Olive Eden Hospital

Quality Report

71 St Paul's Road
London
N17 0ND
Tel:**020 8885 8750**
Website:

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	**Inadequate**
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	**Inadequate**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

This was a focused inspection we reviewed and rated the safe and well-led domains. At the previous inspection in May 2016, we also identified a small number of concerns for the effective and responsive domains. At this inspection we assessed the progress made by the service. We also identified and reported on some new concerns in each of the domains. Therefore, we have re-rated the service as inadequate overall.

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

- Staff did not always ensure that patient risk assessments and care plans contained accurate and up to date information. This meant we could not be assured that patients' physical health needs were fully met.
- Robust safeguarding processes were not in place and staff had not been suitably trained in safeguarding children. Staff had not sought advice from the local authority safeguarding team after some incidents, to establish whether a safeguarding alert was necessary. Staff did not always ensure patients privacy and dignity was protected. Some patients were deprived of their liberties without lawful authorisation.
- Individual patients did not consistently receive support from the required number of staff. Staff who worked at the service had not all completed appropriate training to care for patients. For example, there were low levels of compliance with training on diabetes and epilepsy. There were patients at the hospital with diagnoses of these conditions.
- Whilst overall medicines management practice was good, there were two occasions in the last six months when patients had not received or were at risk of not receiving their prescribed medicines.
- There were fire safety concerns at the service. The service had not implemented some of the agreed actions following a fire risk assessment in June 2017. Some firefighting equipment was not easily accessible.
- Staff had not reported all incidents which had occurred and there were inconsistencies in the recording and reporting arrangements and the provider's policy. Incidents were not always investigated in line with the service policy and the provider had not implemented a suitable process to support staff to learn lessons from them.
- The standards of cleanliness in the kitchen on the male unit were not consistently maintained and some food was out of date.
- The service did not have robust governance arrangements to maintain the safety and quality of the service provided to patients. Quality assurance arrangements were not robust and policies and procedures were not all up to date. Team meetings lacked structure and staff had limited awareness of about local risks. Staff had not received an annual appraisal.

However:

- Staff were trained in de-escalation techniques, they used verbal de-escalation and did not restrain patients. Staff did not use seclusion or rapid tranquilisation.
- Staff spoke positively about their experience of working at the service and found the hospital manager to be supportive and approachable. Appropriate levels of medical cover were available 24 hours each day.
- The provider had systems to ensure staff were up to date with mandatory training and that pre-employment checks were carried before staff commenced their employment.
- Clinic rooms were clean and appropriately equipped and patients and staff had access to call alarm systems.
- The provider had systems in place that showed adherence with the Mental Health Act so that patient's rights were protected.
- Senior managers had responded to the staff survey 2016, and introduced an awards programme for staff.
- Staff knew how to use the whistle-blowing process and to report any concerns. Staff reported a good culture of team working, mutual support and the satisfaction of working in a supportive environment.

After the inspection we wrote a letter to the provider saying we would potentially take urgent enforcement

Summary of findings

action using section 31 of the Health and Social Care Act if they did not take immediate action to improve the safety for the patients in the hospital. The provider voluntarily agreed not to accept any new admissions into the hospital and has provided an ongoing action plan explaining the improvements that are being made.

We also served a warning notice for regulations 12,17 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as we were significantly concerned about the impact of these beaches on the care and welfare of the patients at this hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Inadequate 	

Summary of findings

Contents

Inadequate

Olive Eden Hospital

Services we looked at:
Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Olive Eden Hospital

Olive Eden is an independent hospital run by Sequence Care Limited. It provides a service for adults with a primary diagnosis of a learning disability or autism who may have mental health needs. The service is split into Eden Court a unit for up to nine men and Olive Grove a unit for up to five women. At the time of our visit there were 12 patients using the service. Nursing and support staff and the multidisciplinary team worked across both units.

The length of stay for patients ranged from two months to five years.

Olive Eden Hospital is registered with the CQC to carry on the regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures; treatment of disease, disorder or injury.

There was a registered manager in post at the time of this inspection.

Olive Eden Hospital was last inspected in May 2016 and there was one requirement notice which inspectors found had not been met in August 2017.

Our inspection team

The inspection team consisted of one inspection manager, two CQC inspectors, and two specialist advisors with backgrounds in pharmacy and nursing for patients with learning disabilities.

Why we carried out this inspection

This was a focused inspection and we reviewed and rated the safe and well-led key questions. At the previous inspection in May 2016, we had identified a number of concerns for the effective and responsive key questions. At this inspection, we assessed the progress made by the service. We also identified and reported on some new concerns in each of the key questions. Therefore, combining the ratings from the last inspection for effective, caring and responsive with the ratings of Safe and Well-led from this inspection, we have re-rated the service as inadequate overall.

When we last inspected Olive Eden Hospital in May 2016, we rated the service as good overall. We rated this core service as good for safe, effective, caring and responsive and requires improvement for well-led.

Following the May 2016 inspection we told the provider that it must take the following actions to improve the service:

- The provider must ensure that there are systems and processes in place to maintain accurate, consistent and accessible patient care records.

We also told the provider that it should take the following actions to improve the service:

- The provider should ensure patient risk assessments are reviewed or updated following incidents and also in terms of potential self-harm using a ligature point.
- The provider should ensure that when restraint is used, it is accurately recorded to ensure it is carried out in a safe and appropriate manner and can be reviewed afterwards.
- The provider should ensure that staff understand the organisation's seclusion policy and procedures.
- The provider should evidence that policies and procedures are reviewed and updated where necessary to ensure staff carry out their duties and responsibilities in line with current guidance.

Summary of this inspection

- The provider should review the arrangements around individual patient's activities, taking into account patients' views.
- The provider should continue to review how they work with relatives and carers to ensure they are fully informed and involved where appropriate in decisions about care.
- The provider should have an improved system to record, address and learn from informal complaints.
- The provider should ensure the manager has access to the correct information on site in order to effectively manage the service.
- The provider should ensure patient discharge plans are clearly identified and progress towards their discharge goals are recorded.
- The provider should ensure that care plans and other patient records are improved so that essential information can be located and they are easy for staff to use.

We issued a requirement notice in relation to the following breach of the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 17 Good governance

How we carried out this inspection

We carried out a focused inspection and considered two of the five key questions:

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

We also identified some additional concerns and checked on improvements made following the May 2016 CQC inspection under the key questions:

- Is it effective?
- Is it caring?
- Is it responsive?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited each of the units at the hospital and looked at the quality of the ward environment
- spoke with four patients who were using the service
- spoke with the registered manager
- spoke with 12 other staff members; including a doctor, nurses, two therapists and a psychologist
- spoke with the social worker of one patient
- spoke with the relatives of two patients
- looked at eight care and treatment records of patients
- carried out a specific check of the medicines management on each unit
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

The patients we spoke with had mixed views about the service and the staff who cared for them.

One of the patients told us that some members of staff were very nice and caring but not all staff were like this.

Some patients told us that they were bored and that there was nothing to do. We observed that activities did not take place routinely at the hospital, although we saw people were supported to go to the local shop and two of the patients were supported to go away for the weekend. Families who visited arranged for some activities for their relatives.

We were informed that a patient survey was undertaken each year and that results were published on the provider's website.

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?

Inadequate

We found the following areas the service provider needs to improve:

- At the previous inspection in May 2016 found that patient risk assessments were not always reviewed and updated following incidents, and that ligature risk assessments were not adequately completed. During this inspection we found that this had not improved. Patient risk assessments were not always updated if the patient had been involved in an incidents. We also found that risk assessments had not been completed for all patients and that some were overdue. Ligature risk assessments were generic and lacked detail.
- Some patients did not receive the appropriate level of observations as staff were not properly deployed and were not familiar with the provider's observation policy and procedure.
- There were inconsistencies between information stored on the patients' electronic file and paper copy. Agency staff did not have access to patients' electronic records.
- Fire safety arrangements at the service did not ensure that staff, patients and other visitors were protected in the event of a fire. Some actions identified in the hospitals fire risk assessment had not been completed. Fire extinguishers were stored in locked cupboards and the arrangements meant it was hard to access them quickly in an emergency. Some patients did not have a fire evacuation plan in place.
- The provider had procedures in place to address safeguarding concerns and staff had received training in safeguarding adults. However, we saw that staff had not recognised potential safeguarding concerns and had not discussed these concerns with the local authority safeguarding team or made safeguarding alerts where appropriate. Staff had not received training in safeguarding children.
- Improvements were needed to manage and administer medicines as one patient had not received their medicines in line with their prescription and another was due to run out and additional supplies had not been ordered. We raised this with the manager so that action was taken to ensure medicine was available.
- Systems to report and learn from incidents were not robust.
- Some environmental risks were not appropriately managed, for example potentially harmful cleaning materials were not always securely stored. The male kitchen was not hygienic and out of date and mouldy food stuffs had not been disposed of.

Summary of this inspection

However:

- At the previous inspection in May 2016 we found that restraint was not always undertaken in a safe manner. During this inspection staff told us that they no longer restrained patients and that verbal de-escalation was used.
- At the previous inspection in May 2016 we found that staff were not familiar with the provider's seclusion policy. During this inspection staff informed us that patients were not secluded.
- Staff take up of mandatory training was high. Pre-employment checks were carried out before staff started their employment.
- Appropriate levels of medical cover were available 24 hours each day.
- Patients and staff had access to call alarm systems.
- Clinic rooms were clean and appropriately equipped.

Are services effective?

We did not rate effective at this inspection.

- Patient care plans were not up to date and from looking at patients records we could not assured that patient's physical healthcare needs were consistently met.
- Staff had not all completed necessary specialist training to care for patients at Olive Eden Hospital. For example, there were low levels of compliance with training on diabetes and epilepsy. There were patients at the hospital with diagnoses of these conditions.
- Some patients were subject to restrictions linked to a Deprivation of Liberty Safeguard when these were out of date and outstanding applications had not been followed up.

However:

- The provider had systems in place that showed adherence with the Mental Health Act so that patient's rights were protected.

Are services caring?

We did not rate caring during this inspection.

- Staff were observed to be caring and they were working positively to support each patient with their complex behaviours.

However:

- During the inspection, we saw that one patient's privacy and dignity had not been protected.

Are services responsive?

We did not rate responsive during this inspection.

Summary of this inspection

- At the previous inspection in May 2016 we found that staff had not developed detailed discharge plans for patients. During this inspection we found that this had not improved, discharge plans were not all detailed, personalised or person centred. The extent to which patients achieved their goals linked to their discharge plans were not clear.
- At the previous inspection in May 2016 patients had mixed views about their activities. Whilst a programme of activities was in place for each patient, there was variable feedback from patients about their level of satisfaction with activities. During this inspection this this had not improved, we found that whilst patients had activity plans on their file, the actual provision of activities was better for some patients than others and patients had mixed views about their activities.
- At the previous inspection in May 2016, the service did not have a system to record, address and learn from informal complaints. During this inspection this had not improved, family members expressed dissatisfaction about the handling and response to their informal complaints regarding their relative's care and treatment.

Are services well-led?

Inadequate

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

- At the previous inspection in May 2016 inspection we found that policies and procedures were out of date. During this inspection this had not improved, we found that the some policies and procedures remained out of date.
- At the previous inspection in May 2016 we found that the provider had not ensured the manager had access to all relevant information on site to effectively manage the service. During this inspection this had not improved, we found that the manager did not have a copy of the corporate risk register as well as some basic staffing information.
- At the previous inspection in May 2016 we found that suitable systems were not in place to maintain accurate, consistent and accessible patient care records. During this inspection this had not improved, patient care records were not all accessible, accurate or consistently maintained.
- Governance arrangements were not robust and quality assurance processes did not ensure patients and staff were kept safe or that the service learned when things went wrong.

Summary of this inspection

- Patients and staff were not consulted about the provider's vision for the service including how this may affect patients. Building work was due to commence during the week of inspection. We raised our concerns with the provider who promptly took action to suspend the planned work.
- Team meetings were ineffective as pertinent issues were not covered and the meetings were not discussion based.
- The service had not identified local risks relating to the running of the service and therefore mitigating actions had not been considered.
- We were not able to evidence that staff had not acted on feedback from patients because a recent patient survey and action plan was not available.

However:

- Staff we spoke with told us that they had good support from the manager.
- The manager knew all of the patients and had an understanding of their care needs.
- Senior managers had responded to the staff survey 2016, and introduced an awards programme for staff.
- Staff knew how to use the whistle-blowing process and to report any concerns. Staff reported a good culture of team working, mutual support and the satisfaction of working in a supportive environment.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- The provider had systems in place that showed adherence with the Mental Health Act (MHA) so that patients' rights were protected.
- There was an MHA administrator within the organisation who provided advice and support regarding implementation of the MHA.
- All of the documentation relating to the MHA for the detained patients was available to view and was in good order. We saw that staff had explained patients' rights to them on admission and routinely thereafter. The second opinion doctor's decision was clearly recorded in the patient's file.
- Training records demonstrated that 61% of staff had received training in the MHA. The staff we spoke with showed a good understanding of the MHA Code of Practice and guiding principles.
- There were notices with information about the independent mental health advocacy service on the units. The service could be contacted by staff and patients directly during visits or by telephone on the publicised number.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety-two percent of staff had received training in the Mental Capacity Act (MCA). MCA training was mandatory.
- Some patients were detained in hospital without legal authority. There were 10 Deprivation of Liberty Safeguard (DoLS) applications made in the last 12 months to protect people without capacity to make decisions about their own care and treatment. The DoLS authorisation had expired for two patients and the application for three other patients were recorded as pending. The manager maintained a deprivation of liberty safeguard tracker and recorded that each expired application had been followed-up once although there were significant delays for two of these. The manager had also sent one chasing letter for one of the patients whose application was pending but not for the others. There was no record that the service had communicated further with the relevant local authorities concerning the patients whose DoLS authorisations had expired, or were pending.
- For the patients awaiting a new DoLS application, the circumstances of their care and treatment involved close and continuous supervision by staff in a locked environment. There were environmental restrictions for patients. This meant that patients were detained without lawful authority.
- The provider had a policy on the Mental Capacity Act. The policy did not contain sufficient guidance for staff. It consisted of one page and did not describe the five principles of the Act. This meant that if staff referred to the provider's guidance, there was insufficient information to assist them in assessing a patient's capacity.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate
Overall	Inadequate	N/A	N/A	N/A	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	
Caring	
Responsive	
Well-led	Inadequate

Are wards for people with learning disabilities or autism safe?

Inadequate

Safe and clean environment

Safety of the ward layout

- Access to the hospital grounds was via an intercom. There was one main entrance to the building and within the hospital there were secured doors to separate male and female units. Staff practice was for one door to be opened at a time creating an 'air lock'. We observed that staff always ensured this happened before entering either unit.
- The layout of the hospital meant that there were blind spots on both units. Appropriate measures to mitigate these were in place. For example, the service had installed convex mirrors to improve sight lines. Patients assessed as being at risk were supported with one to one observations.
- A ligature risk assessment had been completed and patient bathrooms were equipped with anti-ligature fixtures. Ligature cutters were available on site and staff knew where these were located. Patients assessed at risk of fixing ligatures were nursed on increased observations, including one to one. However, we saw that the ligature risk assessment lacked detail and did not clearly identify the location of specific ligature points within the hospital. This meant that staff may not be aware of all potential ligature anchor points, or the measures required to manage or mitigate them. The ligature cutters on the male unit were located in the manager's office which was locked when they were not there. We raised this with the manager who told us they would arrange for staff to be able to access this quickly in the event of an emergency.
- Fire safety arrangements at the service did not ensure that staff, patients and other visitors were protected in the event of a fire. An independent assessor had completed a fire risk assessment in June 2017. There were a number of outstanding actions from this assessment which included fire action notices to include details of fire assembly points, ensuring the magnetic mechanism on certain doors was operating effectively and checking that magnetic doors were released when the fire alarm was activated.
- On Eden Court we saw fire extinguishers were available and had been serviced. However, these were kept in locked storage, with the keys held in the office. This meant there could be delays in staff accessing the keys to use the equipment in an emergency.
- Whilst fire drills took place each month, these did not indicate how long it had taken to evacuate the building. We saw that one patient had refused to participate in the drill on two occasions, but a fire evacuation plan that addressed their support needs was not available in their care and treatment records.
- We observed that some environment risks were not appropriately managed. For example, staff did not always store items such as cleaning fluids correctly and in accordance with Control of Substances Hazardous to Health (COSHH) legislation. The laundry room where COSHH items were stored was not kept locked at all times. This meant that patients could access potentially hazardous items, which if ingested could make them unwell or cause injury.

- The service adhered to same-sex accommodation guidelines. There was a garden at the main entrance to the hospital which was used by both male and female patients. All patients were supervised by staff whilst in the garden.
- Staff and patients had access to appropriate call alarm systems. Staff carried personal alarms to summon help when needed. Patients could access call alarm systems in their bedrooms, bathrooms and communal areas.

Maintenance, cleanliness and infection control

- Overall the service was clean and well maintained. However, we observed some areas which required repair and some equipment which was not clean.
- On the first day of our inspection the metal around the keypad to the female unit was damaged exposing a sharp edge. Tiles in the main entrance had come away creating a potential trip hazard. A glass panel at the bottom of the kitchen door was cracked. We raised these maintenance issues with the manager who informed us they would contact the maintenance team.
- The provider carried out infection control audits every two months. The audit carried out in June 2017 identified actions that needed to be taken. Records showed that an action plan had been developed and all actions completed. However, we identified that several actions were still outstanding for example, colour coded signage was not displayed.
- Patient bedrooms and most communal areas were visibly clean. Staff carried out the cleaning and completed the cleaning schedules so this could be monitored. However, we found that staff had not kept the kitchen on the male unit clean. The kettle, oven and one of the fridges were visibly dirty. Each patient had their own cupboard to store food in and patients were able to store food in the fridge and freezer. There was some food which was out of date and some mouldy food in the male kitchen. These issues were raised with staff at the time of the inspection and appropriate action was taken to address them.
- Overall, we saw that equipment was maintained. Whilst the majority of portable electrical appliances had been electrically tested, we saw that the toaster on Olive Grove had not.
- Staff had access to personal protective equipment such as gloves and aprons. Whilst hand sanitizer dispensers were provided within the hospital, these were empty at the main entrance and in the staff toilet. Staff filled these promptly when we raised this with them.

Clinic room and equipment

- The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. The services resuscitation equipment included an automated external defibrillator (AED), which would be used to restart a person's heart. There was also an oxygen cylinder.
- Staff maintained equipment well and kept it visibly clean, however, clean stickers were not used by the service.

Safe staffing

- Suitable numbers of staff were rostered on each shift, however, staff were not always deployed to ensure patient safety was maintained. During July and August 2017, we found that staff were not always allocated appropriately for Eden Court. On three occasions some patients did not receive the one-to-one or two-to-one care they required because a member of staff was allocated to care for more than one patient. Family members reported that patients did not consistently receive one to one or two to one support in accordance with their agreed level of care. Allocation sheets for night duties were not always accurately completed, which meant the provider could not demonstrate that staff were appropriately allocated to patients on the night shift.
- The manager used a tool to calculate how many nurses and rehabilitation facilitators were required on each shift. The ward manager could adjust staffing levels to take account of patient needs. Bank and agency care staff covered vacant shifts. Where possible these were bank and agency staff who were familiar with the service. When agency and bank nursing staff were used, those staff received an induction to the hospital to ensure they were familiar with the patients and the unit.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse. Staff were available to facilitate patient trips to the local shops and to support them to go on holiday.

- The service staffing establishment was five qualified nurses. At the time of inspection there were two vacancies for nurses. There were two team leaders, four senior rehabilitation facilitators (SRF) and 15 rehabilitation facilitators (RF) employed by the service. Most staff either worked a day shift from 8am until 9.30pm, or a night shift 9pm until 8:30am. Some members of staff, the manager and deputy manager worked office hours.
- The staff sickness rate was 12%. Six members of staff had left the service in the last 12 months. The manager confirmed that this included long-term sickness.
- Staff were recruited safely to make sure they were suitable to work with patients who needed care and support. Written references from previous employers had been obtained and Disclosure and Barring Service (criminal records) checks were made before employing any new staff to check that they were of good character.

Medical staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. Medical cover for the service was provided by two part-time consultant psychiatrists. Psychiatrists visited their patients each week. They were also available on-call out of hours to respond to any emergencies. Patients were all registered with a GP.

Mandatory training

- Staff had received and were up to date with mandatory training. Overall compliance with completion of mandatory training was 89%. Staff were required to undertake nine mandatory training courses. This included attending courses on emergency first aid, safeguarding of vulnerable adults (SOVA), physical interventions, medication and the Mental Capacity Act. Staff also completed online training on food safety, health and safety, infection control and fire prevention. Refresher courses were to be undertaken between every one and three years, depending on the course.

- We requested that the service provided detail of their emergency first aid training and if this included basic life support, however this was not confirmed by the service. Staff informed us that they had completed basic life support as part of their induction.

Assessing and managing risk to patients and staff

Assessment of patient risk

- At the last inspection in May 2016 we recommended improvements were made in assessing risk. During this inspection we saw this had not improved. We reviewed the risk assessments of five patients. We saw that risk assessments had been completed for four patients shortly after admission. However, risk assessments had not been updated for four patients following incidents and for one patient potential risks associated with epilepsy had not been addressed. This meant that some potential risks to patients had not been identified and changing risks had not been responded to.

Management of patient risk

- There were arrangements in place for observing patients at risk of harm although not all staff were familiar with these or followed them. At the time of inspection nine of the 12 patients received one-to-one or two-to-one care. During the inspection we observed one patient on continuous observations alone in the corridor and raised this with the manager who dealt with it promptly.
- Some staff were not familiar with the provider's observation policy and procedure. For example, a member of staff told us that for two patients on one-to-one observations they would wait outside the patient's bedroom with the door closed during a family visit. They were not able to tell us what the provider's policy said about managing one-to-one observations during family visits, or what the individual patients care plans said about how one-to-one observations should be managed during family visits. This meant that patients were at risk of receiving care and treatment that was unsafe and did not meet their needs.
- Staff applied blanket restrictions only when justified. Doors to the kitchen on both units were kept locked to protect patients from possible harm. We saw that staff facilitated supervised access to the kitchen for patients at any time.
- The provider had implemented a smoke free policy. There were designated areas outside of the building where patients could smoke if they chose to do so.

Use of restrictive interventions

- The manager informed us that there had not been any instances of restraint in the previous 12 months and that restraint was not used. During the inspection we saw

good examples of staff members interacting with patients and when patients displayed challenging behaviour they spoke with them in a calm manner to de-escalate the situation.

- The service did not have a seclusion room and we saw that patients were not secluded in their bedrooms or other areas. At the previous inspection in May 2016, we recommended that staff understood the organisation's seclusion policy. During this inspection we found that staff did not seclude patients.
- Staff had knowledge of how to use rapid tranquilisation; however, staff had not administered rapid tranquilisation to a patient in the preceding 12 months.

Safeguarding

- Seventy-eight percent of staff had completed Safeguarding of Vulnerable Adults (SOVA) training, which was below the provider's target of 85%. Whilst staff we spoke with demonstrated an understanding of safeguarding issues, we saw that some potential safeguarding concerns such as bruising to a patients arm had not been identified as such. Appropriate action such as contacting social services to seek advice on whether an alert should be made, had not been taken. This meant that the provider could not be sure that patients were protected from the risk of abuse.
- Safeguarding information in an accessible format was not displayed for patients. This meant that patients did not have the information and contact details for reporting any issues or concerns that they had.
- At the time of the inspection, there was a child under the age of 18 at the service. The provider did not have a safeguarding children's policy in place, staff had not received training on safeguarding children and staff were unaware of the contact details for the children's safeguarding team. This meant that staff may not follow appropriate safeguarding training. The service had a safeguarding adults policy that outlined what abuse was and how staff should respond when they were concerned of potential or suspected abuse.

Staff access to essential information

- At the previous inspection in May 2016, we found improvements were needed to patients' records. During this inspection we saw that improvements had not been made. The service used both paper and electronic records to record the care and treatment provided to patients. Bank and agency staff could not access electronic records which meant there was a risk they could not access information they needed to provide safe care and treatment. Patients paper records were bulky and were difficult to navigate. This meant there was risk that all staff could locate quickly information they needed to provide care and treatment that was safe and met patients' needs.
- We saw that fire evacuation plans for two of the five patients' records we reviewed were not available in the patients paper records. The admission assessment for one patient was not in their paper records. We raised this with staff at the time of the inspection; they printed off copies of the missing documents and added them to the patient's paper record.
- Patients' paper records were not well maintained. We saw that one patients risk assessment had been filed on another person's paper records. Some documents contained with patients' paper records were duplicated. There was no overall summary on patient files, which staff could refer to 'at a glance' to ensure they understood the overall needs of the patients. Some of the staff were unclear how to meet specific patient needs. For example, some staff were unaware what information was recorded in the patients care plan.
- At the previous inspection in May 2016, we found that not all incident forms were placed in patient files. During this inspection we found no improvement. This meant that staff may be unaware of individual incidents patients had been involved with.

Medicines management

- Whilst there were appropriate arrangements in place for recording and correctly storing medicines. Not all patients received medication as prescribed. For one patient, medication had not been administered as prescribed. This patient had extended their home leave and additional supplies of their medicines had not been supplied to cover the entire period they were away from the hospital. We saw that the medication for another patient was due to run out and additional supplies had not been ordered. We raised this with the manager so that action was taken to ensure medicine was available.
- Medicine administration records (MAR) were clear, accurate and fully completed. Patients had detailed medicines treatment plans in place. Staff had information to help patients make decisions about 'as and when required' medicines and patients received

these safely. Medicine audits had been carried out in January, April and June 2017 to monitor the quality of medicines management. Staff had completed all actions from the June 2017 audit.

- Controlled drugs were stored safely in a locked cabinet. Staff monitored room and fridge temperatures on a daily basis to ensure medicines were stored at a safe temperature.
- The service had an annual visit from a pharmacist to review the services medicine management arrangements. The most recent visit took place in July 2017.
- The registered manager informed us that Medicines and Healthcare products Regulatory Agency (MHRA) alerts had not been received since the group hospital director left the organisation five months ago. MHRA alerts inform staff what medicines or equipment may place certain patients at risk and whether any medicines have been recalled.

Track record on safety

- The service had not reported any serious incidents within the past 12 months.

Reporting incidents and learning from when things go wrong

- Systems to report incidents and learn from them were not robust. Not all incidents that should be reported were.
- Staff had reported a total of 52 incidents in the period 1 May 2017 to 11 August 2017. However, we saw two examples where staff had not reported incidents, which had occurred. For example, one patient had extended their home visit and additional supplies of their medicines had not been supplied to cover the entire period they were away from the hospital.
- Staff understood the process to record and report incidents using an accident and incident report (AIR) form. Rating systems used on the AIR form (low, medium, high) were different to those in the providers policy and procedure (green, amber, red), which meant there was a risk that incidents were not rated correctly. There was also a risk that appropriate actions in response to the incident did not occur in a timely fashion as they were incorrectly rated.
- We saw that incidents rated, as amber had not been investigated by the manager, in accordance with the provider's policy and procedure. This meant there was a risk that lessons from incidents were not identified and shared with the staff team thereby reducing the likelihood of them recurring.
- The manager told us that they discussed lessons learned from incidents with staff at team meetings as well as at daily handovers. We looked at team meeting minutes but did not see that discussions relating to incidents were recorded. We spoke with six staff members; they were not able to give us examples of any changes that had been in the care and treatment of individual patients or within the hospital that had been made following learning from incidents.
- Following an incident debrief meetings were held, during the inspection we were able to see records of recent debriefs.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff understood duty of candour and told us that they would share information with patients and their parents or carers as soon as practicable following an incident.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

This was a focused inspection and we did not consider all of the areas regarding the service being effective. Where we had identified concerns in the May 2016 inspection we assessed the progress made by the service. As part of this process we also identified some new concerns.

Assessment of needs and planning of care

- We reviewed five patient care and treatment records. Care plans did not always include relevant or up-to date information.
- Staff had not consistently updated patients' care plans or recorded the next due review date; four of the five care plans were overdue for review. Changes had occurred for some patients and their files had not been updated. For example, staff had not updated a patient's

self-harm care plan following an episode of self-harm and it was overdue for review by two months. Staff had not reviewed the mental health care plan of another patient in July 2017 as scheduled. This meant that the care needs of patients may not be accurately recorded in their care and treatment records.

- The care records for patients' physical health needs were not always completed accurately and this meant there was a risk of patients' physical health needs not always being met.
- Two patients had a diagnosis of epilepsy. Staff had not recorded whether one of the patients had had a seizure or not since February 2017. The second patient had two seizure charts. Staff used one seizure chart to record 'no seizures' on a given day and the other to record when seizures had occurred. The records were stored in separate sections in the patient's file. This meant there was no central record detailing the patients' seizure activity or absence of seizures.
- The care plan for one patient who had a diagnosis of epilepsy, recorded that in the event of a seizure, staff should call an ambulance. This patient had a seizure and staff had not called an ambulance. The provider told us that guidance for staff, including when staff should call an ambulance for this patient had been placed in the clinic room. Staff had not updated the patient's care plan to reflect this. This meant that if new or temporary staff cared for this patient, they may be unaware that the guidance in the patient's care plan was not accurate.
- The hospital passport for one patient recorded that they had constipation and that their stools should be monitored. Staff had not completed a care plan for this and there was no evidence that staff had monitored this patient for constipation.

Best practice in treatment and care

- We reviewed five patient care and treatment records. We found that staff had not managed some aspects of patient's physical healthcare in each of the patient records we reviewed.
- Staff had not consistently and accurately recorded the food and fluid intake and output for one patient. This patient had longstanding eating difficulties. Staff had not recorded sufficient information in their food and fluid monitoring charts to know how much food and fluid the patient had consumed. Staff had not recorded the patient's output in the monitoring charts. This meant that staff were unaware of whether this patient had consumed sufficient quantities of food and fluid.
- Staff had not supported patients to be assessed by appropriate healthcare professionals in three of the five records we reviewed. For example, one patient had missed several hospital appointments; staff had not documented the reasons for this on the patient's file. We found examples of incidents that had occurred where a trained doctor or nurse should have assessed the patient but this did not happen consistently. For example, one patient had swallowed some crayons but staff had not ensured that a suitably trained healthcare professional had assessed the patient following the incident. This meant that patients may not receive appropriate healthcare intervention by trained professionals.

Skilled staff to deliver care

- Staff did not always have the right skills and knowledge to meet the needs of the patient group.
- The manager had not ensured that staff received the necessary specialist training for their role. There were patients at Olive Eden Hospital who had diagnoses of diabetes, epilepsy, personality disorder and a history of self-harm. There were also patients with eating and drinking difficulties. Staff had not all completed specific training in these areas. Training records showed that 24% of staff had undertaken training regarding diabetes and 29% of staff had undertaken training regarding safe eating and drinking. Thirty-nine percent of staff had completed epilepsy training, 32% of staff had completed training on personality disorders and self-harm. This meant that not all staff were suitably trained to care for patients' individual needs.

Adherence to the MHA and the MHA Code of Practice

- The provider had systems in place that showed adherence with the Mental Health Act (MHA) so that patients' rights were protected.
- All staff were expected to complete MHA training every 12 months, although this was not mandatory. Training records demonstrated that 61% of staff had received training in the MHA.
- Staff had ensured that all documentation relating to the MHA for the detained patient was available to view and

was in good order. One patient at the service was subject to section 3 of the MHA. Records relating to their detention were complete and contained all required information.

- Staff explained the patient's rights to them on admission and routinely thereafter and recorded this on their file.
- Staff ensured that the patient was able to take Section 17 leave (permission for patients to leave hospital) when this had been granted.
- Staff requested an opinion from a second opinion appointed doctor when necessary.
- Staff stored copies of the patient's detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- The provider had an MHA administrator within the organisation who provided advice and support regarding the implementation of the MHA.
- The unit had notices with information about the independent mental health advocacy service on the units. The service could be contacted by staff and patients directly during visits or by telephone on the publicised number.

Good practice in applying the MCA

- Ninety-two percent of staff had received training in the Mental Capacity Act (MCA). MCA training was mandatory.
- There were 10 Deprivation of Liberty Safeguard (DoLS) applications made in the last 12 months to protect people without capacity to make decisions about their own care and treatment. The DoLS authorisation had expired for two patients and the application for three other patients were recorded as pending. The manager maintained a deprivation of liberty safeguard tracker and recorded that each expired application had been followed-up once although there were significant delays for two of these. The manager had also sent one chasing letter for one of the patients whose application was pending but not for the others. There was no record that the service had communicated further with the relevant local authorities concerning the patients whose DoLS authorisations had expired, or were pending.
- For the patients awaiting a new DoLS application, the circumstances of their care and treatment involved close and continuous supervision by staff in a locked environment. There were environmental restrictions for patients. This meant that patients were detained without lawful authority.
- The provider had a policy on the Mental Capacity Act. The policy did not contain sufficient guidance for staff. It consisted of one page and did not describe the five principles of the Act. This meant that if staff referred to the provider's guidance, there was insufficient information to assist them in assessing a patient's capacity.

Are wards for people with learning disabilities or autism caring?

This was a focused inspection and we did not consider all of the areas regarding the service being effective. Where we had identified concerns in the May 2016 inspection we assessed the progress made by the service. As part of this process we also identified some new concerns.

Kindness, dignity, respect and support

- At the inspection, we saw many examples of staff working with the patients in a kind and supportive manner. Many of the patients had very complex needs and staff were calm and patient when meeting their needs.
- However, we saw that in relation to one patient the staff had not respected their privacy and dignity. We observed that staff were providing continuous observation for a patient in the patient's bedroom. The patient did not have any clothes on and the door to the patient's room was open. We spoke with staff about our concerns. The staff caring for the patient were not familiar with the correct protocol to ensure they respected the patient's privacy and dignity. We raised this with the manager who took prompt action to ensure the patient's privacy and dignity was protected.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

This was a focused inspection and we did not consider all of the areas regarding the service being effective. Where we had identified concerns in the May 2016 inspection we assessed the progress made by the service. As part of this process we also identified some new concerns.

Inadequate

Wards for people with learning disabilities or autism

Access and discharge

Discharge and transfers of care

- Patient discharge plans lacked detail and were not person centred. At the previous inspection in May 2016, we found that discharge plans were not all detailed, personalised or person centred. The extent to which patients achieved the goals linked to their discharge plans were not clear. During this inspection we found no improvement in discharge planning arrangements for patients.
- Discharge was delayed due to non-clinical reasons. The length of stay for patients at the hospital varied from between two months to five years. We reviewed the discharge plans for five patients. The patients' discharge plans had not stated the specific actions the provider was taking to facilitate their discharge. Staff had not set clear timescales. For example staff had assessed a patient as fit for discharge in April 2017; there was no evidence in their records of why the patient had not been discharged. This meant that staff did not provide sufficient support to patients to facilitate their discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- At the previous inspection in May 2016, we found that patients had mixed views about the activities they were involved with. During this inspection, we saw no improvement; some patients reported that there was not enough to do.
- Patient activities were limited. Whilst a programme of activities was in place for each patient, there was variable feedback from patients about their level of satisfaction with activities. During this inspection, we saw that staff had placed activity plans on patient files, and they had supported two patients to go on holiday. One patient also had a Saturday job and staff supported patients to go to the local shop. However, we did not observe other activities taking place during our time there. When relatives came to visit, the relatives engaged with patients and played games with them. Some of the patients we spoke with told us they were, 'bored' and one of the relatives told us that there was nothing for patients to do.

Listening to and learning from concerns and complaints

- At the previous inspection in May 2016, the service did not have a system to record, address and learn from informal complaints. During this inspection this had not improved. The relatives of two patients had made several informal complaints but they had not always felt listened to. Relatives told us that sometimes staff acted on their complaints but this was not consistent. This meant that the service may not be improved for patients following an informal complaint.
- The provider had a system in place to deal with formal complaints. There were arrangements to record and investigate complaints and take actions to address the issues raised.
- Leaflets on how to complain were displayed in the entrance to the hospital. Patients told us they would speak to a member of staff or the manager if they had a complaint. We saw in their files they had each been given information on how to complain and staff said they would support patients to make a complaint if they wished to do so.
- Staff were able to describe the procedure for registering complaints from patients and how they would support them to do so.

Are wards for people with learning disabilities or autism well-led?

Inadequate

Leadership

- The manager had some understanding of the service they managed although improvements were needed. It was identified as part of the May 2016 inspection that the manager had gaps in their knowledge. At the inspection in August 2017 we found that the manager still required support to fill some of these gaps. We provided examples of investigating incidents as well as understanding safeguarding arrangements. names of all the patients and had a good understanding of each patient's individual needs. The manager talked about the importance of enabling patients to pursue their interests and supporting patients to sustain close relationships with their families.
- The nurse in charge had the skills and experience to perform their role, however, they did not all have sufficient knowledge to perform their role. During the

inspection, an agency nurse was in charge of one of the shifts. The nurse was not familiar with individual patients' needs or which staff were responsible for caring for them during that shift.

- The manager was visible in the service and approachable for staff and patients. The manager had recently taken over responsibility for a second hospital which meant that their time present at Olive Eden Hospital had reduced to three days per week. The exact number of days the manager was on site could vary according to the needs of patients at each of the two services. Whilst the manager was at the other service, staff could make telephone contact with them as needed for advice and support.
- Staff knew who the senior managers in the organisation were. Senior managers visited the service regularly.
- Leadership development opportunities were available, including opportunities for staff below team manager level. The manager had completed leadership training and specific training on mentoring. The manager also encouraged staff to complete National Vocational Qualifications in Health and Care levels two to four.

Vision and values

- Staff knew and understood the provider's vision and values although this was not consistently applied. Sequence Care stated that it aimed to empower people to achieve their personal goals and independence through providing personalised, holistic care.
- Staff supported patients to stay with their families and they encouraged them to visit regularly. However, staff had not regularly updated patient risk assessments or care plans. Staff had not consistently ensured that patients' individual needs were met.
- The provider's senior leadership team had successfully communicated the provider's vision to staff; however, they had not involved staff in discussions around proposed changes. The provider planned to reconfigure the service, commencing work in September 2017. The aim was to transform the hospital into a care home. The provider had not sought feedback from staff or patients and their families about the strategy to make changes to the service.

Culture

- Staff spoke positively about their experience of working at the hospital. Staff told us they felt respected and supported by the manager and other staff who worked at the service.
- Staff told us they felt positive and proud about working for the provider and their team and that they found the manager approachable and felt able to raise concerns without fear of retribution.
- Staff knew how to use the whistle-blowing process. The service had a whistleblowing policy and procedure. The policy stated that if staff did not want to approach their manager, they could approach a more senior person in the organisation.
- Teams worked well together and when there were difficulties, the manager dealt with them appropriately. It was documented in the minutes of the July 2017 meeting that the manager raised concerns regarding teams not working well on occasions and reminded staff to talk to each other nicely and respectfully.
- Staff appraisals had not taken place in the previous 12 months. The appraisal form when used, included a section for the manager to set actions for individual competencies and to develop a plan of training for the year ahead.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.
- Staff sickness rate for the service was high but the manager informed us that this included long-term sickness.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- The provider had recently introduced an awards programme for staff to value their performance. Each quarter the manager nominated a member of staff who had demonstrated excellent performance and the nominee received a gift voucher.

Governance

- The board of Sequence Care Limited provided overall governance. The manager of the service met with other managers across the organisation every two months to share information and discuss operational matters.
- The service had systems in place to assess, monitor and improve the quality and safety of the service but these were not always effective. At the previous inspection in

May 2016, the CQC identified a total of 11 concerns and told the provider that they must or should address and take action for each of these concerns. During this inspection we found that the provider had taken action in relation to three of these concerns, one in part. All other actions were outstanding. We found that the service did not sufficiently assess risks to the environment and that fire safety arrangements were not adequate. Some areas of the hospital were not kept clean and some required repair. Patient risk assessments and care and treatment records were not kept up to date. Physical healthcare needs had not been consistently met and suitable arrangements were not in place to ensure patients going on home leave were supplied with medication as prescribed. Safeguarding processes were not followed and staff had not reported incidents consistently or correctly categorized them. The service had not always followed the principles of the Mental Capacity Act. Policies and procedures were not all up to date or reflective of the latest national guidance and quality assurance arrangements were not robust.

- At the previous inspection in May 2016, we found that some policies and procedures were out of date. During this inspection, we found that improvements had not been made. The provider had not reviewed and updated some policies and procedures, for example the provider's guidance on self-harm and the mental capacity act were overdue for review, the provider had not referenced relevant guidance and the documents lacked detail. This meant that staff may not have access to the correct and most up to date guidance.
- At the previous inspection in May 2016, we found that patient records were not always accurate and consistent and that some information was not accessible in the required format. During this inspection, we found that there was no improvement in the completion and accessibility of patient records.
- There was no clear framework of what must be discussed at team meetings. We reviewed team meetings for May, June and July 2017. There was no standing agenda and meetings focused on housekeeping duties such as cleaning and preparing food for patients. The manager and staff had not, for example, discussed safeguarding, incidents or new or amended best practice guidance, such as guidance from the National institute of Health and Care Excellence ('NICE'). This meant that staff may be unaware of essential information to comply with relevant guidance as well as improve the service for patients.
- The organisation's policy on formal investigations did not provide clarity on which incidents managers should investigate. The service had not investigated two of the incidents that the manager had rated as 'amber.' The meant the service failed to identify learning from incidents or make improvements to the quality of the service.
- Staff undertook and participated in local audits. Some audits were not sufficient to provide assurance on the quality of care provided to patients. Staff did not consistently act on the results from audit findings. The service had a programme of audits throughout the year, which included audits of patient care plans and risk assessments, infection control and medicines. We found variance in the quality of the audits. The provider failed to consider the quality of patient records as part of the care plan and risk assessment audits. The provider focussed on when staff had last updated patient records, there was no assessment of the content of these records. The provider had undertaken infection control audits but we found that staff had signed off some actions as completed when they had not been. The nurses had completed medicines audits well and action had been taken in line with the agreed deadlines.
- Staff understood the arrangements for working with other teams. The service worked closely with commissioners and care co-ordinators and other visiting health and social care professionals. Staff contacted the care co-ordinator if their patient had been involved in any incidents.

Management of risk, issues and performance

- Sequence Care Limited maintained a corporate risk register; this did not include service level risk. There was no formal process to escalate record and report on risk at location level. The majority of the ten risks on the register related to corporate risk and were not specifically relevant to Olive Eden Hospital.
- Staff were not aware of the risks recorded on the corporate risk register and there was no formal process to escalate or report local risks. Staff focus was on the needs of patients and the manager informed us that the top risk for Olive Eden Hospital was intruders. Staff

concerns had not been reflected on the corporate risk register. This meant that local risks were not formally recorded or monitored and that mitigating controls had not been put in place.
- The service had plans in place for emergencies. The provider had developed a service continuity plan which informed the manager and staff of action they should take in various emergency or disruptive scenarios. For example, unforeseen staff shortages, a flood, disruption of utility supplies, fire or adverse weather conditions.

Information management

- The service had systems to collect data. As a small hospital, these systems, such as records of incidents and accidents were straightforward and were not over-burdensome to frontline staff. Patient information was stored securely although information was inconsistent between hard copy and electronic files.
- Information governance systems included confidentially of patient records, however, we found two examples of patient information, which had been placed on another patient's file. This meant that patient's confidentiality was not always protected.
- Electronic patient information was stored securely. Staff were required to enter a password to access patient records electronically. The manager informed us that the system was backed up by head office and that there were arrangements in place in the event of a system failure.
- The manager had access to summary information about the hospital, although this was not stored locally and the manager had to contact head office to obtain information for example, sickness data, staff turnover, as well as the corporate risk register.
- The manager made notifications to external bodies, although they were not made consistently. For example, the manager had not reported one police incident to the Care Quality Commission.

Engagement

- Staff, patients and carers could access information about the provider through the organisation's website, although this was not up to date. There was an annual survey to gauge patient feedback as well as an annual survey for staff feedback.
- We requested a copy of the most recent patient survey and action plan for Olive Eden Hospital. The provider directed us to look for patient feedback on their website. The provider had included a statement on their website about patient feedback from 2015 but there was no detailed or recent information. We requested a copy of the action plan for patient feedback; however, the manager did not provide this to us.
- We requested a copy of the most recent staff survey and action plan for Olive Eden Hospital. The manager informed us that the staff survey, which took place in 2016, included two action points that were highlighted as unsatisfactory, pay and valuing staff for their contribution. The manager informed us that both of these actions had been implemented.
- Staff could raise concerns at any time as well as more formally through their supervision process or at team meetings. We saw evidence in supervision records that staff had raised concerns with their supervisor. There was no evidence that discussion took place at team meetings. Meeting minutes listed improvements staff were required to make, for example with general housekeeping or updating patient records but they did not evidence that discussions had taken place.
- Staff, patients and carers had not been involved in the decision about the future of the hospital or the building transformation. The provider had plans in place to transform the hospital into a care home. Work was due to commence in September 2017 with a sample room to be converted in August 2017. The provider had not consulted staff or considered and documented the risks to individual patients' welfare. We raised our concerns with the provider who immediately postponed the work.

Learning, continuous improvement and innovation

- Staff were not involved in research or national audits.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patient risk assessments and care plans are reviewed and updated as required, including after incidents have occurred.
- The provider must ensure that patients are continuously supported and observed by the correct number of staff at all times.
- The provider must ensure that patient's physical healthcare needs are appropriately identified, recorded and met.
- The provider must ensure that patients monitoring records for patients nutritional and hydration needs are completed accurately and with sufficient detail.
- The provider must ensure that patients' receive medication as prescribed.
- The provider must ensure that there are robust safeguarding processes in place.
- The ligature risk assessment must include sufficient detail to identify and mitigate risks.
- The provider must ensure that the kitchen on Eden Court is clean and that all food stored in the patient kitchens is within its expiry date. Items must be clearly labelled with the date the item was opened as well as its expiry date.
- The provider must ensure that there are suitable systems in place to protect patients in the event of a fire.
- The provider must ensure that staff have completed relevant training.
- The provider must ensure staff receive an annual appraisal.
- The provider must ensure that there are suitable systems in place to manage DoLS applications.
- The provider must ensure that policies and procedures are in place, are up to date and reflect local arrangements as well as relevant national guidance.
- The provider must ensure that there are suitable systems in place to learn from incidents.
- The provider must ensure that staff clearly define patient discharge plans and that staff record progress made towards patient discharge goals.
- The provider must ensure there are suitable arrangements in place to monitor the quality of the service.
- The provider must ensure local risks are identified and that suitable arrangements are in place to mitigate these risks.
- The provider must ensure that patient feedback is recorded and acted on.

Action the provider SHOULD take to improve

- The provider should continue to ensure that all COSHH items are kept locked at all times.
- The provider should continue to ensure that the ligature cutter on Eden Court is accessible to staff at all times.
- The provider should review the arrangements around individual patients' activities.
- The provider should ensure that patient records are placed in the correct patient's file.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The care of service users must be appropriate, meet their needs and reflect their preferences.** • The provider had not ensured that care plans were person centred. **This was a breach of 9 (1)(a)(b)(c)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users must be treated with dignity and respect.** • The provider had not ensured that patients' privacy and dignity was respected at all times. • The provider had not ensured that patients had clearly defined discharge plans, including specific goals. Progress made had not been consistently recorded in discharge plans. **This was a breach of 10 (1),(2)(a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a way that is safe for service users.**

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that ligature risks had been documented in sufficient detail.
- The provider had not ensured that firefighting equipment was accessible in the event of a fire.

This is a breach of 12 (2)(f)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Service users must be protected from abuse and improper treatment.

- The provider had not ensured that robust safeguarding arrangements were in place.
- The provider had not ensured that DoLS applications were completed on time and that applications awaiting decision were actively chased.

This was a breach of 13(1),(2),(3),(5)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The nutritional and hydration needs of service users must be met.

- The provider had not ensured that patients had received adequate nutrition and hydration at all times.

This was a breach of 14(1),(2),(4)(a)

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Suitable arrangements are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

- The provider had not ensured that there were suitable systems in place to protect patients, staff and other visitors in the event of a fire.
- The provider had not ensured that there was a system in place to ensure all patient areas were kept clean at all times.
- The provider had not ensured that there was a system in place to dispose of out of date food to ensure food stored in the patient kitchen was fit for consumption.

This was a breach of 17(1),(2)(b)

This section is primarily information for the provider

Enforcement actions

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a way that is safe for service users. • The provider had not ensured that patient risk assessments were reviewed and updated following incidents or periodically as planned. • The provider had not ensured that patients' physical healthcare needs were accurately documented and that patients receive appropriate physical healthcare in accordance with their individual needs. • The provider had not ensured that patients' received medication as prescribed. **This was a breach of 12(1),(2)(a)(b)(f)(g)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not taken action to address all concerns from the May 2016 inspection. • The provider had not ensured that actions from fire safety risk assessments had been implemented. • The provider had not ensured that there were systems and processes in place to maintain accurate, consistent and accessible patient care records. • The provider had not identified risks at service level. • The provider had not ensured that all policies and procedures were up to date and reflective of relevant national guidance.

This section is primarily information for the provider

Enforcement actions

- The provider had not ensued that suitable guidance had been developed for staff to report incidents.
- The provider had not ensured that there were suitable systems in place to learn from incidents.
- The provider had not ensured that team meetings provided staff with clear direction and included discussion around areas of significance to the service.
- The provider had not ensured there was a suitable programme of internal audit or that where issues had been identified they were acted on.
- The provider had not ensured patient feedback was shared with the service and that it had been acted on.

This was a breach of 17(1),(2)(a)(b)(c)(e)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training and appraisal.

- The provider had not ensured that patients received the correct level of staff observation at all times.
- The provider had not ensured that staff had completed relevant training.
- The provider had not ensured that staff had received an appraisal.

This was a breach of 18(1),(2)(a)