All Hallows Healthcare Trust

# All Hallows Hospital

## Inspection report

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27 October 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This inspection took place on 11 and 27 October 2016. The inspection of 11 October was announced and the second inspection took place within a stated timescale.

The service provides long term care for up to 16 people with complex nursing and care needs. It also provides rehabilitation services and end of life care.

The service has a condition of registration to have a manager registered to manage the service. The registered manager resigned after our first inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

All Hallows Hospital is a permanent home to some people with complex health needs. The culture of the service did not reflect this. Care was provided in respect of healthcare but did not always take account of the whole person. Staff were generally caring but systems and practices had not been developed to reflect the nature of the service provided.

Risk management and quality assurance processes were not implemented effectively to ensure people received safe care and treatment. The monitoring of medicines had failed to identify that nursing and care staff were not effectively recording when medicines had been given, meaning that we could not be sure that

medicines had been given as prescribed. We were given an example when a person had not received the percutaneous endoscopic gastronomy feed (PEG) as required. Staff did not demonstrate an understanding of the importance of effective recording. Following our first inspection the service had taken steps to address this issue but recording was still not being carried out effectively on our second inspection. Risk assessments did not contain sufficient detail to enable staff to effectively manage risk and were not always reviewed regularly to ensure they met people's changing needs.

People had mixed views as to whether there were sufficient staff available to meet their needs. We were given two different methods of how the provider was planning staffing levels. One method was based on capacity and the other on dependency. This did not assure us that the provider was ensuring there were adequate staff available to meet people's needs.

People told us that the food was good and that they received a choice of what they wanted. However, we found that people with PEG feeds did not always have their intake monitored. People's nutritional needs were not effectively assessed in relation to conditions they may live with such as diabetes.

Staff training and competency was not effectively monitored. Following our first inspection the provider had put procedures in place to monitor staff training but this was still a work in progress on our second inspection. This meant that we were not assured that staff had received the appropriate training and competency checks.

The service did not carry out an assessment of people's care and support needs before they began providing care. Care plans did not reflect the needs of people receiving care and support. People receiving end of life care did not have sufficient detail in their care plans to ensure their preferences were met regarding how they received their care and support. People receiving rehabilitation did not have their condition assessed and their goals addressed before receiving care and support. Care plans contained contradictions and actions assessed as necessary were not always being carried out.

People's social support was not related to their nursing and care support. Care staff were not provided with the background, hobbies and interests of the people they supported. However, an enthusiastic activities co-ordinator, supported by active voluntary group provided a variety of social interactions.

The governance framework in place was not effective and was not used to drive improvement. It was difficult to determine how the provider had planned services to meet the needs of people admitted for rehabilitation and end of life care. There was no clear rationale or model of care for the services provided.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Records did not demonstrate that people had received their medicines as prescribed.

Risks were not assessed and managed to ensure people received their care and support safely.

Staffing levels were not assessed to ensure that there were sufficient staff on duty to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

People's dietary needs were not identified. Their fluid intake was not monitored effectively.

Staff training was not effectively monitored.

Staff sought people's consent before providing care and support.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

End of life care was not planned to ensure people's preferences and choices were clearly recorded and acted upon.

People were supported with their religious needs.

People were encouraged to be as independent as possible.

### Is the service responsive?

**Inadequate**

The service was not responsive.

Care plans did not reflect people's full care and support needs. They contained contradictions about what support people required

Care provision had become compartmentalised. The culture of the service did not recognise the needs of the whole person.

The activities co-ordinator provided support for people's preferred activities and social engagement.

There was a complaints procedure.

## Is the service well-led?

**Inadequate**

The service was very poorly led.

The service vision and values had not been developed to meet the needs of the people it supported.

Systems and processes for monitoring the quality of the provision were not effective and this had not been recognised by the management team.

There was no clear direction, ownership or clinical oversight of the service.

# All Hallows Hospital

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 and 27 October 2016. The first visit was announced and the second visit was carried out within a specified timescale.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of inspecting adult social care services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service.

During the inspection we spoke with five people using the service and seven relatives. We also spoke with 14 members of staff; this included the chief executive, the registered manager who resigned during our inspection, the acting manager who took over when the registered manager resigned, five nurses, four care staff, a physiotherapist and the activities co-ordinator.

We looked at seven people's care records and records relating to the management of the service. These included policies and procedures, audits and quality assurance reports, training records and staff records.

We carried out observations of the care and support provided throughout the day.

Inadequate

# Is the service safe?

## Our findings

Our first visit to the service found medicines were not stored safely. There were unsecured emergency medicines left on the top of the resuscitation trolley and the trolley itself was not locked. This was a risk because people could access these medicines. Checks of the resuscitation trolley were also not undertaken regularly we found six occasions where weekly checks had not been carried out since January 2016. The lack of checks could have resulted in insufficient medicines or out dated medicines. We sent a letter to the service detailing our concerns. On our second visit the service had addressed these concerns but we identified further failings in the management of medicines.

An audit carried out by the service dated 1 to 30 September 2016 identified 18 omissions on the medicines administration record (MAR) in September. An audit dated October 2016 identified 43 omissions on the MAR records for October. We asked a member of nursing staff about the omissions. They did not display concern about the omissions telling us, "I know they have been given." However, they were unable to explain how they knew the medicines had been given to people. We spoke with the acting manager who had taken over when the registered manager resigned after our initial visit. They told us that they had instigated the audit, that they had spoken with staff following the initial audit and would follow up with disciplinary action if omissions continued. Medicines which had not been recorded as given included analgesia, diuretics and condition specific medicines. Furthermore, we found, from a review of eight MAR charts reviewed during our second inspection, that 50% of these records contained one or more medicines omissions. Although we were assured medication had been provided staff could not demonstrate this or that monitoring was in place which would check the potential effects of missed medication.

Risk management policies and procedures were not followed to ensure people were protected from harm. We looked at care plans for two people who had been identified as at risk as they required the use of moving and handling equipment. One risk assessment was dated 26 November 2011. It had been reviewed on 3 December 2011 and 15 March 2012. No further reviews of this risk assessment were recorded. This risk assessment stated, 'To assess daily how [person] will react to the use of the stand aid. If behaviour highly aroused do not use. Consider hoist and sling or allow to rest in room on mattress with one to one care.' The care plan in another section stated, 'Uses stand aid or full hoist and sling.' There was no guidance for staff as to exactly what behaviour constituted 'highly aroused' and when the decision should be taken to use a sling instead of a stand aid or when the person should be left in their room.

The moving and handling risk assessment for the second person stated that they had reduced mobility due to obesity. The last, undated, entry on their risk assessment stated 'Frame plus one – two with sara steady, depending on the day.' There was no guidance as to when the person would require one or two care staff to support.

We looked at care plans for two people who had been identified as requiring bedrails for their safety. We found these care plans did not contain suitable and sufficient risk assessments to effectively manage this risk. The assessments did not contain any of the checks recommended in the Medicines and Healthcare Products Regulatory Agency guidance. This could lead to these people receiving unsafe or inappropriate

care.

Risk assessments were not updated regularly to ensure they met the needs of the person. We were looking through one person's care plan with a member of the nursing staff. We queried the risk assessment with them. The member of staff proceeded to update the risk assessment stating that most of what was documented was no longer relevant. People are at risk of receiving unsafe care if care plans do not adequately assess risks and demonstrate the procedures put in place to mitigate the risk and provide guidance for staff on these procedures.

This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 - Safe care and treatment.

Our first visit identified that the public could access a gym by passing through parts of the service where people were receiving care and support. This could compromise people's safety with members of the public accessing the service. On our second visit the service had put in security measures with people using the gym required to sign in at reception and being supervised by a member of the physiotherapy team whilst using the gym. The acting manager also advised that only people previously receiving care and support from All Hallows Hospital were allowed to use the gym. This provided us with reassurance that people were safe from unauthorised people accessing the service. However we remain concerned that the provision of this service is based in people's permanent home and the provider had not fully considered the potential implications of this.

People and their relatives had mixed views as to whether there were sufficient staff to keep people safe and meet their needs. One person said, "I feel safe, if I ring my bell they come quickly, they have been very kind." Another person, when asked how quickly staff responded to their buzzer replied, "Quick, but not always, it is OK." One person expressed concerns about the staff available to support them in the morning. They said, "Mornings are the busiest but they are alright but I have soiled the bed. There are times when I feel it is too lonely, they come and answer the bell and say we are dealing with another patient but will get to you as soon as possible, evenings are OK." A relative told us, "They have difficulty in retaining staff; they use a lot of nursing and care staff from agency who don't have the knowledge of the residents." This person also went on to tell us they had had to go and find staff when people's alarms were sounding for 20 minutes or more with no response from staff. The registered manager told us that they did use agency staff but tried to use regular staff so that they got to know people's needs.

Following our first visit the provider had supplied us with information on staffing levels. This showed that staffing levels were assessed against occupied beds and was 'occasionally reviewed at informal fortnightly registered managers' meeting with the Head of Human Resources'. However, on the day of our second visit the acting manager told us that staffing levels were assessed using people's dependency levels. They were unable to demonstrate when staffing levels had been adjusted due to a change in dependency levels. They told us this was because the number of people using the service on the day of our inspection they were overstaffed according to their staffing tool. This contradiction did not reassure us that the service was providing sufficient numbers of staff to keep people safe and meet their needs.

People told us they felt safe living in the service. One person said, "Happy, feel safe, staff kind." Another person said, "I feel safe as there is always someone on the premises and they try to do their best, nurses are always about." However on our first visit the service was unable to provide details of safeguarding training undertaken by staff. We have subsequently been told by the service that all staff attend safeguarding training annually. Staff we spoke with were able to describe what constituted abuse tell us how they would report abuse. Our records show that the service has made two safeguarding notifications to CQC in the last

year.

The service carried out relevant checks to ensure that staff it employs are of good character and suitable to work in the service. Checks were also carried out to ensure that staff with professional qualifications are appropriately registered.

Requires Improvement

# Is the service effective?

## Our findings

People told us that the food was good. One person said, "Food is lovely, I like the homemade Cornish pasties, the food is really good. Breakfast they leave you until you want to get up, they leave it to you." A relative told us, "[Relative] likes tinned mackerel so they got some in, they also got lamb mint burgers in, it is pureed but still attractive."

However, people's nutritional needs were not always identified, monitored and managed. The care plan for one person stated that they lived with Type II diabetes, and obesity. The person had been admitted to the service on 23 August 2016. Between this date and our inspection the person, had put on weight, approximately 17kgs. On the day of our inspection they had chocolate pudding and white sauce as part of their lunch, this food is high in calories. The section of the care plan entitled 'Eating and Drinking' had recorded on 20 October 2016, weight had increased. There were no further details of action that had been taken to address this. The lack of a care plan for this person regarding their nutritional needs relating to their obesity had resulted in an exacerbation of this condition because they had gained weight and could also have a serious impact on their other conditions and recovery.

Relatives expressed concerns to us that people with percutaneous endoscopic gastronomy (PEG) feeds did not have their fluid intake recorded correctly. One relative said, "Paperwork, fluid recording is up and down. I look and it is not always being written up and quite often they say [relative] has had thickened fluids but it has not been written up." Another relative said, "It needs improvement, record keeping is not very good. The dietician recommended 1900 mls daily but according to the records not always being met." Another relative told us, "It could be poor record keeping, but I know for a fact that a PEG feed a month ago was missed, the extra bag was on the shelf and not used. I challenged the nurse she said sorry." We asked a member of nursing staff how people's fluid intake was recorded. They showed us fluid recording charts in people's rooms which were not fully completed and were not totalled. They were unable to tell us how these records were used to monitor people's fluid intake. They went on to tell us that people with PEG feeds had their fluids recorded and were totalled on the medicines records. We looked at these and found that this was the case. However, due to the concerns recorded earlier in this report regarding missed medicines and fluid charts in people's rooms not being totalled we are not assured that people's fluid intake was being monitored effectively and therefore people may not be receiving the fluid intake they required and be at risk of dehydration.

This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 14 – Meeting nutritional and hydration needs.

On our first inspection visit the service was unable to produce accurate details of staff training or competency checks. The service has subsequently supplied a record of the training staff had undertaken. However, this information was supplied with the caveat that it was, "A work in progress and reviewed as a result of the last inspection 2 weeks ago." This lack of up to date and effective record keeping did not reassure us that staff had received up to date training relevant to their role which equipped them to care and support people effectively.

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The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The acting manager was aware of the DoLS authorisations in place and when these needed to be reviewed.

People told us that staff obtained their consent before providing care and support. We observed a member of care staff knock on a person's door and call out, "Hello [person], going to help you get up now, what would you like to wear today, the brown shirt and white blouse?"

People were supported to maintain good health and had access to healthcare services to receive on-going healthcare and support. We spoke with a visiting GP who told us that their practice carried out a daily 'ward round' in the service. They said the service made prompt referrals and took any actions they suggested. People told us that they received support from other healthcare professionals such as chiropodist and optician when required. Leaflets about maintaining good health, including diet, were available in the service.

Requires Improvement

# Is the service caring?

## Our findings

Palliative Care is provided to terminally ill people and end of life care is provided when people reach the final days or hours of their lives. Three members of staff could not confidently talk about what support was in place for people at the end of their lives. We looked at the care plans for a person receiving end of life care and a person receiving palliative care. Neither made any reference to the person's end of life wishes being discussed with them or their family and there was no emphasis on how their quality of life was being maintained during their time at All Hallows Hospital. In addition both had a daily care plan left blank with a strike through with the wording 'unsuitable as end of life patient'. The lack of information meant we could not be assured staff were taking the appropriate action (in the final days and hours of a person's life) to ensure people were receiving care to make them comfortable, pain free and respected their wishes. Managers confirmed that staff training was planned for end of life care to include effective care planning.

Despite these concerns people told us that staff treated them with kindness and compassion. One person said, "If I say I am cold they attend to it and say do you want a blanket, do you want something warmer to wear?" We observed care staff showing concern for people's wellbeing and taking practical action to relieve any distress. When one person wanted to wear a shirt which was still in at the laundry, the carer went to retrieve it for them. We observed a member of care staff speaking with a person. They said, "[Person] it is [carer], have you still got a headache, how are you feeling?" This was a positive interaction with the member of care staff making eye contact with the person.

The service had a chapel attached; we spoke with the Lay Chaplin. They told us that they held regular services in the chapel, this included a bereavement service where the names of people who had died were read out. They also told us that the chapel was used every Sunday for Holy Communion and that blessings and Communion were carried out in people's rooms if required. Other religious denominations also visited and supported people with their religious needs. One person told us that their relative received a blessing every Sunday. This gave people the opportunities to practice their faith and receive additional support.

People told us that their views regarding how their care and support were listened to. One person said, "Think I am listened to and if they can get something for me they do, like a cup of tea for instance."

The service held a Long Stay Patients Forum every six months where people and relatives could raise any issues. Meetings were attended by the Chief Executive, the registered manager and other support staff from the service. A relative told us that the purchase of outdoor furniture for the service garden had been raised at this meeting and that this had subsequently been provided. Another relative said, "We have a regular patient/relative forum, lots of discussion, views are always listened to, taken down in minutes and generally worked on. I can say exactly what I want. I am [relatives] voice and I am respected for that."

Some of the practices and language used by staff were outdated and had not been fully considered. For example All Hallows Hospital is a permanent home to some people and therefore being referred to as a 'Long Stay Patient' did not accurately reflect the service being provided to them. We found that whilst there were significant and complex healthcare needs for some people, this was described in healthcare terms only

and did not always take account of the whole person. Although generally staff were described as caring some of the systems and culture had not been considered to ensure it was still appropriate and reflective of the service provided .

People were encouraged to be as independent as possible. One person said, "When I came in I could not walk, they gave me time to settle…now I can walk with my walker." Another person said, "I watch TV in my room and sometimes I go down to the lounge, my choice where I go." We observed this person navigate their electric chair out of their room and into the corridor where they stayed for a while watching the comings and goings and was encouraged by a member of care staff to go to the lounge where they joined other people.

Staff respected people's privacy and dignity. One person said, "They always knock and ask if it is alright to come in. They always tell me what they are going to do, they are caring." A relative said, "They allow time for our privacy but are still in and out checking on [person]."

Inadequate

# Is the service responsive?

## Our findings

The service did not carry out a full assessment of people before providing care and support. Five care plans inspected contained no pre-admission assessment detailing people's needs. Two senior staff who were responsible for the admission of people into the service said that there was no formal admission assessment procedure before admission. They told us that if a person was being admitted from hospital there was no time allowed to visit the person and carry out a full assessment of their needs. They said that a verbal handover on the telephone was acceptable. They also told us that the service would take people they could, "Cope with." This was contrary to the service Statement of Purpose of which said, "To meet assessed needs through the care we provide being based on thorough admission and assessment processes, the systemic, on-going planning of person-centre care plans, risk assessments, appropriate equipment and records/documentation." Without a needs assessment the service could not be assured that they could meet people's needs safely and effectively.

Some of the practices and language used by staff were outdated and had not been fully considered. For example All Hallows Hospital is a permenant home to some people and therefore being referred to as a 'Long Stay Patient' did not accurately reflect the service being provided to them. We found that whilst there were significant and complex healthcare needs for some people, this was described in healthcare terms only and did not always take account of the whole person. Although generally staff were described as caring some of the systems and culture had not been considered to ensure it was still appropriate and reflective of the service provided.

Care plans did not guide staff on people's care and support needs. This put people at risk of inappropriate care. For example the care plan for a person who had been admitted for rehabilitation contained no assessment of the abilities of the person when they were admitted, an explanation and plan of what rehabilitation would take place, and what the objectives of rehabilitation would achieve. Senior staff we spoke with told us that it was not usual procedure to carry out an assessment of this type, again this was contrary to the service Statement of Purpose.

The care plan for this person also stated under a heading 'Other Diagnosis, operations, etc. (PMH)' that the person lived with Type II diabetes, hypothyroidism, asthma, chronic kidney disease, chronic obstructive airway disease, sleep apnoea, anaemia and obesity. There was no care plan in place showing how this person would be supported to manage these conditions whilst they were receiving their rehabilitation. As previously mentioned in this report the lack of a care plan for diabetes and obesity had resulted in an exacerbation of the obesity. This care plan also recorded in the section 'elimination identified needs' that the person was prone to constipation and UTI's. There was no explanation as to how these could be prevented and identified.

Care plans contained contradictions and actions recorded in care plans were not always being carried out. For example, one person's care plan recorded in one place that they were unable to feed themselves but in another section recorded that they should be encouraged to feed themselves. Another example was where the care plan stated 'Record any adverse behaviour on a behavioural chart. The last behaviour chart was

dated August 2015. We asked staff if incidents of behaviours that may be challenging for this person were being recorded. They directed us to a chart in the person's room. This did not record any challenging behaviour shown by the person. This meant that we could not be assured the service was updating care plans to ensure this person was being supported appropriately.

Care plans were reviewed regularly but did not demonstrate that people had been involved in the reviews or fully explain any changes and how these should be implemented. For example the review of one care plan dated 20 October 2016 stated 'Needs help to put in place.' There was no explanation of what it was the person needed help to put in place or the help they required.

Planning for people's social support and nursing support was separate. The care plans accessible to nursing and care staff contained limited information about people's preferences and social needs. One person's 'This is Me' record in their care plan was dated April 2011and had not been updated. There were comprehensive records of people's background and preferred activities which had been compiled by the activities co-ordinator but these were kept locked away and were not accessible to care staff. This divide had resulted in care and nursing staff not seeing 'activities' and social engagement as part of their role. This was demonstrated when we observed two care staff sitting behind a person in the lounge. The person was in a high backed wheelchair looking out of the window. They carried on a conversation between the two of them, making no attempt to engage the person in conversation.

This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9 – Person-centred care.

The activities co-ordinator, supported by a team of volunteers, was working to provide people living at the hospital (long stay patients) with stimulation and social engagement. They did not provide support to people receiving rehabilitation. The activities co-ordinator explained how they organised specific volunteers to specific people to develop relationships between the volunteer and the person they were supporting. We were shown an activities assessment form which they completed with the person and their family so that they could personalise the activities. We saw examples of where people had been supported to follow their interests. They also completed a record of activities people engaged in or refused. This record also showed if a person became agitated and would not take part in an activity. However, this record stayed with the activities and was not used in care planning to identify how the behaviour could be addressed. The activities co-ordinator told us that when they were off work activities were covered by volunteers.

The service had had one formal complaint in the past year. This had been resolved to the satisfaction of the complainant. It has been dealt with using the service complaints process which set out details of how a complaint would be dealt with, including timescales. Information about how to complain was available in the service reception.

Inadequate

# Is the service well-led?

## Our findings

There was a governance framework in place, however it was not effective and was not used to drive improvement. The provider had a Clinical Governance Committee with the aim of providing an overview of clinical governance responsibilities and management within All Hallows Healthcare Trust and provide the provider with assurance as to how All Hallows Healthcare Trust monitored the quality and safety of the care and support provided. The failure of this committee to effectively monitor medicines administration, risk assessment procedures and the quality of care assessment and planning within All Hallows Hospital demonstrated a failure of leadership. Whilst senior management told us the committee had identified some issues in the months before our inspection, action had not been taken quickly or robustly enough to address the issues. They had therefore they continued, and opportunities missed to ensure that the quality of the service improved.

The service had a registered manager who left the service after our first visit. On our second visit the service was being managed by the registered manager for the providers domiciliary care service.

There was a failure to ensure systems and processes operated effectively throughout the service to ensure high quality care and that these were understood throughout the organisation. An example of this was the bed rail assessment. The bed rail risk assessment in care plans was not adequate as demonstrated earlier in this report. However, when we reviewed the policy on bed rails this was comprehensive and described the regulations which needed to be met. This policy had not been communicated from managers to those providing the day to day care.

The medicines management policy stated that medicines signature omissions would be audited monthly by a registered nurse, quarterly by the Head of Department and annually by the Head of Department. This audit process had failed to identify the high number of signature omissions referred to earlier in this report or record actions to address this issue. None of these three levels of audit had been effective.

The clinical audit programme also detailed the same audit process for care plans and risk assessments. These audits had failed to ensure that care plans and risk assessments contained sufficient accurate information for staff to deliver safe and effective care. This failure meant that the provider was unable to demonstrate that it was taking all necessary actions to ensure that people were receiving high quality, safe and effective care.

The provision of care within the service was compartmentalised and task driven. An example of this was excellent information developed by the activities co-ordinator not being shared with other care staff to enhance their knowledge of people's backgrounds. The staff team had not been developed to make sure they displayed the right values and behaviours towards people. This was demonstrated when two members of care staff sat behind a person in the lounge and did not engage with them.

It was difficult to determine how the provider had planned services to meet the needs of people admitted for rehabilitation and end of life care. There was no clear rationale or model of care for the services

provided. As a result we have asked the provider to tell us more about their strategic plans for the future.

A survey had been carried out in August 2016 to ascertain how people felt about the quality of care they received. However, the chief executive told us that the results of this survey had not been used to identify trends over time. Staff survey results had been collated in August 2016. Comments made by staff recorded on the analysis did not reflect the results in the survey but there was no explanation for this. This staff survey did not separate the results for All Hallows Hospital from the results for the providers other two services. This meant that we could not be sure how the results would be used to drive improvement in All Hallows Hospital.

This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation17 - Good governance.