Spiral Health C.I.C

1-168947026

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1894456834	Spiral Health Preston Unit	Spiral Health Preston Unit	PR2 9HT

This report describes our judgement of the quality of care provided within this core service by Spiral Health C.I.C. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Spiral Health C.I.C and these are brought together to inform our overall judgement of Spiral Health C.I.C

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Overall summary

Spiral Health Preston Unit is operated by Spiral Health Community Interest Company (CIC). We carried out an announced inspection of the Spiral Health Preston Unit on 27 March and 5 April 2017 as part of our national programme to inspect all independent services. We inspected the core service of community health inpatients as this was the activity undertaken by the provider at this location.

An unannounced inspection was carried out in August 2015 in response to an increase in the number of patients with pressure sores and to assess the criteria for admission to the unit. Following this inspection a requirement notice was issued to the provider for them to make sure the service adhered to policies and procedures for the safe disposal of medication.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

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

We found the following areas of good practice:

- The unit had systems in place to report and investigate incidents and safeguarding concerns about vulnerable adults.
- The unit was visibly clean and had sufficient and appropriately maintained equipment to safely provide care.
- The unit used assessments to identify and monitor patient risk, before and after patients were admitted to the unit.
- The unit had sufficient staffing levels to provide safe care to the patients. Staff were supported with training and appraisal with over 90% of staff having completed both.
- The unit used a recognised tool to monitor the improvements of performance in daily activities for patients on the unit.
- There were strong working relationships between the disciplines and with external stakeholders which supported safe and effective care.
- Staff were kind and respectful to patients on the unit and respected and protected patients' privacy and dignity.
- Patients were involved in their care and were given information and explanations about the care they were receiving.
- The unit had good links with charities and other organisations to provide support and empowerment to patients to manage their own health once they left the unit.
- The services were planned to meet the needs of people in the local population who had been admitted to hospital. The services were delivered to provide additional support to those who needed it.
- Staff were positive about the leadership and the culture within the unit.
- Good response to audits and information of concern meant the service and staff had learned from and acted upon such information.
- The ward clerk gave a telephone call to patients two weeks after they had been discharged from the unit to see how they progressing. If there were any concerns these would be passed to clinical staff or to social services.

However, we also found the following issues that the service provider needs to improve:

- The oxygen cylinder on the resuscitation trolley was empty at the time of the inspection, despite having been checked on the previous day.
- The unit was not routinely completing the consent form in the patient records which gave consent for physical examination and to be involved in the assessment and care planning.
- The cleaning schedules for daily, weekly and monthly cleaning by staff were poorly completed.
- We saw examples of the evaluations of the pressure wounds being unclear in medical records.
- We saw induction checklists for new staff which had not been fully completed.
- The unit did not arrange regular social or group activities for patients on the unit.
- The unit did not arrange any social or group activities for patients on the unit.

Summary of findings

- The unit did not have access to an interpreting service for patients and families who did not speak English as their first language.
- The complaints procedure and complaints leaflet gave different information about how to complain. The complaints procedure signposted people to the incorrect ombudsman.
- The unit had not completed quality and governance reports from August 2016 to January 2017.
- The unit did not have a risk register in place to record and assess clinical risks affecting the unit.
- The unit did not collect feedback from the 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, even though a regulation had not been breached, to help the service improve. We also issued the provider with a requirement notice that affected Spiral Health Preston Unit. Details are at the end of the report.

Summary of findings

Our inspection team

Our inspection team was overseen by an Inspection Manager, Lorraine Bolam, Care Quality Commission.

The team included two CQC inspectors and one specialist, a nurse with experience of managing community inpatient services.

Why we carried out this inspection

We inspected this service as part of our ongoing independent provider inspection programme.

How we carried out this inspection

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

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

We inspected community health inpatients which covered all the activity undertaken.

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of audits. We requested information from the commissioners of the service. We placed comment boxes at the unit before our inspection, which enabled staff and patients to provide us with their views. We did not receive any completed comments.

We carried out an announced inspection on 27 March 2017 and an unannounced visit on 4 April 2017 during the night shift.

We held a focus group meeting where staff could talk to an inspector and share their experiences of working at the hospital. We interviewed the management team and a member of Spiral Health CIC's Executive Board. We spoke with a wide range of staff, including nurses, health care assistants, the resident medical officer, therapists, administrative and support staff, totalling 23 personnel. We also spoke with nine patients who were using the service.

We observed care in the unit, reviewed six sets of patient records, including prescription charts and observed a staff handover. We observed how equipment was used and maintained and we checked the general environment.

What people who use the provider say

- The unit had only recently started actively seeking patients' feedback.
- We posted comment cards in the unit before the inspection but we did not receive any comments.
- Patient's and relatives were positive about the care and treatment they received. They said they were involved in discussions about their treatment and staff treated them with dignity and respect.
- At the time of the inspection the unit did not collect friends and family test data. The friends and family test is a test used in care organisations where patients are asked whether they would recommend friends and family to use the organisation.
- The unit was in the process of setting up a patient experience team to seek and collect feedback from patient's who had used the unit. The team had started seeking feedback from patients following their

Summary of findings

discharge from the unit to check their progress, including the friends and family test and was contacting patients two weeks following their discharge to see how they were.

- The unit scored 77.6% for the patient-led assessments of the care environment (PLACE) for privacy, dignity and wellbeing from February to June 2016. This was below the England average for hospitals which was 84.2%.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- Governance arrangements were being developed at the time of the inspection. The unit had just started a quality and patient safety committee. The unit was in the process of setting up leads and a monthly quality meeting.
- Quality and governance reports were not completed for from August 2016 to January 2017.
- The unit did not have a local risk register in place to record and assess clinical risks affecting the unit.
- At the time of the inspection the unit did not collect feedback from patients.
- The provider should ensure the daily checks are adequately completed by staff in relation to the oxygen cylinder stored with the resuscitation trolley.
- The provider should ensure the cleaning schedules for daily, weekly and monthly cleaning by staff are well recorded.
- The provider should ensure all drugs to be disposed of are accounted for and staff appropriately record the tablets to be disposed of.
- The provider should ensure all sharps bins are signed and dated when they assembled and started to be used.
- The provider should ensure staff complete the induction checklist to confirm they had completed each part of the induction when they started their role.
- The provider should ensure patients are routinely involved in signing the consent forms for their consent for physical examination and to be involved in the assessment and care planning.
- The provider should consider arranging group and social activities for patients.
- The provider should ensure patients and their families have access to an interpreting service if they did not speak English as their first language.
- The provider should ensure the complaints procedure correctly signposts people to the appropriate Ombudsman.
- The provider should ensure the governance arrangements are further developed and implemented.
- The provider should ensure the there is a risk register in place to record and assess clinical risks affecting the unit, rather than just corporate risks.
- The provider should ensure there is a system in place for collecting feedback from the patients, for example by carrying out the friends and family test.

Spiral Health C.I.C

Community health inpatient services

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We do not currently rate this service.

We found the following areas of good practice:

- The unit had systems in place to report and investigate incidents. Staff were aware of how to report incidents and were confident in using the system. While staff gave us examples of learning from incidents, minutes of the last meetings showed that incidents were not discussed at every meeting.
- Staff had received training in safeguarding vulnerable adults and had a good understanding of what to identify and how to report it.
- The unit had sufficient and appropriately maintained equipment to safely provide care to patients staying on the unit.
- Medical records were legible, dated, timed and signed by clinicians.
- The unit had assessments in place to identify and monitor patient risk, before and after patients were admitted to the unit.
- The unit had procedures in place for the management and transfer of deteriorating patients from the unit to an NHS hospital.
- The unit had sufficient staffing levels to provide safe care to the patients.

However, we also found the following issues that the service provider needs to improve:

- The oxygen cylinder on the resuscitation trolley was empty at the time of the inspection. This also showed that the daily checks had not been adequately completed. However, this was addressed immediately on the inspection.
- While the unit appeared to be visibly clean, the cleaning schedules for daily, weekly and monthly cleaning by staff were poorly completed. The unit also had poor compliance with its audit of the cleanliness of the commodes and we found a commode that had an 'I am clean' sticker but was not clean.

Are services safe?

Safety performance

- The unit recorded limited information which measured safety performance on the unit. At the time of the inspection the unit displayed the number of falls and medication errors within the last month.

Incident reporting, learning and improvement

- The unit used a computer system for reporting incidents. Contracted staff were responsible for uploading incidents onto the computer system and agency staff completed a paper form which was passed to the management team to be uploaded. Staff we spoke with knew what constituted an incident and knew how to use the computer system to report an incident. All incidents were reviewed by the general manager and clinical matron on the unit.
- Staff said learning from incidents was discussed as part of the unit meetings or if it was more urgent in the communication book, so it could be shared to staff working on the next shift. If there was learning specific to a member of staff that would be shared directly with them. We reviewed the minutes of the December 2016, February and March 2017 unit. 'Lessons learned' was an agenda item in the February and March 2017 meetings, but there was only evidence of discussion at the February 2017 meeting.
- Incident trends had been reviewed in a quality and governance report which was prepared for the board. The report for August 2016 (which covered from April to July 2016) categorised incident types and set out how many had occurred in the last three months. However, the unit had not completed reports from August 2016 to January 2017. The unit completed a report covering from February to April 2017 after the inspection.
- Staff gave examples of different incidents which had occurred and the actions that had been taken as a result of them. These included an incident about clinical care and an incident about information governance, which led to confidential waste bins being procured for the service.
- The unit had identified concerns with a number of incidents, relating to the use of agency staff and specifically agency staff on the night shift. Some of the incidents had also triggered safeguarding referrals and complaints from patients. As a result of the concerns the unit stopped using the agency concerned. In addition the unit changed the skill mix of the night shift, recruited assistant nurse practitioners and ensured there was always substantive staff during the night shift.
- We reviewed the serious incident report following a serious allegation within the year before the inspection. No action was taken by the police. The provider report was written by an independent investigator. The manager provided a reflection and learning meeting for staff following this.
- The unit was completing a root cause analysis investigation for an incident, at the time of the inspection, which was still in progress. The unit commissioned an independent investigator to complete the report.
- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Senior staff we spoke with had a good understanding of the duty of candour and the steps the unit needed to take if there was an incident which triggered the duty of candour. They gave us examples of where they had applied the duty of candour and the steps taken.

Safeguarding

- From January 2016 to January 2017 the unit referred 24 safeguarding concerns to the local safeguarding team. In the same period CQC received eight safeguarding concerns about the unit. CQC held two engagement meetings with the provider to monitor the service due to the number of concerns being raised and were kept updated about the progress of the concerns.
- The Head of Business Development for Spiral Health prepared a monthly report on safeguarding cases which was shared with the senior leadership team that looked at the incidents which had been logged as safeguarding issues and looked in detail at individual cases. Where follow up action had been required we saw evidence this had been actioned.
- The unit had a policy for safeguarding vulnerable adults which included examples of issues and the contact details of the local safeguarding team and local police force. The policy was displayed in the staff room, where it could be easily accessed by staff.

Are services safe?

- All staff were required to complete safeguarding adults and safeguarding children training as part of the mandatory training. Clinical staff were also required to complete supplementary on-line safeguarding training provided by the local county council and PREVENT training (PREVENT is National strategy which aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists). At the time of the inspection 91% of staff had completed or been booked into complete the mandatory safeguarding training.
- Staff we spoke with had a good understanding of what should be reported as a safeguarding concern. Staff said they would report the concern to the matron and they would either refer it to the local safeguarding board or the matron would refer it. Staff gave us examples of safeguarding concerns they had reported where they had been concerned about the welfare of patients on the unit.

Medicines

- We found improvements had been made since the inspection in August 2015 when we issued a requirement notice which said the unit must take action because a record was not kept of discarded medication, and large quantities of waste medication was inappropriately and unsafely held on the unit. In addition the provider had not ensured staff followed the medication management policy. During this inspection we found the unit stored medication that was to be disposed of in bins in a locked cabinet. The unit had arrangements for these to be collected weekly by the NHS hospital pharmacy.
- However, while the unit kept a record of the medicines disposed of, there was nowhere to record the date the medicines had been disposed of and there were inconsistencies in how staff recorded the tablets to be disposed of. We saw whole packs of medicines had been put in the bins, rather than individual blister packs. As a result not all drugs were accurately accounted for which had been disposed of by the unit.
- Staff we spoke to were aware of the medicines management policy.
- Medicines in the unit were securely stored and monitored appropriately. Patients brought medicines which had been prescribed to them by the NHS hospital where they had been discharged from, known as 'to take out' (TTO) medication. Medicines for each patient were stored in locked cabinets beside their beds. Additional supplies of drugs were stored in a securely locked cupboard, in a room with key code access. Drugs for each patient were stored in a separate labelled basket.
- The patients' own controlled drugs were stored in a separate locked cabinet and appropriately accounted for. We reviewed the records for controlled medication which showed that a full record was kept for the administration of controlled medication for each patient.
- The unit held a stock of over the counter medicines, for example paracetamol, antacid and laxative medicines. These were stored in a separate locked cupboard. The unit kept a record of the homely medicines which could be given and the staff with competencies to administer them, which we reviewed on the inspection.
- Medicines which needed to be stored at a lower temperature were stored in a locked fridge. The fridge had an alarm which would signal if the fridge fell below two degrees Celsius, or rose above eight degrees Celsius, as this could potentially reduce the effectiveness of medication stored.
- The unit had a full record of controlled drugs which were disposed of by the unit in an appropriate way.
- We observed staff completing a drugs round and saw that they correctly recorded and administered drugs given to patients. During the round the nurse wore a tabard saying they were completing the drugs round. This gave a signal to staff, patients and their relatives not to distract them without a good cause to reduce the risk of drug errors.
- Assessments were completed for patients so they could manage and administer their own medication if they were capable to do so.
- The unit had a service level agreement with a local pharmacy for the provision of drugs which were prescribed by its resident medical officer or out of hours doctors who attended the unit.
- The unit carried out a monthly medicines management audit. We reviewed the audits for January and February 2017 and found that while they both included action plans for all of the areas of non-compliance, three of the same areas of non-compliance were evident in both audits, despite an action plan being in place. This showed that the action plan from the January 2017 audit had not been implemented effectively.
- The unit also carried out a monthly audit to check medication received on admission matched the

medication prescribed by the hospital the patient had been discharged from, records of medication not administered as prescribed, allergies and self-administration of medication assessments. In December 2016, January and February 2017 the unit scored 87.4%, 91.7% and 94.6% respectively. There was an action plan each month to address non-compliance.

Environment and equipment

- Resuscitation equipment was available in a central location of the unit. We checked the equipment and found tamper proof tags were fitted and staff had completed daily and weekly checks of the adult resuscitation equipment. While checks had been completed, including the day before the inspection, we found the oxygen cylinder on the trolley was empty. This meant if the resuscitation equipment was needed there was a risk there would be a delay to giving someone oxygen. On the inspection we raised this with the management of the unit who ensured that the oxygen cylinder was replaced. The manager reported the trolley and oxygen had been used the previous day in response to an emergency. They also made changes to the daily checklist so it was clear that the staff member needed to check whether the oxygen cylinder was empty and needed replacing. While the oxygen cylinder was empty we saw that there were full oxygen cylinders stored elsewhere on the unit. On the unannounced part of the inspection we found the oxygen cylinder had been replaced and the new checklist was in place and had been completed daily.
- In all of the rooms there were emergency call buttons which would notify staff that a patient needed emergency care.
- The unit had a service level agreement with the NHS trust located on the same site for the maintenance and repair of all of the equipment on the unit. We reviewed log books and found there was an up-to-date record of the service history of equipment. We reviewed a sample of five pieces of equipment and found they all had stickers to indicate they had been safety tested within the last year, which was supported by the records.
- Throughout the unit we saw evidence that waste was stored in foot operated bins and clinical and non-clinical waste was properly separated. Waste which was ready to be collected from the unit was stored in sealed plastic bags in a cupboard at the back of the unit. While this cupboard was key code operated, during the inspection we found it was open. This posed a risk to patients or their visitors accessing this area.
- The unit had sharps bins for the safe storage of used needles and other sharp items. These were stored in a room which was key code operated. Two of the four sharps bins had not been signed and dated when they had been assembled and use started.
- The unit had a variety of moving and handling equipment available for patients including hoists, transfer boards and a specially adapted bath. We saw the unit had a stock of walking aids and wheelchairs were stocked for patients who required assistance with walking.
- The unit had a mobile staircase, located in the corridor, which was used by therapy staff for rehabilitating patients for using their own stairs at home or in the community.
- The unit had 10 pressure relieving mattresses and cushions available for patients who were at risk of developing pressure ulcers. The unit also had access to higher specification pressure relieving mattresses which we were told could be ordered if the patient was assessed as needing one.
- Patient-led assessment of the care environment (PLACE), enable organisations to see how well they are meeting the needs of the patient and to identify where services can improve. The unit scored 88.2% for PLACE for condition, appearance and maintenance from February to June 2016. This was below the England average which was 93.4%. However, it should be noted that the service rented the unit.

Quality of records

- Patient records for each patient were stored in a lockable cabinet in the office, only accessible to staff, and drugs and nutrition charts were stored beside the patient's bed. All records were in paper format. Once a patient had left the unit their medical records were stored in a locked room on the unit before being safely archived offsite.
- We reviewed six full medical records and found all the entries in the records were legible, dated, timed and signed by the nurse, therapist or doctor.

Are services safe?

- In all of the records we found completed and up to date care plans and assessments, such as for nutrition and hydration and pain. While we saw care plans in place for patients, we saw two examples of the evaluations of the pressure wounds being unclear within these records.
- We saw evidence in the care records that care goals and objectives were regularly reviewed and monitored
- As part of the unit's monthly nursing care indicator audit the medical records were reviewed to look at the quality of assessments in relation to falls, nutrition, pressure ulcer, moving and handling, barthel index (a measure used for monitoring performance in activities of daily living such as toilet use, feeding, transfers and walking) and medications. Each month a sample of ten records was reviewed and a series of questions checked, some of which related to the quality of the records.

Cleanliness, infection control and hygiene

- The bays, bedrooms and other rooms in the unit were visibly clean and tidy. We observed staff cleaning the bathrooms during the inspection.
- The unit had a service level agreement with an NHS trust for general cleaning. In addition the unit had daily, weekly and monthly cleaning tasks for each shift to complete and checklists to indicate that the tasks had been completed. We reviewed the checklists and found significant gaps in the daily and weekly checklists for the three weeks before the inspection and in the most recent monthly checklist. In the last three weeks, of the 63 shifts, on 14 shifts the daily checklist was not completed and on 13 shifts only partially completed. This meant the unit could not be assured that staff had cleaned areas of the unit when they should have done.
- The unit had an infection control policy and procedures which provided information and advice to staff on maintaining infection control and hygiene measures.
- The unit carried out a monthly environmental audit which looked at whether the rooms and equipment were clean and tidy, waste disposal, sharps and personal protective equipment. We reviewed the January and March 2017 audits which showed that an action plan had been created for areas of non-compliance.
- We saw that all clinical staff on the unit followed the arms 'bare below the elbow' guidance to allow thorough hand washing and reduce the risk of cross infection.
- The unit had a schedule to replace curtains every six months, or before, if a patient had an infectious illness. Curtains across the unit had been changed in November 2017, however, in one of the bays the date the curtains had been changed had not been marked on the curtains. This meant the unit could not be assured that they had been changed within the previous six months.
- Wash basins were available in all of the rooms and hand sanitisers were widely available throughout the unit. During the inspection we saw staff and patients using the hand sanitiser. We saw instructions on hand washing techniques above sinks across the unit. The unit gave us a hand hygiene audit which covered a period of approximately seven weeks from January to March 2017. While the audit indicated high compliance with hand hygiene by staff, the audit did not record how many observations had been carried out over the period.
- The unit used green 'I am clean' stickers to indicate, following previous use, when a piece of equipment had been cleaned, ready for the next use.
- The unit carried out a monthly audit of the unit's three commodes. We reviewed the audits for December 2016, January and February 2017 and found 0%, 67% and 67% of the commodes had been clean respectively, despite 'I am clean' stickers being present on the commodes. We looked at the three commodes and found that while the commode frames and pans all had 'I am clean' stickers, one of the pans was not clean. The audits and our review indicated the commodes were not being properly cleaned which posed an infection control risk to patients using the commodes.
- Personal protective equipment for staff, such as gloves and disposable aprons were available in all of the bays and bedrooms throughout the unit and was seen to be used appropriately by staff.
- The unit had barrier nursing procedures for patients who had or were suspected of having infectious illness. Staff we spoke to had a good understanding of the procedure and said patients who needed barrier nursing would be moved to one of the side rooms, a sign would be displayed on the door and a trolley with equipment moved to outside the door. During the inspection there were no patients requiring barrier nursing.
- The unit scored 96.0% for the patient-led assessments of the care environment (PLACE) for cleanliness from February to June 2016. This was below the England average which was 98.1%.

Are services safe?

Mandatory training

- Staff were required to complete mandatory training every year or every other year (depending on the module). The unit's target was for 100% of staff to have completed mandatory training.
- Staff completed mandatory training at a day long training sessions delivered by an external provider. The mandatory training covered: basic life support; conflict management, complaints handling and lone working; COSHH (Control of Substances Hazardous to Health); equality, diversity and Human Rights; fire safety; food safety; health and safety awareness; infection control; moving and handling; patient consent and confidentiality; safeguarding children; and, safeguarding adults. In addition to the day long mandatory training course all staff were required to complete modules in first aid, PREVENT, person centred practice, dementia and customer services and information governance.
- At the time of the inspection 91% of mandatory training had been completed or booked to be completed by staff.

Assessing and responding to patient risk

- Before patients were admitted to the unit an assessment of their needs was carried out by a multidisciplinary team made up of nursing and therapy staff, by staff at the referring NHS trust. We reviewed copies of the assessments which assessed the needs of the patient and specific risks, for example mobility, falls, cognition, skin integrity, breathing concerns and nutrition. These were reviewed by the unit before a patient was accepted to ensure they met the admissions criteria.
- There was evidence in the care records we reviewed that risk assessments were completed for patients to identify and monitor potential risks. These included assessments of tissue viability, nutrition and hydration, moving and handling, falls and venous thromboembolism (VTE).
- The unit carried out a monthly audit of the assessments for tissue viability, nutrition and hydration, moving and handling and falls. In December 2016, January and February 2017 the unit scored 98%, 100% and 100% for tissue viability assessments. In the same months the unit scored 80%, 82.6% and 98.3% for nutrition and hydration, 100% each month for moving and handling and 98%, 100% and 100% for falls. In each month an action plan was put in place for every area which fell below 95%.
- Patients who were at risk of falls and of developing pressure ulcers were highlighted on a white board, in the office, which listed the current patients on the unit. We observed falls alarms in place for a patient who had been assessed as at a high risk of falls. We also saw evidence in the medical records of patients who were at risk of pressure ulcers having two-hourly ward rounds. The unit had a referral form for tissue viability concerns which would be reviewed by the tissue viability nurse.
- While we saw evidence of assessments in place to assess and respond to risk, during our unannounced inspection we saw a patient with bed-rails in place and no risk assessment in place for the use of bed-rails. An assessment should take place if bed-rails are used, as while bed-rails can prevent a patient from falling from their bed, bed-rails can introduce other risks, such as someone rolling over the top of the rail or climbing over the rail, causing greater injury. We raised this with the managers who showed us the risk assessment for bed-rails which should have been used. The bed-rail assessment was under review at the time of the inspection, which was identified as an area for improvement in the service improvement plan.
- The service used an early warning score (EWS) system to identify deteriorating patients and monitor vital sign observations. The EWS system monitored patients' vital signs to prompt staff to take appropriate action in response to any deterioration. The clinical matron told us a revised EWS system was going to be shortly launched which included more information about what action was to be triggered, for example calling an ambulance, at which EWS score.
- The unit had processes in place to escalate and manage patients who deteriorated on the unit. If a patient deteriorated on the unit they would be stabilised and an ambulance would be called to transfer them to the nearest NHS hospital, which was located on the same site. Staff we spoke with had a good understanding of the procedure.

Staffing levels and caseload

- The unit did not use a staffing tool to determine staffing levels, but carried out a daily review of the number and

acuity of patients to determine whether additional staffing was needed. As of 31 December 2016 the total establishment levels for qualified nurses was 9.3 and health care assistants 16.8.

- The planned and actual staffing levels were displayed on the unit. The planned staffing levels were two nursing staff and four health care assistants during the day and two nursing staff or one nursing staff and one assistant nurse practitioner and two healthcare assistants during the night. We reviewed the staffing rotas for the four weeks before the inspection and found that the unit was meeting the planned staffing levels. The unit also employed a tissue viability nurse for 12 hours a week.
- The unit employed one resident medical officer, from an agency, who worked at the unit Monday to Friday from 9am to 5pm. At weekends and at night the unit had access to an out of hours doctor who could be called to the unit.
- The unit employed physiotherapy staff to cover Monday to Friday and Sunday. On each shift there was a physiotherapist and an assistant practitioner. In addition the unit had two days occupational therapist cover which could be increased if it was needed.
- Staff said they felt there were sufficient staff to provide safe care. However, they said in the mornings they would like more staff as patients needed more support at that time of day.
- Information the unit gave us showed that from 1 January to 31 December 2016 the unit had a turnover of 29.4% of all substantive staff. At the time of the inspection the unit had vacancies of 26 hours for nursing staff per week for the day shift and no vacancies of nursing staff for the night shift. No vacancies during the day shift for health care assistants and 32.5 hours per week vacancies for health care assistants during the night shift. Prior to the inspection the unit told us the high turnover of staff was because of a significant loss in contract and uncertainty about future contracts. The unit said it had made it difficult to recruit and maintain staff. However, in the three months prior to the inspection the unit had recruited nursing, assistant practitioner and health care assistant staff and reduced the vacancies.
- The unit used bank and agency staff to cover sickness, absence and vacancies. Information the unit gave us showed that from 1 October 2016 to 31 December 2016, 273 nurse shifts were covered by bank or agency staff and 290 health care assistant shifts. All bank and agency staff completed a local induction before starting on the unit.
- In 2016 and early 2017 the unit had received a number of complaints and safeguarding concerns about agency staff working on night shifts. In the same period we have also received concerns which related to agency staff working on night shifts. The service told us as a result of the concerns from February 2016 it had changed the skill mix on night shifts, introduced the role of assistant practitioner and ensured there was always substantive staff working with agency staff at night.
- We visited the unit during the night shift as part of the unannounced inspection, we found the staffing numbers and mix reflected the off duty rota and included a mix of permanent and agency staff. All the staff we spoke to on the unannounced inspection were confident about the competency and effectiveness of agency staff working on the unit at that time.
- From 1 January to 31 December 2016 the unit had a staff sickness rate of 2.6% of shifts.
- A handover meeting took place at the start of every shift. We observed a handover at the start of a morning shift and saw there was a thorough review of every patient on the unit and any issues which had arisen during the previous shift. At the handover we saw unit-wide issues which were recorded in the communication being discussed. To support the handover meeting, staff were given a printed document, which summarised each patient on the ward and any specific risks and what interventions were needed during the shift.

Managing anticipated risks

- We saw evidence of risk assessments for anticipated risks on the unit. For each risk an assessment of the risk, existing controls, ratings, gaps in the controls and residual risk was recorded. We saw the risk assessments had recent reviews by the registered manager. Examples of the risk assessments held included, moving and handling risks, health and safety risks, medication administrations and lone working.

Major incident awareness and training

- The unit had a business continuity plan identifying potential threats to service provision, for example fire,

flood, loss of utilities, pandemic or adverse weather conditions. This detailed action staff were to take in the event of occurrences which could disrupt normal operations.

- Staff received fire safety training as part of their mandatory training. At the time of the inspection 91% of staff had either completed or were booked to receive the training.
- Staff were confident about what to do in the event of a fire or other major incident. Staff said they had recently taken part in a simulation using the emergency evacuation equipment which would be used in the event of a fire.
- The unit had a weekly fire test. We reviewed the record of the fire testing held by the unit.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We do not currently rate this service.

We found the following areas of good practice:

- Policies and procedures followed recognised and approved national guidelines. Patients' needs were fully assessed and clear and detailed care plans kept up to date.
- The unit used a recognised tool to monitor the improvements of performance in daily activities for patients on the unit. While the unit used this to measure the improvements for individual patients, it did not use the information to monitor overall outcomes on the unit.
- The unit employed appropriately qualified staff, who received an induction and training to support them in providing safe and effective care.
- Staff were positive about the commitment and support in their professional development.
- There was effective multi-disciplinary team working between different staff working on the unit and with external staff.
- Staff received training about and knew their responsibilities in relation to consent and the Mental Capacity Act.

However, we also found the following issues that the service provider needs to improve:

- We saw examples of the evaluations of the pressure wounds being unclear in medical records.
- We saw induction checklists which had not been fully completed before new staff started their role.
- The unit was not routinely completing the consent form in the patient records which gave consent for physical examination and to be involved in the assessment and care planning.

Evidence based care and treatment

- Staff provided care and treatment that was evidence based. Policies, procedures, assessment tools and pathways followed recognisable and approved guidelines such as those from National Institute for Health and Care Excellence (NICE) and the Royal Colleges. All of the policies referenced the relevant legislation, guidelines and Care Quality Commission key lines of enquiry. A system was in place to review the policies and procedures were reviewed at least every 12 months.
- Patients had a holistic assessment of their needs when they were admitted to the ward. The unit used standardised care assessments, such as nutritional and moving and handling assessments, to ensure patients received consistent care in line with best practice guidelines.
- Senior managers told us they were currently reviewing the medication and tissue viability guidelines to ensure they were in line with latest NICE guidelines.
- The unit employed a tissue viability nurse who was available to provide advice and support on the management and prevention of pressure ulcers.
- We saw evidence that patients had clear and detailed care plans which were up to date and developed in line with good practice guidance. Care plans had personalised goals and objectives were set for every patient. These were developed in collaboration with the patient, nursing and therapy staff.

Pain relief

- Pain was assessed through the use of a pain assessment tool and pain management plans. Of the six patient records we looked at, all of them had a pain assessment and management plan if required.
- Patients had access to the pain relief which was prescribed to them on discharge from the NHS hospital. If patients required additional pain relief while they were on the unit this could be prescribed by the resident medical officer who attended during the week or the out of hours doctors. Nurses were able to give patients paracetamol if required.
- All the patients we spoke to told us their pain was well managed and nursing staff were responsive to their requests for pain relief. We observed nursing staff on the drugs round asking a patient about their pain and offering paracetamol.

Are services effective?

Nutrition and hydration

- The unit used the malnutrition universal screening tool (MUST) to complete an assessment of patient's nutrition and hydration needs. We reviewed a sample of six records and found that for each patient an assessment had been fully completed.
- The unit had a dining room which was bright and inviting where patients were encouraged to eat their meals. Breakfast was served from 7.30am to 9.30am; lunch from 12.30pm and 1.30pm; and dinner from 5pm to 6pm. Patients were offered a range of meal choices such as low sodium and soft to meet their dietary needs. Staff said they monitored and observed each patient's eating.
- The unit offered different food choices to meet the cultural and medical needs of patients, for example it offered halal meals and a low sodium diet. Staff said any other dietary requirements would be discussed with the patient and arranged through the food supplier.
- The unit scored 86.8% for the patient-led assessments of the care environment (PLACE) for food from February to June 2016. This was below the England average for hospitals which was 88.2%.

Patient outcomes

- We saw evidence in the six care records we reviewed of improvements in the barthel index (a measure used for monitoring performance in activities of daily living such as toilet use, feeding, transfers and walking).
- The unit did not routinely collect and monitor patient outcomes. While the barthel index was recorded in patient records it was not used to monitor patient outcomes across the unit.
- The physiotherapy team was participating in a national audit for the rehabilitation of hip fractures.
- At the time of the inspection the unit did not participate in any other local or national audits or benchmarking for community providers.

Competent staff

- Staff on the unit had a yearly appraisal to discuss performance and identify learning needs for the next year. At the time of the inspection 91.4% of staff had received an appraisal within the last year. Staff said they had one-to-one meetings with their manager and said they were around every six to eight weeks.
- The clinical matron was responsible for carrying out clinical supervision for the nursing staff and assistant practitioner on the unit.
- Staff were encouraged to develop their skills and knowledge. In the month before the inspection, during the appraisal process, nurses and care assistants had been assigned as the 'leads' in the unit for falls, safeguarding, medication, pain, dignity, health and safety, moving and handling, nutrition, infection control and patient experience. Each of the leads would receive additional training, would link into other leads at Spiral Health and prepare a monthly summary.
- The unit was currently sponsoring a health care assistant from the unit to complete their training as a qualified nurse at a local university. As well as funding the training Spiral Health had supported the staff member with additional costs, such as the purchase of textbooks.
- Staff said the unit was very supportive of their professional development and if they wanted to go on training, Spiral Health had funding to pay for training courses.
- The unit offered placements for student nurses on the unit. A student nurse told us they had been assigned a mentor for their training and we observed student nurses working with qualified nurses on the shift.
- The unit employed a tissue viability nurse who gave specific training and advice to staff on tissue viability and implementing the tissue viability policies.
- Nursing staff in the unit had recently received management training and the unit planned to extend their role to manage the health care assistants working in the unit.
- Training was offered to staff to ensure they had the up-to-date nursing competencies such as cannulation, venepuncture and IV drug administration.
- New staff completed an induction which was supported by a checklist which needed to be completed by the member of staff with their manager. We reviewed a sample of induction checklists and found that not every area was signed to indicate it had been completed. The unit told us that the incomplete induction checklist we saw had been completed and should have been destroyed. As the checklist was not complete we could not be assured staff had completed the induction before starting their role.

Are services effective?

- We spoke to staff who had joined the unit within the last six months, and completed the induction when they started in their role. Staff were positive about the induction and told us it had given them sufficient information to confidently start in their role.

Multi-disciplinary working and coordinated care pathways

- Nursing, therapy staff, health care assistants and the resident medical officer worked well in the assessing planning and delivery of people's care and treatment on the unit. Nursing and therapy staff had a weekly meeting in which every patient was discussed; the primary focus of this meeting was to discuss each patients discharge. Nursing staff and healthcare assistants took part in handovers at the start of every shift. These were not attended by therapy staff, however, they were given copies of the printed handover sheets.
- Staff were positive about the working relationships between nursing, therapy staff, health care assistants and the resident medical officer. Staff said they worked well together as a team to deliver care and treatment.
- The unit had a doctor's request book for nursing staff to communicate with the resident medical officer, who only worked from 9am to 5pm on Monday to Friday. For non-urgent requests, which would be made to the out of hours doctor, nurses recorded these in the book, which would be reviewed by the doctor during her shift.
- Staff said they worked well with the teams at the NHS hospitals responsible for assessing patients before they were admitted to the unit. Staff said if they had any queries with the referral they would discuss it before accepting a patient onto the unit.
- The unit had identified an issue with referring patients for specialist services at the local NHS trust, which were not offered by the unit, such as a dietician or speech and language therapy. Patients needed a GP referral, but the unit had identified problems with GP's agreeing to referrals. The unit had identified this issue in the service improvement plan and raised it at the meeting with the commissioners.
- Patients who required support from social workers or social care providers were assessed while on the unit and referrals made for social workers to attend the unit. Social work referrals and the date of visit was recorded on the whiteboard in the nursing room.

Referral, transfer, discharge and transition

- Patients arriving at the unit were assessed by physiotherapy staff, occupational therapy staff, where appropriate, and nursing staff. Goals were set for patients and an estimated discharge date planned. At the weekly multi-disciplinary discharge meeting the nursing and therapy staff worked together to assess and review the estimated discharge date.
- The unit had arrangements in place to refer patients who needed additional therapy once they had been discharged from the unit to the local domiciliary rehabilitation team or the local community therapy team.
- The unit restricted patients from being admitted to the unit from 8pm. This prevented patients being admitted through the night.
- The unit did not record the time of discharge of patients leaving the unit.
- The unit collected data about the destination of patients who were discharged from the unit. In the 12 months up to January 2017 the destination of discharge were: 75% home; 7% acute ward; 5% A&E; 4% care home; 4% a rehabilitation unit which was located on the same site; 0% deceased; and 6% other.

Access to information

- Staff said they had no problems in accessing care records from the hospital or the community. Staff said there were occasionally some records missing from the hospital record (such as record of the A&E admission) but these would be sent to the unit once requested.
- All of the unit's policies and procedures were stored on an on-line portal which all clinical members of staff had access to. Printed copies of each of the policies and procedures were stored in files in the office which was accessible for all clinical staff.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) were covered as part of the safeguarding adult's module which was completed by all staff during their mandatory training. At the time of the inspection 91% of staff had completed or been

booked into complete the mandatory training. The Mental Capacity Act and Deprivation of Liberty Safeguards were also covered by the supplementary safeguarding training completed by clinical staff.

- Staff had a good understanding of the relevant consent and decision-making requirements of the legislation. Staff said if they considered a patient lacked the capacity to give consent for a procedure or treatment they would escalate it to senior staff so a mental capacity assessment and best interests decision could be made. Staff gave us examples of patients who had fluctuating capacity and the action to taken by staff to arrange an external assessment.
- There were no patients on the unit with Deprivation of Liberty Safeguards at the time of the inspection.
- Patients on the unit completed a form which gave consent to examination and treatment, which was stored in the medical records. This confirmed the patient had consented for physical examination, photography of wounds, involvement in assessment and care plan and recording of information. We found not every patient had completed the form while on the unit. We reviewed a sample of ten patients on the unit at the time of the inspection and only four patients had completed the form. As the forms were completed inconsistently the unit could not assure itself that patients had consented to their ongoing care and treatment on the unit. We raised this with the management of the unit who told us they would address this immediately.
- We found evidence of community Do Not Attempt Cardio Pulmonary Resuscitation forms in place (DNACPR). These were completed before patients were admitted to the unit. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We do not currently rate this service.

We found the following areas of good practice:

- Staff were kind and respectful to patients on the unit.
- Staff respected and protected the privacy and dignity of patients on the unit.
- Patients were involved in their care and the decisions made about care. Patients were also given information and explanations about the care they were receiving.
- The unit had good links with charities and other organisations.

Compassionate care

- We observed staff being kind, caring, respectful and considerate with patients on the unit.
- We spoke to eight patients during the inspection and all of them spoke positively about the unit and the staff. One patient told us everyone was kind and caring and the place was excellent. Another patient told us they were delighted with the care and very lucky to be there and a further patient said the staff could not do anything better.
- Staff made sure people's dignity was always respected. We saw that when care was being delivered curtains were always drawn around the bed. We saw staff discussing patient's care discretely with them on a multi-bedded bay.
- All of the patients we spoke to said the staff were very responsive to their needs. Patients said when they used their call-buzzers staff had responded quickly. One patient said he had to call the staff member twice in the night and they had been great on both occasions. During the inspection we observed staff during the day and at night responding to call-buzzers promptly.
- As a result of feedback from patients the staff had dedicated a room on the ward to be used for private discussions with patients and family members. This enabled staff to maintain privacy and dignity if someone wanted to discuss their care away from their bedroom.
- The unit scored 77.6% for the patient-led assessments of the care environment (PLACE) for privacy, dignity and wellbeing from February to June 2016. This was below the England average for hospitals which was 84.2%.
- The Friends and Family Test, is a test used in care organisations where patients are asked whether they would recommend friends and family to use the organisation. The unit told us it had only recently restarted asking patients for their feedback, after it had stopped in the summer of 2016. At the time of the inspection the unit did not hold this information.
- The ward clerk gave a telephone call to patients two weeks after they had been discharged from the unit to see how they were feeling and whether they were recovering well. If there were any concerns these would be passed to clinical staff or to social services.

Understanding and involvement of patients and those close to them

- All of the patients we spoke to had a good understanding of their care plans and told us they were involved in the care plan and the decisions made. One patient told us their care plan had changes because of changes to their condition and they were fully informed of this.
- Staff said patients were involved in setting individual goals for their needs. These were created with the patient when they were admitted to the unit. For example one patient wanted the goal of wanting to be able to independently use the toilet, which was agreed with the therapy staff.
- We observed nursing staff clearly explaining to patients what a procedure would involve while carrying it out, to ensure they fully understood the treatment they were receiving.
- All patients received a guide to the unit as part of a welcome pack, this included toiletries. The leaflet explained the purpose of a nurse-led unit, what the care would involve, what items they needed to bring to the ward and visiting times. We also saw Spiral Health patient leaflets with information about falls prevention and tissue viability as well as leaflets from other support services.
- Family members we spoke to on the inspection said there was good communication between them and the staff about the family member and there was good access to visit the unit.

Are services caring?

- The unit arranged dedicated appointments between the resident medical officer, nursing staff and patient's families to discuss their ongoing care and treatment.

Emotional support

- Staff were aware of the impact someone's care and treatment, and staying away from home, had on their well-being. We observed staff discussing the emotional support needed for patients during the staff handover.
- The unit had an arrangement with a National charity for a representative to visit the unit every week to discuss what services they could offer people on the unit and when they left the unit. Staff on the unit had identified a patient who would benefit from the charity's "befriending" service, which had been raised with the representative.
- The unit provided information to patients about the use of community and charity services in the local area such as a charity which supports independent living, a provider of emergency buzzers, a falls service and carer's charity. These services supported and empowered patients to manage their own health once they left the unit.
- Patients on the unit were encouraged to use the dining room to eat their meals, enabling them to prepare for independent living and have an opportunity to socialise with other patients. Staff had decorated the dining room to feel like a restaurant and patients were positive about the sociable environment. Staff said they would count the patients who had come to the dining room to ensure everyone ate their meal.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We do not currently rate this service.

We found the following areas of good practice:

- The services were planned to meet the needs of people in the local population who had been admitted to hospital.
- The unit had admission criteria in place and monitored inappropriate referrals to the unit.
- The services were planned to deliver care for patients who had additional needs, such as those living with dementia or a disability.
- Once assessed, on average, patients waited two days to be admitted to the unit.

However, we also found the following issues that the service provider needs to improve:

- Staff were unable to access an interpreting service for patients and families who did not speak English as their first language.
- There were no regular social or group activities for patients on the unit.
- The complaints procedure and complaints leaflet gave different information about how to complain. The complaints procedure signposted people to the incorrect ombudsman.

Planning and delivering services which meet people's needs

- Services at the unit were planned to provide 24 beds to patients who were inpatients at two NHS hospitals, within medical or surgical specialties, priority was given to patients at the NHS hospital which shared the same site as the Preston unit. The service was commissioned by the local NHS trust which patients were referred to the unit from.
- The unit had admission criteria to ensure the appropriate patients were admitted to the unit. The criteria were that the person was over 18; was medically stable; had 24 hour nursing needs and may or may not have rehabilitation needs; the anticipated length of stay was not expected to exceed six weeks; and, the person gave informed consent to transfer to the unit. The unit had some exclusions such as patients who required tube feeding, who were living with severe dementia; or under the care of the specialist palliative care team.
- The referring NHS trust carried out assessments of patients who potentially met the admission criteria. The unit planned its services by reviewing the assessments to see whether they met the criteria, whether they had availability for the patient and whether they would need additional equipment. Managers said they worked well with the local NHS trust and would discuss admissions, where appropriate, before a decision was made. The unit kept a record of the number of inappropriate referrals each month.
- Senior Management told us the type and complexity of patients fluctuated depending on the patients referred. The unit had restrictions on the number of patients who required two persons for moving and handling or were doubly incontinent; to ensure there was a safe level of staffing for the unit.
- The unit did not arrange any social or group activities for patients on the unit.
- The unit did not arrange regular social or group activities for patients on the unit. However, we were told that the staff arranged seasonal activities such as quiz nights, film nights and choir services.
- The unit had arrangements for a podiatrist to visit the unit for the patients.
- The unit had arrangements for a hairdresser to visit the unit and had also arranged for a charity who bring pets to hospitals and care settings to visit the unit twice a month, although the first visit had not yet taken place. While we were on the inspection a health care assistant was painting the nails of a group of female patients.
- Visiting hours on the unit were from 10am to 8pm which gave visitors flexibility about when they could visit their family or friends. Visitors were advised to avoid mealtimes to protect the time for patients to eat their meals.
- The signage for the bedrooms, toilets, bathrooms and dining room had a brightly coloured yellow background with large dark lettering and pictorial symbols which made it easy to read for patients with poor sight.

Equality and diversity

Are services responsive to people's needs?

- All staff received training on equality and diversity, and Human Rights as part of their mandatory training. At the time of the inspection 91% of staff had completed or been booked into complete the mandatory training.
- The service had commissioned an interpreting service before the inspection. However, staff had not been told about the service so could not access it. Staff said if a patient could not speak English as a first language the unit would rely on family members to translate, other than for basic actions. The Resident Medical Officer currently working at the unit had been able to communicate with some patients who spoke Urdu as their first language. Not having an interpreting service in place posed a risk that the unit could not communicate with a patient, particularly if they became unwell. Family members cannot be guaranteed as an accurate translation, as there is no assurance of their ability or availability to translate.
- The unit was planned to deliver care to patients who were disabled or had reduced mobility. Patients had access to equipment, such as hoists and a specialist bath, so they were able to use the service. We observed staff supporting patients who were disabled to use the dining room with other patients.
- The unit scored 81.4% for the patient-led assessments of the care environment (PLACE) for disability which was higher than the England average which was 78.8%.
- There were no mixed sex breaches from April 2016 to March 2017.

Meeting the needs of people in vulnerable circumstances

- All staff were required to complete a module supporting them to provide care to people living with dementia. At the time of the inspection 12 staff had completed the training.
- The admissions criteria excluded patients with severe dementia or who had a tendency to wander or walk excessively as the criteria said it was unable to provide support to this patient group. Patients who were living with dementia were assessed prior to being admitted to the unit. Patients living with dementia were identified with a butterfly symbol on the whiteboard in the office. Staff said patients living with dementia would be cared for in bays closer to the nursing station, if necessary.
- Signage for the rooms was dementia friendly, with yellow backing, and pictorial diagrams. A member of staff said they encouraged the families of patients living with dementia to bring in photos which they could talk to them about. The unit had a memory tree in the dining room where patients, their relatives or staff were encouraged to write on a leaf and add it on the tree about a memory they had.
- The unit scored 73.0% for the patient-led assessments of the care environment (PLACE) for dementia from February to June 2016. This was below the England average which was 75.3%.
- Staff told us they would provide additional support for patients with learning disabilities, although there were no formal arrangements in place.

Access to the right care at the right time

- Staff on the unit reviewed every assessment before patients were accepted to the ward, reducing the risk of patients admitted not meeting the admission criteria. The unit kept a record of the inappropriate referrals, which was monitored each month, so it could be shared with the referring hospitals. From November 2015 to October 2016 examples of reasons included patients were discharged home, had no nursing needs or the unit were unable to meet their needs. Staff said that it was only rarely that a patient who was admitted had not met the admissions criteria. Staff said when this happened this was because the assessment did not accurately reflect the patient's needs.
- Information provided by the unit showed the mean number of days from assessment by the NHS trust to admission onto the unit was two days. At the time of our inspection there were three patients who had met the admission criteria and been accepted to the unit but were waiting for a bed to be free to transfer.
- The unit kept a record of the average length of stay and longest length of stay each month. From January 2016 to December 2016 the average length of stay each month was between 17 and 29 days.
- Information provided by the unit showed that in the six months from July to December 2016 there were 15 delayed discharges and ten readmissions within 90 days of discharge.

Learning from complaints and concerns

- From January to December 2016 the unit reported 16 complaints about the service. Of these complaints six were upheld, five were partly upheld, three were not upheld and two were ongoing. Of these complaints none were referred to the Ombudsman.

Are services responsive to people's needs?

- Complaints were discussed at the quarterly quality and patient safety committee. Meeting minutes from January 2017 showed two complaints and the themes had been discussed and actions to discuss them at the next team meeting were put forward.
- The unit had a complaints procedure which said complaints would be acknowledged within 24 hours and give an expected time of response, which would be 28 days, unless it was necessary to take longer. The complaints we reviewed had met these targets. The procedure said if a complaint was not resolved it could be referred to the Local Government Ombudsman. The complaints procedure incorrectly signposted people to the Local Government Ombudsman, as the care was NHS funded health care, people should have been signposted to the Parliamentary and Health Service Ombudsman. This could have caused people the inconvenience of contacting the wrong ombudsman. We saw evidence in a complaints response that someone had been incorrectly referred to the Local Government Ombudsman.
- There were also complaints leaflets on the unit, however, the information about the addresses, time limits and escalation was inconsistent with the policy. However, the leaflet correctly signposted people to the Parliamentary and Health Service Ombudsman.
- We reviewed a complaint file at the unit and found the unit had fully investigated the complaint and met with the complainant. The investigation had identified failings and had an action plan. The unit had apologised to the complainant and action had been taken to resolve it for them.
- Staff we spoke with gave us examples of learning from complaints which had been shared with them, such as a reminder to health care assistants in their role in supporting patients.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We do not currently rate this service.

We found the following areas of good practice:

- Staff felt supported in their roles by their managers and leaders of the service. They felt valued for their work and were positive about working at the unit.
- Staff said there was an open and honest culture at the unit. Staff felt comfortable to speak up if they had concerns and were encouraged to suggest improvements.
- The unit had events and activities to engage with its staff.

However, we also found the following issues that the service provider needs to improve:

- Governance arrangements were being developed at the time of the inspection. The unit had just started a quality and patient safety committee. The unit was in the process of setting up leads and a monthly quality meeting.
- Quality and governance reports were not completed for from August 2016 to January 2017.
- The unit did not have a local risk register in place to record and assess clinical risks affecting the unit.

At the time of the inspection the unit did not collect feedback from patients.

Service vision and strategy

- Spiral Health had a vision to 'share our passion for people to enhance the communities in which we work'. This was supported by six values: solution focused 'let's do attitude; person centred in all that we do; investing and developing everyone's potential; respectful, open and honest; actively striving to be the best; listening, learning and communicating. Staff were able to articulate different parts of the vision and values although they did not have a full knowledge of it.
- Whilst the unit did not have a formal local strategy, we saw a record of their plans to improve in a number of areas including; recruitment, staffing, nurse development and training and local governance.
- At the time of the inspection the provider was hoping to move into a clinical commissioning contract which would lead to some changes in the service currently provided.

Governance, risk management and quality measurement

- Governance arrangements at the unit were being developed at the time of the inspection. The service had recognised their need to strengthen and develop its governance processes which were either new or in the process of being implemented at the time of the inspection.
- The unit held a monthly meeting for all staff. The meeting did not have a standard agenda, but covered staffing issues, health and safety issues and any other issues which had arisen within the month before. From February 2017 lessons learned was added as a standing agenda item.
- Within the month prior to the inspection the unit had set up allocated leads for falls, safeguarding, medication, pain, dignity, health and safety, moving and handling, nutrition, infection control and patient experience. The leads would contribute to a monthly quality meeting which would report directly to the board. The first meeting was planned for May 2017. The unit planned for each lead to liaise with leads across the provider and prepare a monthly summary document for their area. A structure of clinical leads will support staff in formally escalating clinical concerns.
- The unit had recently started a quarterly quality and patient safety committee. We reviewed the minutes of the first meeting in January 2017 which looked at risk, clinical effectiveness, patient experience, health and safety, patient safety and quality. At the meeting issues which had arisen on the unit were discussed and actions with dates set. Minutes of the meeting were reviewed by Spiral Health's Board.
- The unit planned to complete Quality and Governance Reports, covering four month periods for Spiral Health's Board. These reviewed a number of quality indicators such as incidents, complaints, CQC notifications, nursing care indicators and patient feedback. While the

Are services well-led?

unit gave us the August 2016 report which covered April-July 2016, it did not complete reports covering the period from July 2016 to January 2017. As a result there was no formal board oversight of the quality or performance of the unit during this period. We saw evidence that, following the inspection, a report had been prepared by the unit for February-May 2017.

- The unit's managers said outside of the formal meetings, the general manager, matron and therapy manager met weekly to discuss any issues on the unit.
- Since October 2016 the unit had a service improvement plan in place which had been developed by the new general manager. The most recent version of the plan covered the period from March to May 2017 and had identified areas for improvement in line with the key lines of enquiry reported by the CQC during an inspection (safe, effective, caring, responsive and well led).
- While Spiral Health had a corporate risk register, the unit did not have a local risk register to record the clinical risks and mitigation in place for risks affecting it. As a result the unit was unable to formally monitor the clinical risks to the service. Senior staff said the main risks which affected the unit at the time of the inspection were the use of agency staff, particularly at night, the embedding of the governance structure and pathways for patients back into the trust.

Leadership of this service

- The unit was led by a general manager, who had been in post since February 2017, but had worked for Spiral Health since July 2016, and a clinical matron, who had been in post since November 2016. The two roles were previously carried out by one person, but the two roles were created as the management team identified there was too much work for one person. The chief executive had close contact with the operational management of the service. Since the inspection the manager has become the Registered Manager with the Care Quality Commission.
- All the staff we spoke to were very positive about the leadership of the unit. Staff said they felt supported by the management and they were confident in approaching any of the leadership team if they had an issue.

Culture within this service

- Staff said there was a very open and honest culture across the organisation from the chief executive to staff working on the unit. Staff said they felt the management team were willing to discuss improvements and changes with them and staff felt they were involved in the running of the unit.
- All of the staff we spoke to on the inspection were positive about working at the unit and felt valued for their work. One member of staff said they loved working on the unit. She said it was busy but they always made time for the patients. Another member of said it was 'like one big family'.

Public engagement

- At the time of the inspection the unit was not collecting friends and family test data. The friends and family test is a test used in care organisations where patients are asked whether they would recommend friends and family to use the organisation.
- The unit was in the process of setting up a patient experience team to seek and collect feedback from patient's who had used the unit. The team would seek feedback from every patient who was discharged, including the friends and family test and had started to contact patients two weeks following their discharge to see how they were.
- The unit had a 'you said – we did' board which displayed changes made to the unit as a result of patient feedback. We saw on the board the introduction of a dedicated private room for patients or their relatives to discuss their care.

Staff engagement

- In February 2016 the unit completed its last staff survey. They planned to complete one in February 2017 however due to the loss of the contracts at this time and the consultations that were taking place a decision was made not to complete the staff survey at this time.
- The unit said Spiral Health had a number of staff engagement activities including a staff member's engagement association and informal opportunities to meet with the chief executive.

Are services well-led?

- Spiral Health ran an annual 'Festival of Ideas' for all staff, which gave them an opportunity to raise and explore new ideas for Spiral Health. Staff we spoke to were very positive about being given the opportunity to discuss their ideas for the business and improvements.
- Spiral Health had an open position on the Board for a member of staff from anywhere within the organisation. The member would have voting rights on the board as any other board member. At the time of the inspection the position was unfilled.
- Spiral Health had a 'Going the Extra Mile' award which was given to staff in recognition of their contribution to the unit. One of the staff members had been nominated and received the award for her commitment to her role.

Innovation, improvement and sustainability

- The provider had carried out a self-assessment against the domains of safe, effective, caring, responsive and well–led and from this they had developed an action /improvement plan to guide them to work through improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operated effectively to enable the provider to assess, monitor and improve the quality and safety of the services provided. Examples included regular quality and governance reports were not completed and a clinical risk register was not in place to record and assess clinical risks. Systems and process were not in place to enable the provider to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Examples included shortfalls in the monitoring of daily checks for cleaning schedules, signing and dating sharps bins, oxygen on the resuscitation trolley and drugs audits.