Gallions View

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Gallions View is operated by Bridges Healthcare Limited. The service is a short stay, planned discharge unit operated by registered nurses, health care assistants, a therapy team and a GP. The service offers short term stays of about one month for medically fit patients awaiting placement or next move following an admission to an acute hospital.

We carried out the focused unannounced visit to Gallions View on 5 December 2019 as we had concerns about the safety and effectiveness of the service following a previous inspection in August 2019, where it had been rated as Inadequate. At this inspection we inspected aspects of the safe, effective and well-led key questions. As this was not a comprehensive inspection we did not re-rate the key questions we inspected. The previous ratings remain in place.

Our rating of this service stayed the same as this was the rating applied following the last inspection in August 2019; when it was rated as Inadequate for safe and well-led; and Requires Improvement for effective, caring and responsive.

Throughout the inspection, we took account of what people told us, what we observed and how the provider understood and complied with the Mental Capacity Act 2005.

Our findings from this inspection were:-

- The service lacked effective governance systems to enable it to operate effectively and ensure compliance with the regulations. Environmental risk assessments had not identified out of date medical equipment in an unlocked cupboard and liquid detergent in a food store.
- An inspection by the fire brigade in November 2019 had noted fire safety concerns at this location. The registered manager had raised these safety concerns, relating to the structure of the building, with the landlord. The concerns had to be addressed by 21 May 2020. Staff we spoke with gave different answers in respect of procedures related to the activation of the emergency exits during evacuation of the building in the event of fire. This could have led to delays in evacuating patients in an emergency. Some staff did not know what patients' personal emergency evacuation plans were or where they were kept.
- Patient sleeping and bathroom areas were not segregated. The service did not safely separate areas for male and female patients in the unit so that the dignity and respect of patients was maintained.
- Staff did not always ensure that medicines were given in line with the instructions of the prescriber. Staff did not routinely record the position of topical patched applied to patients.
- There was no evidence provided during the inspection that a pain assessment tool was in use. This meant that would be difficult for staff to assess if additional pain relief was needed for patients who had difficulty communicating. Staff monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.
- The service had not carried out a formal risk assessment in respect of the need to keep emergency equipment on site.
- The service had not considered the wider needs of patients with dementia or cognitive impairment, who made up a majority of the patient group, and implemented ways to make sure the environment and approach to care better met their needs.
- Staff did not have access to a blood spillage fluid kit to ensure safe clean up of blood and other bodily fluids.

Summary of findings

- Patients' treatment records were difficult to navigate. There was no consistency in recording patient information, which meant that important information could be missed.
- Some staff lacked confidence in moving and transferring patients safely and in completing tissue viability assessments.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, although lacked confidence in some areas. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service had made some improvements since the last inspection. For example, staff assessed and monitored patients' skin integrity and worked with tissue viability nurses to in the prevention and the treatment of wounds. Staff gave patients enough food and drink to meet their needs and improve their health, and kept records of this.
- At the previous inspection the registered manager and staff lacked understand of deprivation of liberty safeguards and had failed to apply for authorisations to deprive patients of their liberty. At this inspection we saw evidence that staff had applied for deprivation of liberty safeguards authorisations for those patients that had been identified as lacking capacity and held best interests meetings to ensure that any restrictions were in the person's best interests. The registered manager and staff demonstrated that they understood deprivation of liberty safeguards.
- The registered manager had worked with commissioners of the service and NHS partners to improve standards of care since the last inspection in August 2019. A number of systems were being introduced but would need time to become embedded.
- Staff assessed the needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs and highlighted how these needs were to be met. Handover records were clear and included all information staff on the oncoming shift would need to know about patients.

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, to help the service improve. We issued the provider with four requirement notices. Details are at the end of the report.

Kevin Cleary

Deputy Chief Inspector of Hospitals

Summary of findings

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Services we looked at
Community health inpatient services.

Summary of this inspection

Background to Gallions View

Gallions View is operated by Bridges Healthcare Limited. It is based in Thamesmead, London. The service primarily serves the communities of the London borough of Greenwich. It accepts patient referrals from a local NHS acute hospital.

Gallions View is a short stay, planned discharge unit and employs registered nurses, and non-registered nurses. An occupational therapist and physiotherapist from a local NHS trust provide 30 hours per week each to patients in the service. A local GP provides medical input two days per week. The service offers short term stays for medically fit patients awaiting placement or next move, following transfer from an acute hospital bed. The service specialises in caring for people living with dementia and has beds for up to 30 patients. The average length of stay at Gallions View is 28 days, whilst patients' ongoing needs are assessed and suitable onward placements are found. At the time of the inspection there were 24 patients.

Gallions View was last inspected in August 2019 and following this inspection was rated as Inadequate. The August 2019 inspection was carried out by an adult social care inspection team according to the regulated activities provided by the service at that time. The provider subsequently applied to cancel the regulated activity Accommodation for persons who require nursing or personal care as it considered the unit to be a community inpatient rehabilitation service rather than a care or nursing home. Given the concerns identified at the August 2019 inspection, we decided to carry out an unannounced focused inspection to check that the service was providing safe and effective care as a community health service inpatient unit. As this was a focused inspection, and did not cover all aspects of the key questions inspected, we did not change the rating for this service.

The service has a registered manager in post. The service is registered by the CQC to provide the regulated activity: treatment of disease, disorder or injury.

At the inspection in last August 2019 the inspection team found that medicines were not safely managed. Systems and processes in place to ensure medicines were available to be administered to clients were not effective. For examples the services own audits identified that medicines had been recorded as administered when the medicines were not available to be administered.

Staff did not support patients in the least restrictive way possible and in their best interests. Staff had little understanding of the Mental Capacity Act and deprivation of liberty safeguards and authorisations were not in place to deprive people of their liberty. Staff did not accurately assess, understand or communicate patients' needs. Staff did not always complete patients' food and fluid charts. The provider's quality monitoring systems were not effective. Internal audits did not identify the issues that were found at this inspection.

Our inspection team

The team that inspected the service comprised two CQC inspectors, an inspection manager, a CQC pharmacist specialist inspector, and a specialist advisor who was a nurse with expertise in dementia care.

How we carried out this inspection

This was a focused inspection. During the inspection we asked the following questions:

- Is it safe?
- Is it effective?
- Is it well-led?

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location. This included information about safeguarding concerns, whistleblowing reports, and statutory notifications.

At the time of the inspection the service employed 20 registered nurses, 30 non-registered nurses and there were 24 patients.

During the inspection visit, the inspection team:

- spoke with six staff including registered nurses, non-registered nurses, the business manager, and the registered manager
- spoke with one relative and used the Short Observational Framework for Inspection (SOFI2) to conduct periods of observation in the unit. SOFI2 is a way of observing care to help us understand the experience of people who cannot talk with us.
- reviewed five sets of patient care records
- looked at a range of policies, procedures and other documents relating to the running of the service.

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?

- The service had fire safety concerns at this location after a fire brigade inspection. Some staff did not know what patients' personal emergency evacuation plans were or where they were kept.
- Staff did not ensure that the dignity and respect of patients was maintained. The service did not safely separate areas for male and female patients in the unit. Patient sleeping and bathroom areas were not segregated.
- Staff did not always ensure that medicines were given in line with the instructions of the prescriber. The location of topical patches applied to patients was not recorded.
- The service had not carried out a formal risk assessment in respect of the need to keep emergency equipment on site.
- Staff did not have access to a blood spillage fluid kit to ensure safe clean up of blood and other bodily fluid spillages.
- Patients' treatment records were difficult to navigate, as there was no consistency in recording patient information. This meant that important information could be missed.
- Environmental risk assessments had not identified out of date medical equipment in an unlocked cupboard and liquid detergent in a food store.

However:

- The service had enough staff to care for patients and keep them safe.
- Staff had received training in key skills, although lacked confidence in some areas.
- Staff understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff assessed risks to patients, acted on them and kept records up to date.

Are services effective?

- Staff did not use a pain assessment tool to assess whether patients who could not communication easily needed additional pain relief.

Summary of this inspection

- The service had not considered the wider needs of patients with dementia or cognitive impairment, who made up a majority of the patient group, and implemented ways to make sure the environment and approach to care more accessible better met their needs.

However:

- The service had made some improvements since the last inspection. For example, staff assessed and monitored patients' skin integrity and worked with tissue viability nurses to in the prevention and the treatment of wounds. Staff gave patients enough food and drink to meet their needs and improve their health, and kept records of this.
- Staff assessed the needs of all patients. They worked with patients and families and carers to develop individual care plans and updated them when needed. Care plans reflected the assessed needs and highlighted how these needs were to be met. Handover records were clear and included all information staff on the oncoming shift would need to know about patients.
- Staffs understanding of deprivation of liberty safeguards had improved since the last inspection.

Are services caring?

We did not inspect this key question on this occasion.

Are services responsive?

We did not inspect this key question on this occasion.

Are services well-led?

- The service lacked effective governance systems to enable it to operate safely and effectively and ensure compliance with the regulations.
- There were no effective systems to ensure that out of date equipment and stock was removed from the service. The environmental audit was not effective in identifying these issues.

However:

- The registered manager had worked with commissioners of the service and NHS partners to improve standards of care since the last inspection in August 2019. A number of systems were being introduced but would need time to become embedded.

Community health inpatient services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are community health inpatient services safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Training compliance at the time of the inspection was 100%. Mandatory training included, basic life support, catheter care, pressure area care, moving and handling, handling medication and avoiding drug errors and infection control and dementia.

Safeguarding

Staff understood how to protect patients from abuse and worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service had raised no safeguarding concerns since the last inspection in August 2019.

Staff worked effectively with other agencies to promote safety, including systems and practices for information sharing. Staff liaised with clients' social workers as required. Staff discussed safeguarding concerns with the lead nurse and service manager who were the safeguarding leads for this location.

All staff had completed safeguarding training for both adults and children. Staff we spoke with were aware of how to identify adults and children at risk of abuse and how to refer on as necessary to the local authority.

Cleanliness, infection control and hygiene

The premises were visibly clean at the time of our inspection. An external cleaning company provided services and the service kept up-to-date cleaning schedules. The cleaner was active cleaning the unit during the inspection.

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean. For example, a commode chair in the sluice room had a 'I am clean' sticker attached with the date of when it was last cleaned.

Staff adhered to infection control principles, including hand washing and wore appropriate personal protective equipment such as disposable gloves. Personal protective equipment was readily accessible to staff. Staff disposed of clinical waste appropriately. Clinical waste was collected and removed regularly by an appropriate external company.

At the time of the inspection one patient was being barrier nursed in order to prevent the possible spread of infection. They had access to their own bathroom during this period. This was not shared with other patients.

However, staff did not have access to a blood spillage fluid kit to ensure safe clean up of blood and other bodily fluid spillages. Some staff we spoke with during the inspection gave conflicting answers about how they would clear up bodily fluids and the cleaning materials they would use.

Environment and equipment

Staff did not ensure that the dignity and respect of patients was maintained. The service did not safely separate areas for male and female patients in the unit. Patient sleeping and bathroom areas were not segregated. Bedrooms did not have ensuite toilets or showers. Patients shared bathrooms. Male and female bedrooms were not segregated in any way when rooms were allocated, female patients had to walk past male bedrooms to reach toilets or bathrooms. There was only one shower available to patients at the time of the inspection as a second shower was being used by a single patient who was an infection risk. This severely limited

patients' options and access to a bath or shower at the time of the inspection. This had further impact on patients' dignity as some would be obliged to travel the length of the unit to use the shower, past the bedrooms of both male and female patients. This was contrary to national guidance on same sex hospital accommodation (Eliminating Mixed-Sex Accommodation. From the Chief Nursing Officer and Deputy NHS Chief Executive. 10 February 2011). There was a risk that patients' dignity and respect would be compromised.

We had concerns about how equipment was stored, restricting access to a bathroom. The only bathroom in the unit was being used to store moving and handling equipment and seated weighing scales, therefore putting it out of use for patients.

Staff we spoke to gave us conflicting information about how to open the emergency exits when evacuating the building in the event of a fire. For example, some staff felt that a padlock on the fire exit door could only be opened with a key, yet this padlock did not need to be unlocked to exit during an emergency. Staff's lack of knowledge may cause a delay in the event of an evacuation. Staff had completed a fire risk assessment. The risk assessment identified key risks. For example, clearing foliage outside the emergency exit door to allow easier exit in case of emergency in the event of a fire and staff being given inadequate fire safety instructions at induction. An action plan was put in place for staff training at induction and also additional training at intervals for staff who had not received training at induction. For example, staff completed additional fire training on 7 November 2019 and 18 October 2019. The service had also planned additional staff training for 6 December 2019 and planned to hold fire simulations with a moving and handling trainer in 2020. We saw that a fire drill had taken place within the previous 12 months prior to inspection and all staff, clients and visitors had been evacuated safely.

The fire brigade completed a fire inspection in November 2019 and noted fire safety deficiencies at this location. We received a copy of the notification on fire safety concerns on 5 December 2019. For example, issues identified included insufficient fire resistance in walls, floors, ceilings and doors; use of wedges holding open fire doors was not been controlled; fire resisting separation in the premises was inadequate. The registered manager reported that wedges to hold open fire doors were no longer used. The registered manager had raised these safety concerns relating to the structure of the building with the landlord. These concerns had to be addressed by 21 May 2020.

Staff had a grab bag that contained personal emergency evacuation plans for patients. Some staff did not know what these plans were and where they were kept.

Staff had easy access to alarms. Staffing levels were adequate to appropriately respond to alarms and manage risks to patients, staff and visitors.

Staff completed monthly environmental audits; which failed to identify issues with safe storage of cleaning detergents. The audit included a check on the safe storage of cleaning detergents and included ensuring the general environment was clean. However, during the inspection we found an unlocked storage cupboard that contained syringes, other medical devices with a number of expired items that included four packs of irrigation solution, and an expired airway tube. The cupboard for storing dry food, as well as containing packaged food items, contained four bags of all-purpose concentrated cleaning liquid, which had expired in 2015. We shared this with staff who promptly removed the expired equipment and cleaning solution. Staff also reviewed their weekly environment audit tool during the inspection and added a review of contents of the cupboards as part of their environmental audit.

Patients were not using or did not have access to their specialised equipment. The provision of standard furniture in the service was the responsibility of the provider while the occupational therapist (OT), from a local NHS trust, was responsible for recommending specialist equipment for patients. This included specialist pressure relieving mattresses and individual slings to be used with hoists. Staff we spoke to said it was difficult to keep track of equipment purchased for individual patients; such as special cushions and slings as these were at times found in the bedrooms of other patients or being used by other patients. The occupational therapist was working with staff to emphasise the importance of patients using the equipment prescribed for them.

A carer reported difficulty accessing the building as the gate to the premises was locked and there was no bell to attract attention. Visitors were expected to telephone the service from the gate in order to get staff to come and let them on to the site.

There was no emergency equipment stored on site. Staff were advised to dial 999 in the event of an emergency. There was no evidence provided that the service had carried out a risk assessment relating to the decision not to keep emergency equipment onsite.

Due to a lack of suitable rooms available in the building; there were was no room where patients could meet adult visitors or other health professionals privately if needed, other than in their bedrooms.

Assessing and responding to patient risk

During the inspection, we reviewed the risk assessments completed for five patients. We found that staff completed and updated risk assessments on admission for each patient and removed or mitigated risks.

Staff responded to changing risks including deteriorating health and wellbeing. They also had support from a senior practitioner staff at all times. This included at weekends and out hours support.

The physiotherapist and occupational therapist from a local NHS trust provided 30 hours input to the service every week and were based in the service most week days. They carried out detailed mobility assessments. The occupational therapist advised staff on the best and safest way to transfer and move patients. This information was in patients' care records and displayed in their bedrooms so that staff had easy access to the information they needed.

Whilst staff completed Waterlow assessments for patients', there was a lack of consistency in terms of the scoring these and in the accurate adding up of scores. The Waterlow assessment gives an estimated risk for the development of a pressure ulcer in a given patient. The occupational therapist planned to work with staff to improve the consistency of Waterlow assessments.

All staff had completed moving and handling training. However, during periods of structured observation on the unit we noted that staff lacked confidence when transferring a patient from a wheelchair to a comfortable chair in the lounge area. For example, the patient spent more than 40 minutes in the wheelchair, in a slumped position, before staff were able to safely move the person. This followed a request by staff for help from the occupational therapist.

Staffing

Safe staffing levels were maintained. Managers reviewed and adjusted staffing levels and skill mix according to patients' needs. The service did not use bank, agency or locum staff and there were no staff vacancies at the time of the inspection. Annual leave and sickness absence was covered by existing staff or staff from the domiciliary care service run by the same provider.

Staffing for each day shift included four registered nurses and three non-registered nurses. This also applied to the night-time and weekend shifts. There was cover from a local GP service for two days a week. In case of a medical emergency staff dialled 999.

Records

The service kept paper records and were preparing to transfer paper records onto an electronic system. Records were stored securely and available to all staff providing care. However, patients' treatment records were difficult to navigate. There was no consistency in recording patient information, which meant that important information could be missed.

Staff kept up-to-date handover records for each patient with important information; this included patient diagnosis, current social circumstances, mobility, discharge plans, dietary needs and important telephone contact details of health social services.

Medicines

Although the overall management of medicines had improved since the last inspection we found that staff were not always administering medicines in the way the prescriber intended. Staff conducted a medicines audit on a weekly basis and we saw that medicines issues were being identified, although not always acted upon.

We had concerns about staff not administering medication in line with the patients prescription. We found discrepancies on the medicines administration record charts. A patient had been prescribed two vitamin D capsules a week. However the stock count of the vitamin D capsules totalled an odd number, which should

have not been possible if staff had administered the correct dose. We found two further errors with medication administration for another patient. Staff should have been administering two 300mg tablet. However, stock balance of this medication indicated that staff had only been administering one 300mg tablet. In addition to this, the same patient was having medication reduced over a period of time. The but the medicines administration records were not written correctly, as a result, staff had not administered the reduced dose as intended by the prescriber. The risk to the patient of a accidental over dose was minor due the mature of the medication but was still a cause of concern. A third patients had been prescribed a tablet to be taken three times a day. The stock balance on 2 December 2020 was 35 tablets, the following day the balance was 14. Staff were unable to explain how this had happened and why there was a discrepancy in the stock balance.

When staff administered topical patches, they did not make a record of the location of administration. Whilst staff told us that they rotated the site of administration, there was no assurance of this. If a patch had fallen off the patient prior to the next dose, staff would not know where to place the new patch.

All medicines were stored securely in a clinical treatment room. Controlled drugs (CD) were in a locked CD cabinet in line with legislation. Access to medicines was limited to authorised staff only. Staff monitored the temperature of medicines storage areas to assure that they were suitable for use.

Medicines for disposal were usually stored separately from the rest of the medicines. However, we saw one box of medicine that was not stored separately. Staff had access to appropriate medicines disposal facilities, for example a sharps bin and a denaturing kit. The service had registered for a waste exemption certificate with the environment agency.

Staff could refer patients to a GP who visited the home twice a week if a medicines review was required. We saw that any medicines changes and the rationales were documented to ensure that all staff were aware of them.

Staff ensured that they had an accurate list of the current medicines that were being taken by patients on admission to the unit. However, when there was a discrepancy we saw that staff did not always take steps to clarify the correct information. The registered manager had recently implemented a new communication book for staff to use to share information about medicines that had been newly prescribed.

Staff took steps to ensure that patients had the correct medicines stock available. We saw evidence of emails that had been sent to the prescriber and the supplying pharmacy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The registered manager received patient safety alerts by email from the central alerting system. If the registered manager was on leave, administrative staff received these emails and passed them on for review by senior staff. However, there were no records to show that alerts had been reviewed to ensure that they were not relevant to this location.

Records did not always clearly indicate why medication was given. We looked at the records for a patient who had been prescribed a medicine for use in agitation, but this was not recorded in patient records. This was discussed with a nurse who explained why the medicine was given on that particular occasion. However, the service did have decision making processes in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff made records to support the use or lack of use of laxatives that were prescribed 'when required'.

Incident reporting, learning and improvement

Between 1 August 2019 and 5 December 2019, the service had reported no serious incidents.

Staff knew what incidents were and how to report them.

Are community health inpatient services effective?
(for example, treatment is effective)

Evidence-based care and treatment

We reviewed five care and treatment records during our inspection.

Staff completed comprehensive assessments with clients on admission to the service. This included assessment of

activities of daily living, a body map, skin assessment, mobility, mental capacity, communication, dietary needs and risk of wandering if a patient is identified to have dementia.

In the previous inspection, there was no clear evidence that patient skin integrity was being protected. In this inspection we saw that staff assessed and monitored skin integrity from admission. For example, staff completed a body map on admission, took photographs with consent if needed and patients were reviewed by a tissue viability nurse.

Care plans reflected the assessed needs and highlighted how these needs were to be met. They worked with patients and families and carers to develop individual care plans and updated them when needed. However, one care plan cited a pain assessment as part of pain management but no pain assessment tool was completed.

The provider had done little to make the environment or approach to care dementia-friendly although a significant number of patients had dementia or were cognitively impaired. The service had installed memory boxes for patients and/or their carers to fill with information about them, one week before the inspection. Memory boxes help improve patient orientation. These were empty at the time of the inspection. However, the service environment was not dementia friendly for example, there were no prominent colour contrast to add clarity to the environment for patients with dementia. We raised this with registered manager during the inspection who cited there were restrictions in the building lease that limited the changes that they could make to the environment.

The communal area was noisy with two televisions playing different channels at either end of the room. A row of five chairs was set in the centre of the room facing the dining tables. The positioning of the chairs, side by side in a straight row, made it difficult for patients sitting there to interact with each other.

Nutrition and hydration

Staff made sure that meal times were protected, and patients had time to eat their meals without interruption. The service displayed meal times by the entrance for visitors.

At the last inspection the team identified that staff did not always keep records of patients' food and fluid intake and output. At the current inspection, we found that staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made dietary adjustments for patients' religious, cultural and other needs. Staff also identified any feeding difficulties at each handover and highlighted advice from a speech and language therapist in their handover notes.

During periods of observation on the unit we saw staff offering a choice of drinks to patients and encouraging them to drink on a regular basis. Staff kept records of what patients ate and drank.

Pain relief

There was no evidence provided during the inspection that a pain assessment tool was in use. Staff reported that a recognised pain assessment tool was used for people with dementia, which was kept in a separate folder. There was no evidence during the inspection that the tool was in active use. This meant that it would be for staff to assess whether patients who could not communicate needed additional pain relief.

Patient outcomes

The occupational therapist monitored the effectiveness of care and treatment. For example, the occupational therapist used validated tools such as the Barthel index for activities of daily living and the elderly mobility scale to assess patients and measure their progress. Patients generally scored better or the same on these measures at the time of discharge.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with

other agencies. For example, staff liaised with speech and language therapist for patients that had eating and drinking difficulties and local social care agencies for placements for patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The overall staff training compliance rate for the Mental Capacity Act and deprivation of liberty safeguards was at 100%.

At the previous inspection the registered manager and staff lacked understand regarding deprivation of liberty safeguards and failed to apply for deprivation of liberty safeguards authorisations, which meant that patients' liberty was being restricted unlawfully. In this inspection we saw evidence that staff had completed deprivation of liberty safeguards applications for those patients that had been identified as lacking capacity and had best interests meetings to ensure that any restrictions were in the person's best interests. The registered manager and staff demonstrated that they understood deprivation of liberty safeguards. Staff also completed mental capacity assessments when needed. For example, staff completed a decision specific mental capacity assessment for a patient with fluctuating levels of confusion. Staff also discussed deprivation of liberty safeguards referrals in handover meetings and highlighted deprivation of liberty safeguards applications in their handover sheets.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limited patients' liberty.

Are community health inpatient services caring?

As this was a focused inspection we did not inspect caring.

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

As this was a focused inspection we did not inspect responsive.

Are community health inpatient services well-led?

Governance, risk management and quality measurement

The service lacked effective governance systems to enable it to operate safely and ensure compliance with the regulations. Although the registered manager was introducing systems to assess, monitor and improve the quality and safety of the service these were not embedded and had not led to improvements in several areas. For example, although staff were counting the medicines stock at each shift they had failed to identify that the amount of stock remaining at each count was not in line with the expected number based on the patient's prescription.

There were no effective systems to ensure that out of date equipment and stock was removed from the service. The environmental audit was not effective in identifying these issues.

The service had not considered the wider needs of patients with dementia or cognitive impairment, who made up a majority of the patient group, and implemented ways to make the environment more accessible and dementia-friendly.

The registered manager had put in place an action plan to improve fire safety training; which had started in November 2019 for staff but some staff were still unclear how to open emergency exits.

However, the registered manager had worked with commissioners of the service and NHS partners to improve standards of care since the last inspection in August 2019. A number of systems were being introduced but would need time to become embedded.

Information management

Staff had access to the equipment and information technology needed to do their work. The telephone systems worked well. However, a carer we spoke with raised concerns about staff not answering the telephone when they called the service.,

The registered manager had access to information to support them in their management role. For example, human resource records, supervision records, appraisals, training data, sickness records, cleaning audits, and annual leave requests.

Patient and carer engagement

Patients and carers had opportunities to give feedback on the service they received. Carers we interviewed were able to feedback directly to the registered manager if they requested this.

Management of risk, issues and performance

The service manager maintained a risk register for the service. A range of risks had been identified for example, governance processes and procedures were insufficiently developed to ensure compliance with legal and regulatory requirements, this identified risk plan was mitigated by developing internal audits.

The service had a business continuity plan. This included severe weather plans and outlined the service manager's responsibility in the event of staff being unable to attend work due to this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that female and male bedrooms are separated so that the dignity and respect of patients is maintained. Regulation 10(1)(2)(a).
- The provider must ensure medicines are given in line with the instructions of the prescriber. Regulation 12 (1)(2)(f).
- The provider must ensure effective governance systems or processes are in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1)(2)(a)(b).
- The provider must take prompt action to address a number of significant concerns identified during the fire inspection in November 2019 in relation to fire safety. Regulation 15 (c)(e)
- The provider must formally risk assess the need for emergency equipment at this location. Regulation 12(1)(2)(a)(b).

Action the provider SHOULD take to improve

- The provider should ensure that staff record information consistently in patient care records so that information can be found easily.
- The provider should ensure a biohazard blood/ bodily fluids spillage kit is available for staff to use for effective cleaning and safe disposal of waste, helping to reduce the risk of cross infection.
- The provider should ensure staff are confident in moving and transferring patients safely and in completing Waterlow assessments consistently and accurately.
- The provider should ensure expired products are removed from the service and detergents are not stored in the food cupboard.
- The provider should ensure that staff are adequately trained and knowledgeable about evacuation procedures.
- The provider should ensure that patients have access to the bathroom.
- The provider should implement measures to make the environment and approach to care more dementia-friendly.
- The provider should use a pain assessment tool to as to assess whether patients, who cannot communicate easily require additional pain relief.
- The provider should ensure that staff record the position of topical patches applied to patients.
- The provider should ensure that staff know what personal emergency evacuation plans are and where they are kept.

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 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014: Dignity and respect**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2014: Premises and equipment**