St Cyril's Rehabilitation Unit

Quality Report

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

We undertook this focussed inspection due to concerns that had previously been identified during a focussed inspection that was undertaken on the 12 and 13 March 2019. We carried out the unannounced inspection on the 6 and 7 August 2019.

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

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

- The service had not always made sure that staff had completed mandatory training in a timely manner. There were areas of low compliance with key training such as immediate life support, tracheostomy care level one as well as continence and catheter care.
- Staff had not always understood how to protect patients from abuse and the service had not always worked well with other agencies to do so. Staff had not always reported abuse in a timely manner. We found a safeguarding incident that had not been reported immediately after it had happened. This meant there was a risk that actions to protect the patient may not have been taken and an investigation into the incident would not be undertaken in a timely manner in order to protect patients from potential abuse.
- Staff had not consistently completed and updated risk assessments for each patient and removed or minimised risks. On reviewing records for all six patients at the unit, we found that risk assessments for important topics such as falls and pressure ulcers had not been completed consistently on five occasions.
- Staff had not always kept detailed records of patients' care and treatment. Records were not always clear, up-to-date and stored securely. We found that medical notes were not always legible, records had not always been stored securely and the service had not archived records in line with best practice guidance.
- The service had not always used systems and processes to safely record and store medicines. This was because a clear record had not always been kept of when controlled drugs had been destroyed.
- The service had not always managed patient safety incidents well. Staff had not always recognised and reported incidents and near misses. Managers had not always investigated incidents. When things went wrong, the service had not always apologised and gave patients honest information and suitable support.
- The service had not used monitoring results well to improve safety. On reviewing minutes of governance meetings between April and July 2019, we found no evidence of patient harm being discussed. This meant that it was unclear if the service had always identified when improvements had been needed. We were informed following the inspection that patient harms were discussed at the incident monitoring meetings that had been held weekly.
- The service had not always checked if leaders were suitable to undertake their roles. We found that the service had not undertaken Fit and Proper Person checks for directors, in line with their policy. This was important as it is a check to make sure that directors are suitable to undertake their roles.
- The service did not have a strategy of how to turn the vision into action. Although the service had implemented a clear vision, we were informed that underpinning strategies to turn this into action had not yet been completed.
- Leaders had not always operated effective governance processes throughout the service. We found that the service had not always made sustainable improvements. We identified several areas when the need for improvement had been recognised but it was unclear how this would be achieved.

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

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff had immediate access to emergency equipment when needed.
- The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment.

Summary of findings

- Leaders were committed to improving the service. We found that the service had worked with an external stakeholder to improve the services provided and that plans had been made to employ a Non-Executive Director to the board.

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

Ann Ford

Deputy Chief Inspector of Hospitals (North), on behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health inpatient services		Our rating of this service stayed the same. We rated it as requires improvement. We did not rate the service following this focused inspection as were following up on concerns that had been raised with us. A summary of our findings about the service appears in the overall summary.

Summary of findings

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Summary of this inspection

Background to St Cyril's Rehabilitation Unit

St Cyril's Rehabilitation Unit is a single storey purpose built facility which provides accommodation to meet the needs of patients. Facilities include quiet lounges, television rooms and dining areas, a therapy suite, gym and hydrotherapy pool.

St Cyril's has a total of 26 beds two of which are one bedroom bungalows. These are designed to help patients transition to a higher level of independence prior to discharge. All patients' bedrooms are single with ensuite bathrooms and fitted with ceiling hoists and a nurse call bell system.

The unit comprises of four bedroom wings, a therapy wing and an administration wing. The therapy wing has a gym and occupational and language therapy.

The service provides a facility for patients with complex needs as a result of neurological impairment or physical disability. There are seven beds in use to meet the needs of patients with challenging behaviour as a result of neurological disability. These patients may or may not be detained under the Mental Health Act (1983, amended 2007). The unit has four separate care and bedroom areas and central communal facilities.

- The Cheshire Suite supports patients with complex physical needs, low awareness or continuing care needs.
- The Grosvenor Suite provides active short to medium rehabilitation with therapy services as required.
- The Westminster Suite offers specialist care to patients with challenging behaviour due to their neurological impairment.
- The Dee Unit supports patients along their rehabilitation programme towards a higher level of independence.

Services provided at the unit under a service level agreement include consultant cover, diagnostics and other allied health professional services.

The hospital has a registered manager who has been registered with the CQC since February 2019. The nominated individual is the Chief Executive.

We carried out an unannounced inspection of St Cyril's Rehabilitation Unit on the 6 and 7 August 2019. During this inspection there was only two areas being used to care for patients.

Our inspection team

The Inspection team was led by a CQC inspection manager, and included four CQC inspectors.

Why we carried out this inspection

We undertook this focussed inspection due to concerns that had been identified during a previous inspection that was undertaken on the 12 and 13 March 2019.

Some of the concerns identified or raised included poor staffing levels as well as delays in reporting safeguarding incidents. In addition, we had concerns that previous improvements may not have been sustained.

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

Summary of this inspection

How we carried out this inspection

The inspection site visit took place on the 6 and 7 August and was unannounced.

We reviewed information before, during and after the inspection. This included patient records, care plans, medicines charts, staff rosters, and staff competency records.

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We did not rate this domain during this inspection. The rating from the previous inspection remained as requires improvement.

- The service had not always made sure that staff had completed mandatory training in a timely manner. There were areas of low compliance with key training such as immediate life support, tracheostomy care level one as well as continence and catheter care.
- Staff had not always understood how to protect patients from abuse and the service had not always worked well with other agencies to do so. Staff had not always reported abuse in a timely manner. We found a safeguarding incident that had not been reported immediately after it had happened. This meant that actions had not been taken and an investigation into the incident had not been undertaken in a timely manner in order to protect patients from potential abuse.
- Staff had not consistently completed and updated risk assessments for each patient and removed or minimised risks. On reviewing records for all six patients at the unit, we found that risk assessments for important topics such as falls and pressure ulcers had not been completed consistently on five occasions.
- Staff had not always kept detailed records of patients' care and treatment. Records were not always clear, up-to-date and stored securely. We found that medical notes were not always legible, records had not always been stored securely and the service had not archived records in line with best practiced guidance.
- The service had not always used systems and processes to safely record and store medicines. This was because a clear record had not always been kept of when controlled drugs had been destroyed.
- The service had not always managed patient safety incidents well. Staff had not always recognised and reported incidents and near misses. Managers had not always investigated incidents. When things went wrong, the service had not always apologised and given patients honest information and suitable support.
- The service had not used monitoring results well to improve safety. On reviewing minutes of governance meetings between April and July 2019, we found no evidence of patient harm being discussed. This meant that it was unclear if the service

Summary of this inspection

had always identified when improvements had been needed. We were informed following the inspection that patient harms were discussed at the incident monitoring meetings that had been held weekly.

However,

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff had immediate access to emergency equipment when needed.
- The management team had introduced a weekly meeting which was held to discuss all clinical and non clinical incidents that had been reported to the incident reporting system
- The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment.

Are services well-led?

We did not rate this domain during this inspection. The rating from the previous inspection remained as requires improvement.

- The service had not always checked if leaders were suitable to undertake their roles. We found that the service had not undertaken Fit and Proper Person checks for directors, in line with their policy. This was important as it is a check to make sure that directors are suitable to undertake their roles.
- The service did not have a strategy of how to turn the vision into action. Although the service had implemented a clear vision, we were informed that underpinning strategies to turn this into action had not yet been completed.
- Leaders had not always operated effective governance processes throughout the service. We found that the service had not always made sustainable improvements. We identified several areas when the need for improvement had been recognised but it was unclear how this would be achieved.

However,

- Leaders were committed to improving the service. We found that the service had worked with an external stakeholder to improve the services provided and that plans had been made to employ a Non-Executive Director to the board.

Community health inpatient services

Safe	
Well-led	

Are community health inpatient services safe?

Safety performance

- **The service had not used monitoring results well to improve safety.**
- In our last inspection of March 2019, we found that the service had not submitted any information to NHS Safety Thermometer between January and March 2019. The NHS Safety Thermometer provides a temperature check on harm that can be used alongside other measures of harm to measure local system progress in providing a care environment that is free from harm. This includes falls, pressure ulcers and hospital acquired urinary infections.
- During this inspection, we noted that submissions had been made to NHS Safety Thermometer between March and July 2019. However, on reviewing governance meetings that had been held between April and July 2019, we did not see any evidence that patient harms included in the safety thermometer had been reviewed. This was a continued concern that had been identified in our previous inspections of March 2017, May 2018 as well as March 2019, and meant that it was unclear how the service had used patient safety information to make further improvements where needed. We were informed following the inspection that patient harms were discussed at the incident monitoring meetings that had been held weekly.
- During the inspection, we requested data about the total number of falls, pressure ulcers and hospital acquired urinary infections that had been reported between March and July 2019. The hospital management team had not collated this information and were unable to confirm how many incidents there had been. This was also a concern that had been previously identified in our last inspection of March 2019.

Incident reporting, learning and improvement

- **The service had not always managed patient safety incidents well. Staff had not always recognised and reported incidents and near misses. Managers had not always investigated incidents. When things went wrong, the service had not always apologised and gave patients honest information and suitable support.**
- The hospital had an incident reporting policy which was available to staff electronically and all staff had access to this. Staff we spoke with could tell us how they would report an incident.
- Between 1 March and 6 August 2019, there had been a total of 104 incidents reported to the incident reporting system. During our last inspection of March 2019, we had concerns that these had not always been managed in line with policy or in a way that made sure that there had been learning to reduce the risk of similar incidents happening again. During this inspection, we identified similar concerns. We sampled 17 out of 104 incidents that had been reported between the 1 March and 6 August 2019, finding that there was no documented action that evidenced learning.
- During our last inspection of March 2019, we found that a high number of reported incidents had not been actioned or closed in a timely manner, meaning that we were not assured that the management team had taken timely action to reduce the risk of a similar incident reoccurring. During this inspection, we found that incidents had been managed in a more timely manner.
- The management team had introduced a weekly meeting which was held to discuss all clinical and non clinical incidents that had been reported to the incident reporting system. Members of the management team informed us that this had been introduced to make sure that all incidents were managed in a more timely manner.
- We reviewed a sample of minutes from these meetings, finding that they had taken place on a regular basis between the 1 June and 6 August 2019. On reviewing the minutes, we had concerns that there was not always documented evidence of learning or actions taken against each incident that had been discussed. However, we attended a weekly incident meeting during the inspection, observing that the meeting was well attended, and learning was discussed.

Community health inpatient services

- We had continued concerns following our last inspection of March 2019 that the level of patient harm had not always been correctly documented. This was because records indicated that between 1 April and 6 August 2019, the level of patient harm had been recorded as 'not-applicable' on 12 out of 104 occasions. Out of these there had been 10 occasions when the level of patient harm had been recorded as 'not-applicable' despite there being evidence that they related to patient safety concerns, such as a patient displaying aggressive behaviour or equipment not being available. Senior managers told us that 'not-applicable' could mean an incident which involved a staff member and they used this information to see if there was any trend in which staff members were being involved in patient incidents. However, this meant there was a risk that trends in patients behaviour and the level of harm may not be identified to help improve standards of care.
- During our last inspection of March 2019, we found that incidents of aggressive behaviour displayed by patients had not always been reported to the incident reporting system, in line with policy. We identified similar concerns during this inspection. One set of patient records indicated that incidents of patient aggression had not been reported on seven out of 10 occasions between the 30 May and the 1 August 2019. Another set of patient records indicated the same on three occasions during the same period. This meant that there was a continued risk that the management team would be unaware that these incidents had occurred and that the patient's care plan would not be amended when required.
- Between 1 April and 6 August 2019, the service had not reported any serious incidents. However, we identified one incident that met the criteria, as stated in the NHS Serious Incident Framework, 2015. On reviewing this incident, we found that although the management team had completed an incident investigation, a root cause analysis tool had not been used (a root cause analysis tool is used to investigate incidents fully so that actions can be implemented to reduce the risk of a similar incident happening again).
- In addition, we found that the incident investigation that had been completed had not identified all areas that required improvements. This was because on reviewing the patient records at the time of the incident, we found omissions in the patient's medical notes which the management team had not identified.
- Since our last inspection of March 2019, the management team had implemented an end of life care and learning from deaths policy. This was important as during our last inspection, we found that the management team had not completed mortality reviews for two patient deaths that had been reported between October 2018 and March 2019. Mortality reviews are important as they help identify any care issues that could potentially improve standards of care in the future.
- Although the management team had reviewed both patient deaths since our last inspection, we noted that the policy did not provide a clear indication of what the minimum requirements for a mortality review should be. This meant that there was a risk that future learning points would not always be identified to improve patient care.
- An up to date Duty of Candour policy was available and the management team understood when the Duty of Candour should be applied. The Duty of Candour is a legal duty on hospitals to inform and apologise to patients if there have been mistakes in their care that have led to a moderate level of harm or above. The Duty of Candour aims to help patients receive accurate truthful information from health providers.
- On reviewing reported incidents, we found three occasions when the management team had not taken all reasonable steps to make sure that the Duty of Candour had been applied when needed. This was because, for example, there had been one occasion, when a patient had been diagnosed with a grade three pressure ulcer, meaning that the patient had suffered a moderate level of harm. Following the inspection, the management team informed us that there was no documented evidence that this had been applied.
- Additionally, we had concerns that there was a continued risk that duty of candour would not always be applied when needed. This was because levels of patient harm had not always been recorded as some had been recorded as not applicable.

Safeguarding

- **Staff had not always understood how to protect patients from abuse and the service had not always worked well with other agencies to do so. Staff had not always reported abuse in a timely manner.**

- The service had an up to date policy for safeguarding adults and children which was available to all staff. However, we found that the safeguarding policies for adults and children were not always applicable to the service that was being provided and did not always include up to date information for staff. For example, we found that it was unclear about when staff should make an immediate referral or when they were required to contact the police. Additionally, the policy did not clearly outline the contact details for staff to make a safeguarding referral, how to make a safeguarding referral out of hours or links to national guidance to help support staff in identifying safeguarding concerns and raising them appropriately.
- In addition, we found that the service did not have policies and procedures for staff to follow when providing intimate examinations or procedures. Guidance from the General Medical Council states that organisations should have a chaperone policy which outlines the formal requirement for staff who are undertaking intimate examinations and procedures to be formally accompanied by another member of staff. This is important, particularly for patients with cognitive impairment, as it reduces the risk of potential abuse.
- We had continued concerns that the safeguarding policy for children did not cover all areas that related to the type of services that the hospital provided. This was because although the hospital held weekly sessions for parents and their children in the hydrotherapy pool, this had not been included, meaning that it was unclear what responsibilities staff had regarding this.
- During our last inspections of May 2018 and March 2019, we found that not all safeguarding incidents had been reported in a timely manner. This was because we found that on both inspections, a member of staff had failed to report a safeguarding incident immediately. On this inspection we found a further safeguarding incident that had not been reported immediately after it had happened. This meant that actions had not been taken and an investigation into the incident had not been undertaken in a timely manner in order to protect patients from potential abuse. This was also not in line with the Department of Health and Social Care, care and support statutory guidance October 2018. This states that where there are safeguarding concerns then it would not only be necessary to immediately consider what steps are needed to protect the adult but also whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate.
- Members of the management team informed us that improvements had been made to make sure that low level safeguarding referrals had been submitted in a timely manner. An agreement with the local authority had been made and we reviewed evidence which indicated that they had been made prior to each submission deadline.
- We identified concerns during our last inspection of March 2019, that when patients had sustained injuries, there was no documented evidence of the likely cause, meaning that it was unclear if patients had sustained avoidable harm. Members of the management team informed us that they had reinforced the importance of accurate documentation to staff so that all injuries could be accounted for.
- We sampled four occasions when patients had sustained injuries between the 1 April and the 6 August 2019, finding that some improvements had been made. On three occasions, there was documented evidence which detailed the likely cause of injury. On two of these occasions, actions had been taken to reduce the risk of similar incidents reoccurring.
- On reviewing incidents that had been reported between 1 April and 6 August 2019, we identified one patient who had become agitated, and found that they had been prescribed medication to manage this. However, on reviewing the occasions when this had been administered, it was unclear in the patient's records if staff had considered managing their behaviour in any other way. We also noted on reviewing the patient's behavioural management plan during the inspection, that there were no alternative strategies recorded for staff to follow. This meant that there was an increased risk that medication would be given inappropriately. Following the inspection the provider sent an electronic version which showed strategies recorded for staff to follow.
- When reviewing records for another patient during the same period, we found that there was no documented evidence of consent being obtained on nine occasions from the patient prior to an invasive procedure being carried out. This was not in line with best practice guidance, as stated in the Royal College of Nursing Principles of Consent Guidance for Nursing Staff, 2017.

This meant that it was unclear if the patient had fully understood the procedure or had been provided an opportunity to refuse and was particularly important as the patient had short term memory loss and there was a possibility that they would not remember why the procedure was being undertaken.

- We found that the service had completed mental capacity assessments when needed. This included key decisions such as an application for a Deprivation of Liberty safeguard or a do not attempt cardiopulmonary resuscitation order.
- All staff were required to complete safeguarding training for adults and children as part of their induction as well as their ongoing mandatory training. This included face to face training which was provided internally, as well as e-learning modules which were provided by an external organisation.
- The management team informed us that e-learning had been introduced for all staff to complete since our last inspection. However, on reviewing the most up to date training figures provided during the inspection, it was unclear what the overall compliance for safeguarding training was. This was because although records indicated that 76% of all staff had completed safeguarding adults training level two via e-learning, the same report indicated that only 67% of registered nurses and 55% of rehabilitation co-therapists had completed safeguarding adults level two training which had been delivered internally.
- In addition, we found limited evidence that safeguarding concerns were discussed at governance meetings, at local or corporate level. For example, we found that there was no documented evidence of a safeguarding concern that was reported in May 2019 having been discussed at board level. This meant it was unclear how safeguarding information and concerns were being shared and escalated appropriately and remained a continued concern since our last inspection.

Medicines

- **The service had not always used systems and processes to safely record and store medicines. Medicines had not always been available for patients when needed.**
- The service had a medicines management policy which was available to all staff. This included topics such as administration, storage and destruction of medicines. Staff we spoke with knew about this and how to access it if needed.
- Registered nurses and doctors were required to complete mandatory training for the administration of medicines through a percutaneous endoscopic gastronomy tube (a tube which enters directly into the stomach). Records indicated that 89% of staff were up to date with this. This was an improvement since the last inspection.
- The management team had recently introduced a standard operating procedure for staff to follow when administering and disposing of controlled drugs. This was important as the medicines management policy stated that two registered nurses had to be present to check these, however, the service had recently decided that they only needed one registered nurse per shift.
- The standard operating procedure stated that rehabilitation co-therapists could witness the administration of controlled drugs. However, the management team had not made sure that they had received training to do this. This was not in line with best practice guidance, NICE guidance 46, Controlled drugs: safe use and management, which states that any non-registered professionals who support the administration or destruction of controlled drugs must have the competencies to do so.
- Medicines including controlled drugs (medicines that require special storage arrangements and record keeping because of their potential for misuse) were securely stored. We found that the number of controlled drugs tallied with the amount recorded and that they had been checked daily. In addition, we found that a member of staff had witnessed and countersigned all entries in the register.
- However, it was unclear if controlled drugs had been disposed of in line with legislation and policy. This was because on reviewing the destruction of controlled drugs register between the 1 April and 26 July 2019, we found that water had been spilt over all of the records, meaning that we were unable to see if all entries had been signed for appropriately.
- Records indicated that between the 1 April and the 6 August 2019, there had been 10 occasions when medicines had not always been available to administer

to patients when needed. Although these had been reported to the incident reporting system, it was unclear what action had been taken to reduce the risk of a similar incident reoccurring.

- We also found that temperatures for fridges used to store medicines were within normal range. However, although there were no medicines stored in the fridges at the time of inspection, records indicated that daily checks had not always been completed. For example, in June 2019, there had been 11 occasions when this had not been completed. This meant that there was a risk that fridge temperatures would not always be kept within normal range if medicines that required refrigerating were available.
- The service had registered a controlled drugs accountable officer since our previous inspection of March 2019. This was in line with the Controlled Drugs (Supervision of Management and Use) Regulations, 2013.

Environment and equipment

- **The design, maintenance and use of facilities, premises and equipment kept people safe.**

- Emergency resuscitation equipment was in place in the main lounge and pool area. A review of the records indicated that the equipment was checked daily. However, we found three pieces of disposable equipment which were out of date.
- We found that during our last inspection of March 2019, improvements had been made to the way that equipment was monitored and how the service made sure that equipment had been serviced in a timely manner.
- During this inspection we found that although records indicated portable appliance testing had been completed in a timely manner, it was unclear if servicing for some equipment was out of date. This was because 42% of equipment which had been listed on the service log did not indicate when they were next due to be serviced. This meant that there was a risk of equipment becoming faulty whilst being used. However, following the inspection we were informed that there were plans to update the equipment log and remove items that were no longer on site.

Quality of records

- **Staff had not always kept detailed records of patients' care and treatment. Records were not always clear, up-to-date and stored securely.**

- The hospital used a paper based records system and the structure of patient's clinical records had been recently changed to reduce the risk of unnecessary duplication. Records that we reviewed were signed and dated appropriately.
- However, we found that not all records were always stored securely. This was because we observed two occasions when patient identifiable information had been left unsupervised in communal areas. This was important as there were several occasions when relatives were visiting patients and there was a risk that patient confidentiality would not always be maintained.
- In our last inspections of May 2018 and March 2019, we found that record audits had been completed, however, we had concerns that actions had not been implemented to make improvements to shortfalls that had been identified.
- During this inspection, members of the management team informed us that the audit process for reviewing the quality of patient records had been amended. However, on reviewing the audits that had been completed, we had continued concerns that actions had not always been implemented to make improvements when needed. In addition, on occasions when action plans had been implemented, it was unclear who was responsible for implementing actions and when actions should be completed by.
- We identified concerns during our last inspections of March 2017, May 2018 and March 2019 that information was either difficult to find or was missing. On this inspection we sampled six patient records, finding that none had been fully completed. This meant that not all records were immediately available for staff to access and there was an increased risk that some aspects of patient care would be missed.
- In addition, we reviewed consultant ward rounds that had been completed on a weekly basis for all patients. On reviewing these, we found that none had been fully completed and most were illegible. This meant that there was an increased risk that patients had not been fully reviewed and that staff would not be able to access the most up to date patient information.
- The service had not made arrangements to archive records in line with national standards. Archived records

were disorganised, and it was unclear if all necessary paperwork had been kept. In addition, there was no clear governance outlining how this should be done or the minimum standards that should be followed.

Mandatory training

- **The service had not always made sure that staff had completed mandatory training in a timely manner.**
- A compliance target of 95% had been set for all mandatory training. However, records indicated that this had not been achieved.
- In our last inspections in May 2018 and March 2019, we found that records for mandatory training had not always been kept up to date, meaning that it was unclear if sufficient numbers of staff had completed the necessary training to undertake their roles.
- During this inspection we found that although mandatory training records had been moved to an electronic system, it was not always clear if compliance with mandatory training had been kept up to date. This was because on reviewing records that were provided during and after the inspection, there were some training modules missing. For example, compliance with training to administer medication using a percutaneous endoscopic gastronomy tube (a tube which allows fluids, nutrition and medication to be put directly into a patient's stomach).
- Although overall compliance with mandatory training had improved since our last inspection, we had continued concerns that there were some areas of low compliance with training. For example, only 50% of registered nurses were up to date with immediate life support training, only 60% of staff were up to date with tracheostomy care level one and two, as well as only 60% of staff being up to date with continence and catheter care. Following the inspection we were informed that compliance with immediate life support training was 80%.

Assessing and responding to patient risk

- **Staff had not consistently completed and updated risk assessments for each patient and removed or minimised risks.**
- During our previous inspection we identified continued concerns around the completion and storage of do not attempt cardiopulmonary resuscitation orders. On this inspection, we found that there was only one order in place for a patient and whilst this could be found there was no review date recorded. This was not in line with best practice guidance and there was a risk that if a patient's condition changed, they would not be resuscitated when needed.
- On reviewing six sets of patient records which accounted for all patients at the unit, we continued to find that patient risk assessments had not been consistently completed on any occasion, which was not in line with best practice guidance or policy.
- We reviewed six patient end of bed records which included percutaneous endoscopic gastrostomy monitoring forms, tracheostomy care, gastric aspirate monitoring forms, fluid intake charts, national early warning scores, clinical observations and enhanced observation forms as well as repositioning forms. Of these, we found that there were omissions for all six patients. These included missing dates for when these assessments should have been undertaken or when risk assessment scores had been calculated incorrectly.
- We also reviewed risk assessments for all six patients, including falls, pressure ulcers, pain assessments, daily exercise records and bed rails risk assessments, finding that these had not been completed consistently for five patients.
- On occasions when patients had been at high risk of falls, the actions taken to maintain patient safety had not been clearly transferred to the patients care plan.
- When we reviewed the falls risk assessment action tool we found that for the majority of patients all sections had been completed even if they were a green, amber, or red risk. This meant it was unclear if staff understood what actions to take in order to reduce the risk of the patient falling.
- We found for one patient, that their pain assessment tool had not been completed on 11 occasions between 24 May 2019 and 8 July 2019. Additionally, there was no record of this being completed for four weeks following the 8 July 2019. For another patient we found 29 omissions between the 24 May and the 9 July 2019. This meant there was a risk that patient's level of pain was not always monitored and that there was an increased risk that pain relief would not always be administered when needed.
- When reviewing a care plan for one patient, we found that the behavioural care plan stated staff should see the interventions outlined in the patient support plan.

However, when we reviewed this we could see no documented evidence of interventions having been implemented. This meant that there was an increased risk that the patient's behaviour would not always be managed appropriately by staff.

- We reviewed records for one patient, finding that a tissue viability nurse assessment on 29 April had outlined recommendations for care of a pressure ulcer which had deteriorated slightly. A further assessment was undertaken on 11 May 2019 and again it noted that the patient had only just received all the elements of the wound care products advised from the visit in April 2019 and the pressure ulcer had remained static. We also noted that the monthly skin integrity care plan for this patient had not been reviewed in April 2019. This meant that we had concerns that the patient may not have received care in a timely manner to help improve their pressure ulcer.
- However, we noted that on reviewing patient care plans, that there had been an improvement since our last inspection of March 2019 as the majority had been reviewed within the specified timeframe.
- The hospital used a national early warning score system to monitor patients' clinical condition and identify any deterioration so that appropriate action could be taken. The national early warning score system had been designed to assign a score to each clinical observation, for example blood pressure and temperature, to indicate potential deterioration in patients' condition and prompt clinical action. The national early warning score document stipulated set actions to be taken when patients overall score reached a specified level. All patients had a modified national early warning score in place due to their presenting condition.
- We found that patient's modified early warning scores had been calculated correctly in most cases and escalated when needed on most occasions. Recent audits undertaken by the management team in April and June 2019 showed that compliance levels were 100% on both occasions.

Staffing levels and caseload

- **The service had enough staff to keep patients safe from avoidable harm and to provide the right care and treatment.**
- Members of the management team informed us that the staffing establishment had recently been reduced due to the reduction in the number of patients who were being cared for at the unit. We were informed that the needs of the patients, such as if they required 1:1 support, had been considered as part of this process.
- Between the 1 April and 19 July 2019, the management team had planned to have two registered nurses on all shifts, 24 hours a day, seven days a week. We were informed that from the 20 July 2019 onwards, this had been reduced to one registered nurse on every shift. Rotas between 1 April and 4 August 2019 indicated that the planned number of registered nurses had been achieved on all but three occasions.
- Rotas for the same period indicated that the planned number of rehabilitation co-therapists had not been achieved on a high number of occasions, for example between 18 March and 30 May, there had been 13 occasions when the planned establishment had not been met. This was important as rehabilitation co-therapists were responsible for undertaking important roles such as providing 1:1 care to patients when needed. However, we noted that since the planned number of rehabilitation co-therapists had been reduced, the planned establishment had been met on all occasions.
- We identified concerns in March 2017 and March 2019 that the hospital did not have a system in place to make sure that appropriate numbers of trained staff were on duty to provide care to patients with percutaneous endoscopic gastronomy tubes and tracheostomies. On this inspection, we found that the management team had made the system clearer so that there was better oversight of this.
- We also identified concerns during our last inspection that there had not always been sufficient numbers of suitably qualified staff to meet the needs of patients with percutaneous gastronomy tubes and tracheostomies. On reviewing rotas between the 1 April and the 16 August 2019, there had always been a registered nurse available with the correct competencies.
- Members of the management team informed us that registered nurses delegated all tasks to rehabilitation co-therapists. This was important as it meant that the registered nurse delegating a task must be competent themselves as they were then required to assess whether the task had been completed to the correct

standard. However, we had concerns that this was not reflected in any clinical or operational policies, meaning that there was a risk that all staff would be aware of this requirement.

- Members of the management team informed us that there were currently vacancies for four registered nurses and 11 rehabilitation co-therapists. We were also informed that the hospital had faced challenges in recruiting new staff and that this was managed as a formal risk on the risk register.
- We identified continued concerns that there was not always documented evidence that agency staff had completed a unit induction prior to starting their first shift. Records indicated that induction checklists had not been completed on two occasions. This meant that there was an increased risk that agency staff would not always be aware of or follow unit's policies or procedures. However, we found that work had been completed to keep the competencies of agency staff up to date. All agency staff also had a photograph as part of their profile so that staff from the unit were able to identify them at the beginning of every shift.
- The management team informed us that arrangements had been made for the service to access two consultants under a service level agreement and had planned for them to be available for five half day sessions a week as well as providing out of hours cover. Although this meant that they were present to review patients, we were informed during the inspection that there was no capacity for them to attend any multi-disciplinary meetings. This was important as patients' needs were reviewed in these meetings by the whole team. Following the inspection we were informed that the opportunity for consultants to attend these meetings was maximised as much as possible.

Are community health inpatient services well-led?

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that there is learning from all incidents that are reported, so that the risk of similar incidents happening again is reduced. Regulation 17.
- The service must ensure that incidents are reported in line with service policy, particularly regarding patient's behaviour, so that appropriate learning is captured and care plans are amended when needed. Regulation 17.
- The service must ensure that Duty of Candour is applied on all occasions when needed. Regulation 20.
- The service must ensure that all safeguarding incidents are reported in a timely manner, reducing the risk of patients suffering avoidable harm. Regulation 13.
- The service must ensure that safeguarding policies and procedures provide up to date and accurate information, detailing appropriate actions for staff to take when needed. Regulation 13.
- The service must ensure that there is documented evidence of the destruction of controlled drugs being witnessed, in line with legislation. Regulation 12.
- The service must ensure that staff complete mandatory training in a timely manner. Regulation 18.
- The service must ensure that there are policies and procedures to protect patients from abuse when receiving intimate examinations or treatment. Regulation 13.
- The service must ensure that consent is documented in line with best practice guidance on all occasions when needed. Regulation 13.
- The service must ensure that do not attempt resuscitation orders are managed in line with best practice guidance and in a way that reduces the risk of patients being resuscitated or not resuscitated inappropriately. Regulation 17.
- The service must ensure that all patient records are fully completed, up to date and legible, including risk assessments such as those for falls and pressure ulcers as well as end of bed monitoring charts. Regulation 17.
- The hospital must ensure that records are stored securely at all times so that patient confidentiality is maintained. Regulation 17.
- The service must ensure that Fit and Proper Person checks for directors are undertaken in line with policy. Regulation 5.
- The service must ensure that on occasions when areas of poor performance is identified, timely action is taken to make improvements to the service provided. Regulation 17.
- The service must ensure that there are effective systems in place to monitor all services that are provided, such as those provided under service level agreements. Regulation 17.

Action the provider SHOULD take to improve

- The service should ensure that the level of patient harm is correctly documented against all incidents that have been reported.
- The service should ensure that on occasions when patients have sustained injuries of unknown origin, that there is documented evidence of the cause of injury as well as making sure that actions are taken to reduce the risk of similar incidents happening again.
- The service should ensure that fridge temperatures are checked in line with policy.
- The service should ensure that there are sufficient numbers of staff on duty at all times.
- The service should ensure that a clear oversight is maintained for all equipment, making it clear whether servicing has been undertaken in a timely manner.
- The service should consider ways in which to operate a system so that patient harms can be monitored effectively.

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 **How the regulation was not being met;** The service had not completed Fit and Proper Person checks for all directors, in line with policy. Regulation 5 (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met;** Compliance with mandatory training was low across a number of key modules. Regulation 18 (2)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met;** There was no documented evidence available which showed that Duty of Candour had been applied when needed. Regulation 20 (1)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **How the regulation was not being met;** We reviewed records for six patients, finding that risk assessments had not been completed consistently on five occasions. The service had not always made sure that there was documented evidence of controlled drugs being destroyed in line with policy and legislation. 12 (2)(a)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met;** Safeguarding concerns had not always been reported in a timely manner. Safeguarding policies and procedures did not provide up to date and accurate information, detailing appropriate actions for staff to take when needed. The service did not have policies and procedures to protect patients from abuse when receiving intimate examinations or treatment. Consent had not always been documented in line with policy and best practice guidance. Regulation 13 (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met;**

This section is primarily information for the provider

Requirement notices

Do not attempt cardiopulmonary resuscitation orders had not been completed in line with best practice guidance.

Incidents of aggression had not always been reported to the electronic reporting system, in line with policy.

Reported incidents had not always been managed in a way that meant that the risk of a similar incident happening again was reduced as much as practicably possible.

Patient records had not always been fully completed and they were not always completed in a way that was legible.

Patient records had not always been kept in a way that maintained patient confidentiality.

The service did not have effective procedures to make sure that patient records had been archived in a way that met national guidance.

Regulation 17 (2)(a)(b)(c)