and those close to them

- Patients were involved in their care during the procedure. For example, patients were asked where they wanted the equipment putting. One patient told us they had requested as little equipment as possible to make it less clinical in their home and this had been accommodated for them.
- Nurses asked about a patient's general wellbeing and health during their visits. If a patient had any issues or concerns, they were directed to an appropriate health practitioner.
- We saw that relatives and carers were supported to participate in care if they wished. The responsibility for providing care to a patient was shared with carers and relatives when they wanted to be part of the care giving team.
- We observed a carer to be well supported throughout a training session. Information and a demonstration was provided at the speed the patient and carer required.
- Should patients or carers decide they could not manage their own care, they were supported in this decision and care was provided as necessary.
- Pictorial guidance to assist a patient or carer following training was available on the internet. Patients were guided to this in order to provide additional support.
- Patients who had received training to manage their own enteral feeds had a follow up appointment every three months to assess their continued ability to manage their own care.
- If a patient had concerns about the enteral feeding tube, they would ring the nurses from their visiting team and if necessary they would request support from the referring hospital.

Community health services for adults

Emotional support

- Nurses we spoke with recognised the emotional impact of enteral nutrition and considered this when providing advice and support.
- Patients said staff on the advice line had assisted them by speaking slowly and clearly, keeping the patient calm and provided reassurance whilst their issue was resolved.
- Staff and patients told us they had time to spend longer on a visit if additional emotional support was needed and would signpost to the GP if required. Staff told us they were never rushed to finish their visit and we observed this during our inspection.

Are community health services for adults responsive to people's needs?
(for example, to feedback?)

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Planning and delivering services which meet people's needs

- The service managers had good links with the local hospital dieticians and specialist consultants. They used these relationships to discuss and understand the need for the services and future developments in their local area.

Equality and diversity

- The patient assessment process took account of the needs of different people, for example on the grounds of age, disability, gender, religion or belief.
- Part of the assessment would be to ensure the equipment required met the patient's specific needs. Any adaptations would be done in line with the discharging hospital, the patient and their carers.
- Nurses we spoke with understood the need to consider any reasonable adjustments, which may be required to accommodate a patient's needs.
- Nurses we spoke with could not provide any examples of where they had to change their practices to meet the cultural needs of patients.

Meeting the needs of people in vulnerable circumstances

- Patients told us the nurses had changed their planned work to give them additional support if their needs changed. This included patients who were unwell and nurses had stayed with them until medical help had arrived.
- Nurses we spoke with were unclear how they would access a translation service should they need it for any patient. They thought this could be done via the advice line. Nurses had used a search engine to find "the odd word" when necessary.
- Nurses we spoke with did not know if the patient information handbook could be accessed in languages other than English. However, we observed it was available in an 'easy read' version with more pictures and a larger font.
- There were no recorded plans of care which contained information about a patient's clinical, social or emotional situation, this may result in patients in vulnerable circumstances may not be identified or managed appropriately.
- Staff told us if there was no reply at a patient's home, the nurse would then contact the patient by phone. If there was no response they would contact the next of kin or other professionals involved in their care such as the dietitian or district nurses.

Access to the right care at the right time

- During the assessment of a patient to use the service the timings of visits was agreed with the patients. These visits were scheduled within a two hour timescale (visit window).
- In February 2017 there were 30 calls to the advice line about visits outside the two hour window. This represented 14% of the total calls. There had been no investigation into themes and trends of these issues
- Nurses made every effort to visit within the agreed window, however, they would ring ahead to inform patients if they were unable to visit at the planned times. If there were changes to a visit plan due to unforeseen circumstances, the resource planners would inform the patients.
- There was a team of office based staff who planned the resources to ensure all visits were provided by appropriately trained staff and were delivered within the agreed visit window.

- Patients, carers and staff could contact this team directly and discuss necessary changes to visit times to meet the needs of patients. This included planned or short notice changes to meet the social needs of patients.
- Patients and carers were informed of any changes to scheduled visits with as much notice as possible. They told us they knew the change of time, but were not always aware of which nurse would be visiting.
- If the request for enteral feeds was made by 3pm, there was a 48 hour turnaround to have the pump and feeds in place. This timescale did not include the first visit by the nurses, but was for delivery of the equipment.
- The length of time a feed took to be administered could be changed to make sure the disconnection visit was within the agreed window for the patient. Nurses tried, where possible, to adjust the delivery of the feed to meet the patient's needs.
- The four patients we spoke with were complimentary about the delivery drivers. They delivered within the agreed window of time and sent a text message to confirm before the delivery as a reminder.
- There was a named nurse system, which provided each patient with an identified lead nurse. This nurse was not responsible for providing every visit to the patient; however, they were their main point of contact to aid a smooth transition from hospital and promote continuity.

Learning from complaints and concerns

- There was a policy for the handling of customer complaints**.** This was for all complaints made against the organisation, including products and services, such as the community nursing service.
- There was no definition in the document of the level of competence of the staff member with responsibility for investigating the complaint. It was stated in the policy there would be a complaint investigation leader and a complaint officer. There was no clarity as to who would fulfil these roles.
- On the database provided, there were 11 complaints which had been recorded against the Fresenius Kabi nursing service in the six months prior to the inspection. Of these, seven were classified as major and three as minor. At the time of the inspection, three investigation reports had been approved and eight reports had not yet been completed.
- Seven of the upheld complaints made were regarding missed or delayed visits and rota changes.
- The complaint documentation we reviewed was not fully completed. We reviewed the files for five complaints. There was no copy of the final response in one file, for another there was an undated response and there was no written response to the complainant in another. There were no root cause analysis reports in any of the files.
- Complaints were discussed as part of the managers meetings and the monthly team meetings.
- Nurses told us when they were informed via email or the internal newsletter that changes had been made they were not made aware that this was due to the outcome of a complaint.
- Information about how to complain was provided in the patient information booklet. The handbook included details about how to contact the Freephone advice line, and details about how to give feedback to the company or independent bodies. The handbook was also available in an 'easy read' version with more pictures and a larger font. The complaint process, however; was not included in the handbook.
- Patients told us they would ring the advice line should they want to complain about the service. Patients, we spoke with, were generally very positive about their care. If nurses were expecting to be delayed, they contacted the patient to inform them. One patient had experienced a bank nurse who was consistently late and complained to the named nurse. This was escalated and the nurse did not return to the patient.

Are community health services for adults well-led?

We have not provided ratings for this service. We have not rated this service because we do not currently have a legal duty to rate this type of service or the regulated activities which it provides.

Leadership of this service

- The leadership was the same for both organisations within Cestrian Court. There was an operations manager for patient services, with a business unit director and head of nursing as the senior management team. The nurses were led by directorate business managers who had responsibility for clinical account managers and

regional nurse managers. There were team leaders who also had nurses directly reporting to them. This structure meant there was local management support in the community for the nurses who were working remotely as, well as senior managers. There were also opportunities for staff to progress within the leadership team.

- There were specific managers who liaised with the hospitals to facilitate a safe and timely discharge for patients who were having either training to deliver their own feeds or having them provided by a community nurse. These managers worked as part of a multi-disciplinary team for discharge and offered support and leadership to the community nurses. Those we spoke with had a good knowledge of both the hospital and community systems.
- Staff of all grades told us their managers were very supportive, approachable and helpful. Examples were given where support had been provided, such as returning to work following illness, being able to discuss a heavy workload and obtain support to reduce it.
- Nurses told us they felt valued and had good peer support within their teams. Team meetings took place on a monthly basis and nurses attended these if they were able. They told us they received the minutes via email if they were unable to attend.
- The managers we spoke with showed a good understanding of their own teams and how they worked together.
- Although nurses were home based, they said their managers were always easily contactable.
- One nurse told us that if they needed to speak to a senior member of staff, other than their manager, they could speak to one of the other manager, including the clinical business manager.
- The rota planning team had developed some strategies to improve their team working. These included a weekly presentation by the team manager to look at any issues which had occurred and discuss ways to improve or celebrate a successful week.
- Nurses discussed there were opportunities to progress within the organisation and felt enabled to apply for management posts if they became available.
- Ways in which team working was encouraged was to develop ways of staff working across the directorates. This was discussed at the November nurse leadership meeting.

Service vision and strategy

- Managers told us the vision for the service was to improve the life of patient's in their care. The way this was to be achieved was documented in the overarching "game plan." The 2017 "game plan" had four strategic objectives, which were underpinned by projects and initiatives. This was separated into divisional game plans for example the nurses' game plan. This identified the business objectives for the nursing services and detailed the nursing projects to deliver this plan within an agreed timescale.
- The objectives and game plan were discussed at the directorate management meetings in February 2017. We saw this included how the various categories and personal objectives for individuals would be managed.
- Nurses we spoke with had a varied understanding of the vision and strategy for the service. The majority were not aware of what the strategy was, whilst others told us it was the same as the organisation's values.

Governance, risk management and quality measurement

- There was a governance structure, which provided a platform for sharing of information between the various divisions of the company and across the geographic directorates. The heads of services had met bi-monthly since 2016. The senior management team met twice yearly at a discussion forum and there were monthly management team meetings and geographical directorate meetings for the nursing services.
- Despite this structure, there was a lack of a robust quality assurance framework. One example was there was no retrospective review of compliance against policy standards, such as the duty of candour or the fit and proper person requirements.
- The recruitment of directors did not meet the fit and proper person's requirements. Three executive files were reviewed. There were no DBS checks, no annual declarations of fitness and no disqualified director and insolvency checks in all three files. Managers confirmed these had not been done. Although confirmation of identity was present in all three files managers confirmed this had not been obtained at the time of their appointment.
- There was no record of a discussion of the quality of the service or the risk register in the senior management team meeting minutes we saw. We reviewed the

minutes of three meetings of the board of directors and four for the executive management team. There was reference to the risks to the service in the executive team agenda; however, there were no minutes for this part of the meeting. Following the inspection the provider told us the nursing risk register was reviewed in the monthly leadership meetings. It was also a mandatory agenda item on all executive management meetings.

- Governance meetings did not always take place in a timely way or in line with the agreed strategy. Clinical governance meetings had taken place in February, May and December 2016. The minutes from the February meeting stated the last recorded meeting was in 2014. It was documented in the minutes of the February 2016 meeting that quarterly meetings had been set up; however three meetings took place and not four in 2016.
- The organisations approach to the identification, management and mitigation of risk was documented in the Quality risk management policy. This policy had become effective in August 2016. The method for allocating a risk priority number was included; however, there was no reference to the forums in which risks were discussed and how assurance was provided to the board.
- There was no documentation of a periodic review of the risk registers. Managers we spoke with told us this was work in progress to identify how and where this should be discussed and recorded.
- Cestrian Court submitted their strategic risk register dated December 2016. This was applicable to all services provided by Fresenius Kabi Limited and Calea UK Ltd. The risk register contained four risks, of which two were rated 'low' and two were rated 'trivial'.
- Where there was a gap in the control for the risk, there was no action to mitigate this recorded on the register. This included the risk of missed treatments through the hard copy prescription not being available in a patient's home. The control was to have electronic prescriptions on the hand held tablet devices; however, there was a delay in this system being implemented and no control for this delay was in place. Managers agreed there were gaps in the control measures.
- We saw that in practice the recorded control measures were not always adequate. The risk of gaps in training and competency records for enteral nurses was to be managed by the six weekly field visits. However, records we saw showed these visits were not taking place six weekly and for some nurses they were several months between visits.
- Managers we spoke with agreed the assessments of risk within the nursing service may not be adequate as there was a lack of a specific risk assessment tool. We were told this would be reviewed following the inspection.
- The key performance indicator dashboard for the service was a capacity report. This gave information for the activity within the service, but did not measure the quality of the service provided.
- The monthly reports which had been developed from the advice line activity did have some quality indicators. These included visits being made on time, equipment failures and clinical reasons for calls. This report was under development and the advice line team had started working with quality assurance to ensure the information collected could be used to improve the service.

Culture within this service

- Staff we spoke with said they felt respected by their immediate line managers and the senior management team.
- Staff of all grades described an open culture, where they felt able to raise concerns and felt assured that appropriate action would be taken. However they told us they did not always get feedback if they raised issues.
- The discharging hospital retained the overall responsibility for patients. This resulted in a culture of reliance on those hospitals to manage the overall care for that patient. One example of this was nurses not being involved in assessing risks for patients as they saw themselves as having a smaller role in their care than other community teams. Some nurses stated they felt deskilled by this approach.
- There was a policy statement in the employee handbook about lone working. This set out the nurses' and managers' responsibilities and the methods to summon help in an emergency and escalate any health and safety concerns.
- Lone worker devices were issued and staff told us and we saw that the system was efficient. Staff said it helped them to feel more protected in their working environment.

- There were processes in place to protect the wellbeing of staff and they told us it was a good organisation to work for with regard to the terms and conditions of employment.
- All staff we observed and spoke with had patient care at the focus of what they did. They spoke passionately about how they could discuss improvements within individuals' care or in the systems of working and felt listened to by managers.
- There was a culture of promoting patient independence with the support of staff and appropriate training, but there was a recognition that this may not be suitable for all patients.

Public engagement

- A questionnaire for patients receiving this service had been developed for use in 2017. This had not been distributed at the time of the inspection. The survey included questions about the hospital service, including the dieticians, the homecare nursing service and the delivery of equipment and feeds.
- Patients and carers were actively involved in their own care and the decisions about how it was to be delivered
- Examples were given by patients of how they had been consulted about their individual care delivery; however, they were unable to say how they had been involved in wider decisions within the service.

Staff engagement

- Several staff meetings were held on a regular basis. These included regional nurse manager meetings monthly and geographical directorate meetings every quarter.
- The minutes of the directorate managers meeting included discussions about how to involve nurses in setting objectives for the coming year and their participation in specialist groups.
- Much communication with staff was via email and staff told us this worked well.
- Every three to four months nurses and other staff in the enteral service held a meeting where an external speaker was invited. They told us this was very useful and the content was led by them.
- A staff survey for the nurses had been completed in 2016. This included questions about the effectiveness of communication and how valued staff were. 63% of nurses thought communication was effective in the wider community; however, this was lower within the directorates with the lowest being in the Midlands at 35%.
- There were 69% of staff who felt valued by the organisation.
- Managers told us this survey had shown nurses were most dissatisfied with their role in participating in the advice line. As a result a specific team of nurses had been employed for this role, instead of community nurses being expected to rotate into this role.
- An employee forum was in place and through feedback cards and meetings via employee champions staff were enabled to make suggestions, present ideas and feedback to reach the right person.
- There was a company reward and recognition scheme. There were monthly nominations for staff for each of the six core company values, in each directorate with the winners receiving certificates and vouchers presented at directorate meetings.

Innovation, improvement and sustainability

- The minutes we reviewed from the directorate managers meeting and the regional nurse managers meeting did not have any items regarding innovation and sustainability. They did have areas for improvement of the service, which included specific work streams to improve clinical outcomes and communication.
- The organisation was exploring the possibilities of expanding services for oncology patients; however, this project is currently at an early research and pilot phase.
- A project to utilise telehealth in the organisations was being explored. This project had not been approved at the time of the inspection.
- Managers discussed how they worked for continuous improvement of the service; however, we found a lack of understanding of the current clinical outcomes for patient's and therefore saw no clear direction for innovation or improvement of services. The focus was on expansion of the business and some staff we spoke with thought this was the future plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that appointment procedures for directors include checks that they are fit and proper persons for that role.
- Ensure there is a clear policy in place for the management of incidents.
- Ensure that safeguarding policies and procedures are in place to protect children and adults who use the service from abuse and improper treatment.
- Ensure that all staff that provide care and treatment to children are adequately trained to protect them from abuse and improper treatment.
- Ensure that a lead for safeguarding within the organisation has appropriate skills and knowledge.
- Ensure that staff have the skills and competence to carry out their duties.
- Mandatory training should be up to date for all staff including those employed on an ad hoc basis.
- Ensure that systems and processes are in place to assess, monitor and improve the quality of the service provided.
- Ensure that systems and processes are in place to assess and mitigate risks to users of the service.
- Ensure systems and processes are in place to act in an open and transparent way with users of the service.

Action the provider SHOULD take to improve

- The provider should develop a system to identify and record incidents as separate to complaints.
- Staff should complete patient's records accurately.
- Patients should have clinical and environmental risks assessed. This should be documented and actions taken to mitigate those risks.
- Policies and procedures should be reviewed and kept up to date with relevant guidance.
- The provider should develop a procedure to assess a patient's mental capacity when this was required.
- Patients should have individualised plans of care.
- The provider should share the vision and strategy for the service with staff of all grades.
- Staff should receive feedback if they raised any concerns.
- The provider should consider how to improve communication with staff across the organisation
- The provider should develop the engagement with staff and patients regarding the service delivery and improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors Appointment procedures for directors were not effective. The provider had not ensured all directors were of good character, had the qualifications, skills, competence or experience or were able to properly perform their tasks by reasons of their health. The provider had not ensured the directors had been responsible for mismanagement in any regulated activity and had not ensured they had any grounds for unfitness specified in Part 1 and 2 of schedule 4. This was a breach of regulation 5 (1)(2)(3)(4)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding procedures were not effective. The provider had not ensured staff who delivered care to children were adequately trained in safeguarding. The policy and procedures for safeguarding did not include the latest guidance for child protection. There was no lead person for safeguarding who was adequately trained to complete this role. This was a breach of regulation 13 (1)(2)(3)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems and processes did not enable the registered person to assess, monitor and improve the quality of the service provided. The systems and processes did not enable the provider to assess, monitor and mitigate the risks relating to the health, welfare and safety of service users. There was no policy or procedure for managing incidents. This was a breach of regulation 17 (1)(2)(a)(b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The systems and processes for the supervision and assessment of the competence of staff did not ensure they had the knowledge and skills required to carry out their duties. Staff who provided care and treatment to children had not completed paediatric life support training. Bank staff were not up to date with their mandatory training. This was a breach of Regulation 18 (1)(2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The systems and processes had not ensured the provider acted in an open and transparent way with relevant persons in relation to care and treatment.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 20 (1)(2)(3)(4)(7)