St Edwards Rehabilitation Home

Quality Report

St. Edwards Rehabilitation Home
160 Melfort Road
Thornton Heath
CR7 7RQ
Tel: 020 8683 1473
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?	Inadequate
Are services caring?	Requires improvement
Are services responsive?	Inadequate
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.

Summary of findings

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

Overall summary

We decided to cancel the registration of this service because of the evidence we found on inspection. This means the provider will no longer be able to operate the service at this location.

We rated St. Edwards as **Inadequate** because:

- The provider failed to maintain a clean and safe environment. The building was in a very poor condition throughout. It had an unpleasant smell and the main lounge was damp. A number of the rooms and the walls and floors throughout were dirty. The garden fence that separated the building from a neighbouring, occupied property was broken in many places. This put the safety of patients at risk and undermined their privacy and dignity.
- The provider had failed to assess or mitigate risks to patients. They had not assessed the risk posed by potential ligature points and had no evacuation plan in the event of fire for the patient at the location. The provider had not assessed the risk of or acted to prevent infections. There was no audit of infection control measures and no soap in the patient's bathroom.
- The provider did not undertake proper risk assessments and did not update risk assessments following incidents to ensure the safety of patients. The provider also did not properly record serious incidents, or record any investigations into incidents when they occurred or the actions the provider intended to take to reduce future incidents.
- The provider had not made all necessary, reasonable adjustments to ensure that a disabled patient could access all parts of the service without difficulty. This was in breach of their duty to make such adjustments under the Equality Act 2010.
- The unit was inadequately staffed. The sole patient at the service at the time of our visit was frequently left alone in the building. Not all staff at the location had the necessary skills, training and experience to undertake their duties; including a volunteer cleaner who was sometimes left in sole care of a patient. The service did not check references for new staff or do background checks on employment history or character. The provider had not undertaken a police check on the volunteer cleaner. The provider did not undertake any formal supervision of staff.
- The provider did not manage medicines according to policy or national guidance. Staff stored dugs in places that were unsuitable to keep them secure and did not properly record the administration of drugs to demonstrate that they had done so safely.
- The provider did not properly monitor the physical health of the patient or produce care plans to address their physical healthcare needs. The staff failed to provide suitable and nutritious food to support the patient's health. The care planning undertaken by staff contained little information that reflected the patient's wishes or preferences and staff did not update care plans in response to incidents. Staff did not regularly update their daily observations of the patient, or record the details of any meetings they had with other professionals to discuss the patient's care and treatment.
- The provider failed to employ proper systems to ensure that they could monitor the quality and safety of the service. The provider either had incomplete audits of the service or had failed to undertake them.
- The provider did not have in place proper systems either to record or to respond to complaints raised by the patient concerning their care and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Inadequate 	

Summary of findings

Contents

Inadequate

St Edwards Rehabilitation Home

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to St Edwards Rehabilitation Home

St. Edwards Rehabilitation Home is a service providing 24 hour support and accommodation for male or female adults between the ages of 18-65, who have been previously using mental health services, in order to promote independent living. It has accommodation for up to five patients.

St. Edwards undertakes the following activities that are regulated by the Care Quality Commission: treatment of disease, disorder or injury.

The service registered with the CQC on 6 June 2013. The CQC has not previously inspected this service. The provider was also the manager in day to day charge of the service.

Our inspection team

The team that inspected St. Edwards Rehabilitation Home consisted of an inspection manager, an inspector, a nurse and a pharmacist.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health 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?

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

During the inspection visit, the inspection team:

- visited all parts of the service and looked at the whether it was safe for patients and whether the facilities were appropriate. We also observed how staff cared for patients
- spoke with the one patient who was using the service
- interviewed the service manager
- interviewed two healthcare assistants
- spoke with one other person who said they were a volunteer
- spoke with a relative of the patient
- looked at an assessment of a patient's needs and their four care plans
- carried out specific checks to see if staff were managing medicines correctly
- looked at a range of policies, procedures and other documents related to the running of the service
- carried out an additional unannounced visit during evening hours

Summary of this inspection

What people who use the service say

Since the opening of the service St. Edwards Rehabilitation Home has had one patient. This patient said that staff generally treated them well and that if they had any problems they felt confident that they could raise them with the staff. The patient's relative said that staff had also treated the patient well.

However, the patient said that they had raised a complaint concerning their medication, but staff had no record of this complaint.

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 rated safe as **inadequate** because:

- There were ligature risks that inspectors observed at the service. Although the purpose of the service was to provide rehabilitation for patients who were not necessarily acutely unwell, its purpose was still to take referrals for people who had been in acute mental health care. Therefore it was necessary for the provider to ensure that ligature risks were identified and take any actions to reduce or manage them. However, the provider had not done an assessment of ligature risks and had not taken any mitigating action.
- The staff had not drawn up an evacuation plan in the event of fire for the patient.
- All rooms in the service were very unclean. There were fingermarks on walls, damp in the main lounge, the patient's room was not clean and neither was their shower. An upstairs toilet was extremely dirty and there was an unpleasant smell in every part of the location.
- The fence of the garden used by the patient was broken in several places allowing access from the occupied, neighbouring property as well as allowing the patient to be seen. This undermined both the safety as well as the dignity of the patient.
- The provider had not taken appropriate steps to ensure that they properly assessed the risk of infection and to take all necessary steps to prevent the spread of infection. The provider admitted that they had not undertaken a risk assessment or audit in relation to infection control.
- There were not sufficient numbers of staff to ensure that the patient was safely cared for. The patient was usually in the care of only one staff member, but often was also left alone for short periods while staff went out. This created risks for the patient. Inspectors also found that staff did not store medications securely.
- The provider did not undertake proper risk assessments or update any risk assessments when incidents happened, including whether the patient was able to leave the location in the event of fire when unsupervised. This meant that staff did not have proper information to assess the risks to the patient or to decide what actions should be taken to reduce risk.

Summary of this inspection

- Staff did not manage medicines safely. They did not store or administer drugs according to either legal requirements or the policies of the provider.
- Although the staff said that serious incidents had occurred involving the patient, they did not record them. This meant that staff had no information from which to investigate incidents, learn from them, or plan how to reduce them in the future.
- Staff did not properly monitor the physical health of the patient and there was no physical healthcare plan for them.
- The provider did not keep accurate or up to date records of staff sickness, turnover or the levels of bank and agency usage.
- The first aid box was not accessible to all staff.
- Staff did not keep regular and up to date observation notes of the patient.
- The provider did not have in place proper recruitment systems and policies to ensure that the provider employed fit and proper persons.
- The provider had not conducted background checks in respect of a volunteer cleaner who was sometimes alone with the patient to reasonably satisfy himself that they were cleared to work with adults in a vulnerable situation.

Are services effective?

Inadequate

We rated effective as **inadequate** because:

- The care plans written by staff for the patient were of poor quality. They failed to state how staff intended to plan and support the patient's rehabilitation and did not state how staff planned to monitor and support their physical health needs.
- Staff did not have all necessary qualifications, skills and experience to meet the needs of the patient and to deliver the service for which the service was registered with the CQC. Staff did not have specialist training in rehabilitation despite the service being intended to support the rehabilitation of patients. Also, a volunteer cleaner who the provider said was sometimes in sole charge of the patient had no relevant skills or experience.
- The provider did not meet the nutritional needs of the patient. The staff did not undertake any assessment of the patient's nutritional needs and only gave the patient processed food that was microwaveable and did not provide fresh vegetables or fruit.
- Staff did not undertake any clinical audits, or use any recognised ratings scales to measure outcomes. Therefore the manager was not able to assess whether they were delivering best practice in treatment and care.

Summary of this inspection

- Staff received no formal supervision. This meant that there was no system in place to support staff, identify problems individually with them, supervise their progress and development, or to formally resolve any staffing issues.
- The provider did not have a good understanding of the fundamental principles of the Mental Capacity Act relating to the rights of patients.
- There were no records of any staff meetings or handovers taking place to discuss the patient's needs. Where staff came into contact with external agencies in respect of the patient's care, such as hospitals or GPs, they kept no record of any discussions with other health professionals.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- We observed that staff interactions with the patient were generally very short and task-focussed. Staff were not observed interacting with the patient to discuss their care, treatment or rehabilitation.
- The staff did not inform the patient about the availability of any independent advocacy services to support them in raising issues regarding their care.
- The care plans of the patient contained no evidence of the patient's views or preferences.

However:

- The patient said that staff were generally good to them and the patient's sister said that staff had done all they could to support them.

Are services responsive?

Inadequate

We rated responsive as **Inadequate** because:

- The facilities did not promote the comfort and dignity of the patient. The patient's bedroom was unclean, as was their shower. The door in the patient's shower room was broken and staff had leant it against the wall.
- The provider had not made all necessary, reasonable adjustments to ensure the patient was able to access the shower room or garden. This was in breach of their duty to make such adjustments under the Equality Act 2010.
- The patient undertook no activities with the staff other than occasionally going to a local park. Staff said that the patient did not wish to participate in any activities, but there was no evidence of the staff encouraging the patient to consider the benefits of any rehabilitation.

Summary of this inspection

- There was no formal complaints system or policy in place to record the complaints of patients or the responses to them. Staff said that the patient had not made any complaints, but the patient said that they had made a complaint regarding their medication. There was no evidence that staff acknowledged or investigated this complaint.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- The provider did not take the necessary steps to ensure that the appropriate systems and processes were in place to monitor and improve the quality and the safety of the service.
- The provider did not maintain accurate, complete and up to date records of the patient's care and treatment and the decisions taken in relation to the patient.
- There were no formal procedures in place for the staff to give feedback regarding any concerns regarding the service.
- The provider failed to carry out appropriate checks on staff before they began working at the service.
- The provider allowed untrained staff to be left alone with the patient.
- Staff did not receive supervision.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was not mandatory for staff and staff training records did not indicate whether staff members had received any training in the principles of the Act, but two staff members demonstrated that they understood these principles. However, the manager of the service showed that they did not fully understand some of the main points of the law.

Staff had made one recent application for Deprivations of Liberty Safeguards authorisation. This was rejected as the local authority assessed the patient as having capacity to make a decision regarding taking leave from the service.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Inadequate	Inadequate	Inadequate

Notes

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate

Are long stay/rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

- The layout of the unit meant staff did not have clear lines of sight into every area at all times. There were also ligature anchor points in each of the rooms. These included handles and hinges on all doors, shelving by the computer and TV in the lounge, and curtain rails in each of the bedrooms. Although the unit was for rehabilitation and not for patients who were very unwell, unclear lines of sight and the presence of ligature risks still created a risk. The manager had not carried out a ligature anchor point risk assessment of the premises or any environmental risk assessments. Consequently there was no plan in place to mitigate or reduce the risks to patients. This put patients at risk of harm.
- Staff kept a first aid box in the kitchen. The contents of the box were all in date. However, there was no list of contents so it was not possible to tell whether anything was missing. The box was also on top of a cupboard and out of reach of one of the staff members. This created a risk to patients because it meant that a staff member might not be able to access the box quickly in an emergency.
- Up-to-date records showed that staff carried out weekly safety checks of the equipment in the unit. Fire equipment checks were also up to date and records showed that fire drills took place once a month. Staff demonstrated that other smoke alarms in the unit were functioning correctly. There was a fire risk assessment for the premises dated 20 January 2016. This identified actions that staff had to take by May 2016 relating to improved fire exit signage and the need to install emergency lights to help with evacuation. The provider, who was also the manager of the service, was in the process of completing this work. The manager stated that they had ordered the lights but had not yet installed the evacuation signs.
- The fire assembly point was in the garden of the unit. However, the provider had not made legally required adjustments to help the patient access the garden. This created a significant risk of harm as it meant they might not be able to leave quickly enough if fire broke out. There was a fire evacuation operational plan for the service dated 19 May 2013 to 19 May 2014. However, the manager said that the patient did not have a personal emergency evacuation plan. The staff sleeping accommodation was upstairs and the patient's room was downstairs. The manager stated there were no call buttons in the patient's bedroom and if they needed help at night they would shout. The patient confirmed this and said that if staff did not hear their calls they attempted to climb the stairs to shout closer to the staff bedrooms in order to be heard. The lack of a personal emergency evacuation plan and a personal alarm for the patient put them at significant risk of harm in any emergency.
- The environment throughout the unit was extremely poor. Although the staff had completed an up to date

cleaning rota, much of the unit was visibly unclean. There was a very strong unpleasant smell on entering the premises, which appeared to be a mixture of mould and mildew.

- Damp was evident in many of the unit's rooms, particularly the main lounge, causing the plaster to bulge in many places. Damp was also visible on the wall and ceiling of the patient's bedroom. The manager explained that this was caused by a leak in the roof, which he had reported to the landlord. Representatives from the insurers had visited the service to assess the damage. This had happened three to four months ago. There had been no further contact from the landlord about repairs.
- Downstairs, in addition to the damp, dirty marks were visible on the walls of the lounge and hallway. In a shower room next to the kitchen the door of the shower unit had broken off and was leaning against a wall. A small plastic chair in the shower was marked and stained. There was a cigarette butt on the floor and there was no soap. The patient's bedroom carpet and curtains were dirty and the fireplace had broken tiles. On the first floor, there were three bedrooms and one bathroom, which were cleaner than those on the ground floor. However, in the attic bedroom above the first floor the room was clearly unclean, with cobwebs in the window, a dirty carpet and a very unclean en suite toilet. The very poor environment throughout the unit created very significant health risks to patients and staff alike. Some staff acknowledged the poor conditions. One said that the unit was 'not at the right standard'. Another staff member said the unit needed to be improved 'to look like a home for somebody'.
- The patient used the unit's garden. However, the fence that divided it from a neighbouring property was broken in several places. This meant that anyone in the neighbouring garden could easily see into the service garden as well as access it. This created a substantial risk to the safety and the dignity of patients.
- There was a lack of infection control processes or procedures. There was no soap in the downstairs toilet, located in the shower room, for the use of the patient. Staff used washing up liquid in the downstairs kitchen to clean their hands because the soap dispenser was empty. There was soap in the upstairs bathroom for the staff, but this was not accessible to the patient. Staff sometimes needed to handle clinical waste and the manager told us that they did not have clinical waste bags so used plastic bags to dispose of clinical waste. They then took this to the GP surgery.
- Under the Health and Social Care Act 2008 and related Codes of Practice registered providers of care must take steps to assess the risk of and prevent the spread of infections in the services they provide. These steps must include ensuring that policies and procedures are in place. However, when we asked the manager whether there was an infection control policy or procedure for the service he stated there was not. He also confirmed that staff had not received any training in infection control. He said he was planning to arrange this but had no set date for training. Before we visited, the service had told us that staff had completed cleanliness and infection control risk assessments. However, when asked during the inspection whether staff had done this the manager replied that they had not. Instead, he provided a template of an infection control audit tool, but staff had not completed any part of the audit. The provider had therefore failed to meet their legal duty to put in place the necessary policies and procedures to prevent and control the spread of infection. This created a significant risk of harm to patients, staff and any visitors to the service.

Safe staffing

- The manager said that the service had three members of staff, himself and two healthcare assistants (HCAs). The manager was the only qualified nurse and lived on the premises. Information provided by the service about when each of the three staff members worked was incomplete. For example, the rota for February 2016 had many shifts left blank. The manager said he often stayed at the location and covered all night shifts and any of the shifts left blank on the rota. One of the HCAs only worked weekends and the manager said that the other HCA worked the day shifts. The manager said that he also worked as a mental health nurse at another location. When we asked whether he worked night shifts in that other job the manager confirmed that he did. The last time this occurred was in November 2015. The manager stated that this could happen in the future. However, he could not explain who would cover nights at the service in his absence.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- We returned for an unannounced inspection nine days after first vising the location. When we did so, a different person to the three present on the rota was present at the location. They were alone with the patient and explained that they worked as a volunteer cleaner at the location. However, when the manager returned on the evening of our unannounced inspection he confirmed that this person was the volunteer cleaner and that they worked at the service two or three times a week. He also confirmed that this person was sometimes in sole care of the patient when other staff members had to go out. The manager said that the cleaner had no healthcare qualifications, or experience and he had received no training in any relevant skills from the service. This put both the patient and staff member at risk of harm. When asked about this specific risk, the manager replied that the cleaner could call him to discuss any problems.
- The service did not provide complete information regarding the use of bank and agency staff. One of the HCAs was bank staff but because the monthly rotas had many blank shifts on them it was not clear how many shifts in total bank and agency staff covered.
- The service provided no information regarding staff sickness or turnover, any vacancy numbers or unfilled shifts.
- The manager of the service did not use a staffing tool to calculate the number of staff required, but said that as there was only one patient there was sufficient levels of staff.
- Only one qualified nurse worked at the location. This was the manager, who did not work there all the time. This created a risk to the patient living at the location because there was not always a qualified member of staff present to meet their care and treatment needs. There was no medical cover provided by the staff.
- Staff said that one member of staff was enough to look after the patient, give them enough 1:1 time with staff and to ensure they could take part in activities. Staff said that physical interventions had never been necessary. The patient said that they were happy with the support they+++++-- received from staff. However, the manager said that he or the staff member on duty sometimes left the location for up to 30 minutes, for example to go to the shops, leaving the patient alone at the location. This created a risk of harm because sometimes the patient was unwell and required personal care. Also, the manager had told us that the patient was sometimes in the sole care of a person who had no experience, qualifications or training. This meant that staffing was not sufficient because there was not always an experienced and qualified staff member on duty to ensure the patient's safety. This created a significant risk of harm to the patient.
- The manager provided training records for both HCAs but not himself. He said that the volunteer cleaner had not completed any training at all, even though this person was sometimes in sole care of the patient. The record of one HCA showed that they had completed training in a variety of topics and there were certificates to show that the staff member had completed this training. The same staff member had yet to complete data protection training. The training record for the other HCA was complete, but there were no certificates to prove completion. There was no training schedule or other evidence to indicate what training was mandatory for any staff member. There was no evidence to show that the provider had conducted a training needs assessment in respect of staff. Both HCAs said that they mostly received training in the other healthcare jobs that they did at the same time as working at the service. There was no evidence that staff had any specialist training in the care of mental health service users in a rehabilitation service.
- Registered providers of care must undertake checks to ensure that they employ fit and proper persons. The checks required are specified in Schedule 3 of the Health and Social Care Act 2003 (HSCA). These checks must relate to employees' previous employment history as well as checks recorded by the Disclosure and Barring Service (DBS). DBS checks provide information to employers regarding whether their employees have criminal records and whether they are also barred from working with adults in a vulnerable situation or children. With regards to employment checks on the two HCAs the manager said that he had not asked for any employment references from previous or current employers for them. The manager also did not have a full employment history for them or any explanation for any gaps in their employment history. In respect of the volunteer cleaner the manager had no employment information. With regards to DBS checks the manager provided evidence of background checks he had undertaken in respect of the two support workers as

well as the cleaner. The manager showed us DBS certificates for the two HCAs as well as himself. These were dated at the time of their initial employment and showed that the DBS service had completed the highest level of checks for them and that there were no concerns about them. However, the DBS certificate he provided for the volunteer cleaner was only for a standard level of check and did not include any checks to see whether the DBS had barred them from working with adults in a vulnerable situation. The absence of sufficient information regarding employees' employment history and references and an insufficient DBS check for the cleaner were a breach of the statutory requirements for employing fit and proper persons under the HSCA. This created a substantial risk of harm to any patients using the service.

Assessing and managing risk to patients and staff

- Staff said that they had never had to undertake any physical interventions with the patient at any time during their stay at the service.
- We examined the one care record that staff had made for the one patient that was using the service. This contained an initial risk assessment for the service user that staff had completed when he first came to the service. However, this risk assessment was not always clear in when stating what risks staff had identified. The manager said staff assessed and recorded additional risks in the service user's care delivery plan. However, this plan did not contain any formal assessments of risk to the service user, but instead contained care plans. This was despite the fact that staff had told us that incidents involving risk to the patient had occurred on many occasions. These incidents involved the patient leaving the service and not returning. Staff did not say how many times this had occurred but it had happened several times and they were frequently concerned about their safety. The manager told us that they had become sufficiently concerned about the patient's safety following these incidents to apply to the local authority to lawfully restrict their liberty under the Mental Capacity Act. This did not result in the restriction of the patient's liberty because an assessment concluded that they had capacity to make decisions about going outside. The manager then told us that staff had completed risk assessments and action plans to make the patient safer as a result of these incidents, but was unable to find any to show us. The lack of formal risk assessments created a risk of harm to the patient because it meant that staff were not properly identifying risk and planning how to mitigate those risks.
- The care record of the patient showed that the staff kept observational notes detailing what happened with the patient during a day. However, staff did not keep notes every day but only on some days. On the day of our second visit, staff had not recorded any observations for the previous three days. The manager explained that they only wrote things down when a new and different event happened and that it was not necessary to record repeated events. This created a potential risk of harm to the patient because staff did not make continuous observations regarding their health.
- There were no blanket restrictions in place at the service.
- Staff indicated that they knew how to raise safeguarding alerts. The manager reported that there had never been any incidents of safeguarding at the service.
- A pharmacist inspector visited the location to inspect the staff's management of medicines. Medicine records showed that the staff administered a variety of medicines including those whose administration is strictly regulated. Records of staff receiving medicines were up to date and signed and the quantities of drugs present at the service corresponded to what records showed should have been there. Records also showed that the two HCAs had passed medication competency assessments in 2014 and 2015 and that staff monitored the temperature of the drugs cupboard every day. However, the storage of the strictly regulated medicines was inadequate to keep them properly safe and secure. Also, when the pharmacist inspector arrived at the service the medicines cupboard where staff stored these medicines was open with the keys in it. This meant there was a risk that an unauthorised person could remove medicines from the cabinet.
- Staff kept a daily record the drugs they administered, included those strictly regulated by law. This record must be signed by two people: one person to administer the drug and another who witnesses the administration or who checks afterwards that the amount their colleague gave was correctly recorded. A person can only give a regulated drug alone if they do so in accordance with training and policy, and only if the second signature indicates a stock check and not a

Long stay/rehabilitation mental health wards for working age adults

Inadequate

witnessing of the giving of the drug. However, staff did not follow these rules. This was because the records showed that each time a member of staff administered a regulated medicine another member of staff signed and wrote that they were a 'witness', not a stock checker. But staff confirmed that only one staff member alone ever administered regulated medicines and another staff member was never present to witness it. Although a 'witness' always signed the record this person was in fact a colleague checking the stock later on. Also, the required two signatures were not always present. For example, on 8 February 2016 there was only one signature. The service did not have an appropriate policy regarding any medicines brought into the service.

- Records for the administration of other drugs were not up to date as there were none for the two days prior to the visit of the pharmacist inspector. Also, the quantity of some medicines present at the time of inspection did not match the amount that the records stated there should be. It was therefore not possible to determine whether staff had administered medicines correctly.
- Records showed that the patient had attended several appointments with doctors at a local acute hospital regarding their physical health. However, the staff kept no records of what was discussed at any of the patient's medical appointments or any decisions taken regarding their care and treatment.

Track record on safety

- We asked the provider to report how many serious incidents had ever taken place at the service. The provider had replied that no serious incidents had ever taken place at the service. However, this was contradicted by staff who told us during the inspection about the patient's history of leaving the location and not returning and the fact that staff were very concerned about these incidents. The staff kept no formal records of these serious incidents.
- The provider gave us no information about any safety improvements they had made to the service in response to incidents of any type.

Reporting incidents and learning from when things go wrong

- The staff told us that they knew how to report incidents and that where any incidents took place they recorded this and then took appropriate steps to ensure those incidents did not happen again. For example, a member of staff said that following incidents of the patient leaving the service and not returning staff had made an agreement with them that they would call staff by a specified time in the evening to let them know where they were. The patient's sister confirmed this agreement was in place. In another example, staff said that on many previous occasions the patient had taken food from the kitchen and ate it at various times of the day, including at night. They said that they were concerned that the patient was eating too much food and not preparing it properly. Therefore, they put the fridge containing their food in the upstairs office. However, staff did not record any of these incidents or record any action plans in response to them. This meant that staff were not able to evidence how they were responding to incidents or learning from those incidents or identifying the risks associated with them.
- Staff said that, occasionally, a meeting took place following an incident. They gave an example of staff meeting with the patient's social worker on one occasion to discuss with them their absences from the service. However, there was no evidence that staff formally investigated incidents, reported on them or met as a staff group to discuss those incidents and any lessons to be learned.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We saw one assessment of the patient's needs dated 22 October 2015. This was relatively detailed. We saw four care plans that staff had completed for the patient, one which staff had completed on the patient's arrival at the service in January 2014. However, the quality of the care plans was poor. They contained no physical healthcare plan or any risk assessments and had no detail

regarding how the service intended to plan, monitor and support the patient's rehabilitation. They did not include personal input from the patient and they had not signed them.

- Records showed that staff did not undertake formal and regular monitoring of the patient's physical health. The only evidence of the staff undertaking any physical health assessment was that they had weighed the patient upon arrival in 2014. Staff said they also took their blood pressure when they felt unwell, but there were no records of this taking place. Staff said that they were aware of the patient's physical healthcare problems. In the patient's records there was evidence that they attended appointments at local acute hospital in respect of their physical healthcare. However, the staff did not record any monitoring of the patient's physical health. This created a risk of harm to the patient.

Best practice in treatment and care

- The patient attended a local GP practice for the supervision of their physical healthcare.
- Staff conducted no clinical audits and they did not measure any clinical outcomes. This created a risk of harm to the patient because staff did not formally monitor rehabilitation, or whether care and treatment were effective in any way.

Skilled staff to deliver care

- The patient received support from different professionals, comprising the healthcare assistants and qualified nurse manager at the service, a local GP, drug and alcohol workers at a local service and a social worker.
- The staff at the service consisted of one qualified nurse manager, two healthcare assistants and a volunteer cleaner.
- There was no evidence of any formal induction programmes for the new staff.
- Staff members said that they received regular formal supervision from the manager. However, this was contradicted by the manager, who said that he provided no regular formal supervision for staff. The absence of any staff supervision records confirmed this. The lack of any supervision created a risk of harm to both staff and patient because it meant that a very important system for supporting staff and identifying and resolving any problems was not available. We saw a completed annual appraisal for each of the health care workers. However, one of them had had not been signed by either the manager or the member of staff, so it was not possible to know whether the record was a complete or accurate statement of the appraisal.
- We saw training certificates for one HCA, including first aid and medicines administration, but there was no information available regarding training for any other staff. Staff said that they had not received specialist training in respect of providing rehabilitative care. Given that the purpose of the service was to support patients with their rehabilitation before returning to the community this was evidence that staff did not have the necessary skills to meet this purpose. One volunteer cleaner, was sometimes left in sole charge of the patient when other staff members were out. The manager told us that this person had no training in healthcare whatsoever.
- There were no records of staff performance, and how this was monitored, supported or improved.

Multi-disciplinary and inter-agency team work

- Staff said they sometimes met to discuss the patient. However, there were no records of any staff meetings to confirm this.
- Staff accompanied the patient on a regular basis to his local GP surgery, to some hospital and other external appointments. Staff had also met with the patient's social worker. However, there were no records of what took place when the staff met with any professionals involved with their care and treatment. This meant that that the service could not provide any evidence of how it worked with other agencies in order to provide effective rehabilitation.
- Staff said that they conducted handovers between shifts. However, there were no records of any handovers taking place.

Good practice in applying the Mental Capacity Act

- There were no records indicating that staff had received any training in the Mental Capacity Act, but both HCAs demonstrated that they understood the main principles of the Act. However, the manager of the service showed that he did not fully understand these principles.
- The manager explained that he had applied to the local authority to lawfully deprive the patient of their liberty

Long stay/rehabilitation mental health wards for working age adults

Inadequate

after the patient had repeatedly left the service and not returned. Staff in hospitals may legally deprive patients of their liberty if the local authority assesses that the patient does not have capacity to make decisions and it is in the patient's best interests to deprive of their liberty in order to administer care and treatment. The local authority assessed the patient as having capacity and therefore rejected the manager's application. The manager said he made the application because the patient was making unwise decisions regarding not returning to the service, as well as 'going out in the rain'. However, this displayed ignorance of a fundamental principle of the Mental Capacity Act, which states that a person does not lack capacity simply because they make an unwise decision.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Requires improvement

Kindness, dignity, respect and support

- We observed several interactions between three staff members and the patient during our visit. Staff were generally friendly and respectful towards them. Staff also demonstrated controlled and calm responses in challenging situations. However, staff interactions with the patient were very brief and task-focused. Most of the time during our visit staff appeared not to interact with the patient. They did not discuss with them issues relating to their care, treatment or rehabilitation. While the staff acknowledged that the patient had personal care needs there was no evidence that they were attempting to engage them in understanding the need for better self-care.
- The patient stated that staff treated them well and said that the manager 'was a good person'.
- The staff said that they managed the patient's personal needs as best they could. A relative of the patient confirmed this. However, there was considerable evidence to show that staff did not meet the patient's needs, as the service was very dirty, the facilities were poor, there was no planning of the patient's rehabilitation and staff managed medicines incorrectly.

The involvement of people in the care they receive

- There was some evidence of involvement of the patient in his care, treatment and rehabilitation. However, the patient's care plans did not include any of his personal views and they had not signed any assessments or care plans. The patient also did not have a copy of a care plan and did not appear to know what their care plan was. There were no records of meetings between the patient and any professionals responsible for his care.
- When asked whether staff had ever offered the patient the support of an independent advocacy service to raise any issues regarding their care or rehabilitation they said staff had not.
- The patient's relative visited them regularly. They said that staff informed them whenever the patient had any medical appointments.
- The service held no meetings with patient to review his care or rehabilitation or in order to obtain their views.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Inadequate

Access and discharge

- Only one bed out of a total of five had ever been occupied at the service.
- Staff did not provide any written evidence of any discharge planning. There was no information about how the staff intended to fulfil the purpose of the service and the needs of the patient, namely their care, treatment and rehabilitation.

The facilities promote recovery, comfort, dignity and confidentiality

- There were a limited number of rooms to support the patient's rehabilitation. This included a lounge, kitchen, garden and a smoking area for him. However, the poor conditions found in many parts of the service meant that they failed to promote the patient's comfort, recovery or dignity.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- As the patient was the only person at the location they were able to meet visitors privately, either in the lounge or their bedroom.
- Staff stored food in two fridge freezers. One was located in the ground floor kitchen and the other in an upstairs office. Staff kept food for both the patient and themselves in the upstairs fridge freezer, although it was difficult to know who the food belonged to as staff had not labelled anything. Staff said that the patient mostly liked to eat frozen ready meals. However, there was no evidence that the staff had undertaken any assessment of the nutritional needs of the patient or had provided him with any information concerning the health benefits of a balanced diet. There was no evidence that staff made any fresh fruit or vegetables available. Instead, the staff appeared to accept the patient's desire for microwaved food and made no attempt to engage with them regarding the need for a healthy diet in order to support their recovery and sustain good health.
- The patient was able to make hot drinks at any time.
- The patient was able to personalise his bedroom.
- The staff said that they would safely store the valuables of any patients in a locked cupboard in the staff office. The patient at the time of our visit had no valuables.
- The patient took part in virtually no activities in respect of his rehabilitation. The only activity that occasionally took place was when a member of staff took him to a local park. Staff explained that they had attempted to support them in attending activities such as group therapy, but the patient was mostly against this, saying they did not want any help. The patient's relative confirmed this. However, as a rehabilitation unit there is an expectation of a rehabilitation pathway being followed and there was no evidence that staff were making any efforts to encourage the patient to consider the benefits of any new activities.

Meeting the needs of all people who use the service

- The personal circumstances of the patient meant that staff legally had to make adjustments to the environment to support their access to both the shower and the garden. However, staff had not done this and provided no evidence of plans to make any such adjustments.
- Information displayed for patients on the notice board of the service was very limited. This consisted of a leaflet for a local advocacy service, a notice confirming registration of the service with the Care Quality Commission, some emergency numbers to call for staff and a health and safety leaflet. There was no information for patients on their legal rights, available activities, local services, how to make complaints, or spiritual support.

Listening to and learning from concerns and complaints

- The service had a complaints policy which was up to date and reviewed annually. The manager stated there had been no complaints about the service since it had been registered. However, the patient said that they had complained to staff about an incident concerning their treatment, but there was no record of any complaint from the patient.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Inadequate

Vision and values

- Staff did not know of any specific vision and values of the organisation, although they said that they worked there in order to support patients' rehabilitation.
- There was no visible statement of the organisation's vision or values in any part of the service and staff were unable to provide evidence of any.
- The manager was also the provider of the service and was known to all staff.

Good governance

- There were records of training received by the staff. However, it was not clear from these records what training was needed, what was mandatory and the manager was unable to provide certificates for one of the two HCAs to prove what training courses they had completed.
- The manager did not provide any formal supervision for the staff.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- The manager had failed to undertake proper checks on the suitability of staff and left the patient in the sole care of a person with no relevant training or skills.
- The service only had one qualified nurse who only worked some of the shifts. Most of the shifts were covered by one healthcare assistant.
- Documentation of care was generally poor or absent.
- There was no evidence to show how the service planned to maximize staff time on direct care and rehabilitation activities with the patient. Staff did not keep daily observation notes or update care plans or risk assessments. Medicine records were incomplete and staff had not completed them according to legal requirements. Staff did not record any staff meetings or handovers. Any handovers and staff meetings were not recorded and management did not supervise staff. There were no minutes or records of any meetings with the patient, or any persons or agencies involved in their care and rehabilitation. The staff interaction we observed with the patient was short and displayed no rehabilitative component. We did not see staff engage the patient to discuss their care, wishes or interests. This was despite the fact that on the day of our visit there were three members of staff on duty, three times the number usually in place. The service did not perform any clinical audits.
- The staff did not report any incidents which took place at the service, nor investigate them effectively nor respond to any incidents with formal action plans. There was limited evidence of staff learning from incidents. This was only done in respect of asking the patient to call the service when he was outside. However, there was no evidence of whether this plan succeeded in reducing the risk of harm to patient caused by him leaving for long periods.
- The manager provided a copy of a "quality audit tool" he had completed on 16 November 2015. He said that the purpose of this document was to monitor and help improve the quality of the service. He said he completed it every quarter, filling it in with information about the service so that he could measure performance and identify improvements. However, the document was incomplete. For example, the section entitled 'person centred active support measure' contained 15 items against which the service should be rated. However, the manager had only written information about the service against six of the 15 items, leaving the other nine items blank. In another section of the audit entitled 'cleanliness and infection control' the manager had indicated that he had completed a cleanliness or infection control risk assessment. However, when we asked the manager whether he had completed an infection control audit or risk assessment of the premises he replied that he had not. Instead he showed us a blank infection control audit form. The incomplete and inaccurate audit was evidence that the manager was not undertaking proper governance of the service.
- We asked the manager whether he had completed any medication audits. He said he did this monthly. However, he could not find a completed copy of any medication audit. Instead, he provided a copy of a blank audit template.

Leadership, morale and staff engagement

- The service provided no data regarding staff sickness or absence rates or any bullying or harassment cases involving staff.
- Two staff members said that they were happy working at the service and felt confident that if that had any concerns the provider would listen to them. They also said that they had not previously needed to raise any concerns about the service.
- There was no evidence of any opportunities for staff development
- There were no formal processes for staff to give feedback on the service or to provide any input into how the service should be developed. One staff member observed that the service required improvement but that the provider was reluctant to make any improvements until the patient had left. The staff member was not able to explain why this was the case.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that it undertakes a full assessment of all ligature risks at the unit and takes the appropriate steps to reduce the risk of all ligatures identified.
- The provider must ensure that personal evacuation plans are in place for patients in the event of fire.
- The provider must ensure that the premises of the service are clean, secure and properly maintained.
- The provider must ensure that they properly assess the risk of infection and take all reasonable steps to prevent, detect and control the spread of infection.
- The provider must ensure that take all reasonable steps to ensure the dignity and respect of patients and have due regard to the protected characteristics of any patients as defined under the Equality Act 2010.
- The provider must ensure that all staff providing care and treatment have the appropriate skills and qualifications to do so safely.
- The provider must ensure that there are suffient numbers of suitably qualified staff to meet the needs of patients.
- The provider must put in place proper recruitment procedures to ensure that all staff employed at the service and those persons left alone with the patient are of good character and have the necessary experience, qualifications and training to meet the need of patients and deliver to safe care.
- The provider must ensure that all risks are appropriately assessed, plans put in place to reasonably reduce those risks and that all risk assessments and plans are updated in response to incidents involving risk.
- The provider must ensure that all medicines are managed and administered safely in accordance with policies and statutory regulations.
- The provider must ensure that serious incidents are properly recorded and that systems are in place to investigate serious incidents, identify learning from them and ensure that all appropriate actions are taken to put learning in practice in order to keep patients safe.
- The provider must ensure that patients' care plans are person-centred, reflecting their views, prefences and needs.
- The provider must ensure that staff properly plan and monitor the physical health of patients.
- The provider must ensure that proper systems and processes are in place to allow the provider to properly assess, monitor and improve the quality and safety of the service.
- The provider must ensure that all staff receive appropriate support, supervision, training and professional development.
- The provider must ensure that the nutritional needs of patients are adequately met.
- The provider must ensure that patients' observation notes are regularly completed and updated
- The provider must ensure that they maintain an accurate, complete and contemporaneous record of the care and treatment of the patient and the decisions taken in relation to that care and treatment .
- The provider must ensure that proper systems and policies are in place to record the complaints of patients and the procedures relating to how staff will respond to complaints.

Action the provider SHOULD take to improve

- The provider should ensure that first aid boxes are properly labelled and within reach of all staff and patients.
- The provider should ensure that records of bank and agency staff usage are complete and up to date.
- The provider should ensure that complete and up to date records are kept of staff sickness, vacancies and turnover.
- The provider should ensure that complete and up to date staff records are kept, including complete records of training, sickness, performance and supervision.
- The provider should ensure that they are properly trained in the main principles of the Mental Capacity Act.
- The provider should ensure that staff interaction with patients fully supports patient care and rehabilitation.

Outstanding practice and areas for improvement

- The provider should ensure that staff make patients aware of the availability of any advocacy services to support them to voice their preferences and concerns regarding their care and rehabilitation.
- The provider should ensure that proper systems and policies are in place to support staff to raise any concerns or give feedback regarding the service.

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
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider failed to ensure the fence between the garden of the property and an adjacent property supported the privacy and dignity of the patient. **This was a breach of regulation 10(2)(a)** The provider did not have due regard to the protected characteristics of the patient as defined under the equality Act 2010. **This was a breach of regulation 10(2)(b) and (c)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not undertaken a ligature risk assessment and had not taken any steps to reduce the risk of existing ligatures. **This was a breach of regulation 12(1)(a) and (b)** The staff did not undertake proper risk assessments in relation to the patient and they did not update any assessments following incidents.The provider did not properly monitor the physical health of the patient or produce care plans to address their physical healthcare needs. **This was a breach of regulation 12(1)(b)**

This section is primarily information for the provider

Enforcement actions

The provider had not put in place an evacuation plan for the patient in the event of fire.

This was a breach of regulation 12(1)(d)

Staff did not store, manage, or administer drugs safely in accordance with policies or statutory regulations.

This was a breach of regulation 12(1)(g)

The provider did not have in place adequate systems, policies and procedures to assess, prevent, detect and control the spread of infections.

This was a breach of regulation 12(1)(h)

One volunteer who was sometimes in the sole care of the patient had no qualifications or experience and no staff had received training in the rehabilitation of patients.

This was a breach of regulation 12(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider failed to provide suitable and nutritious food in order to sustain the good health of the patient. **This was a breach of regulation 14(1)**

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

This section is primarily information for the provider

Enforcement actions

The fence to for the garden used by the patient was sufficiently broken to allow access from the neighbouring garden. This meant that the premises were not secure.

This was breach a of regulation 15(1)(b)

The location was in a very poor condition throught, with visibly unclean rooms including the patient's bedroom, washing facilities and an upstairs toilet. Damp was evident and a very unpleasant smell existed in all parts of the location. Walls and floors were unclean throughout.

This was a breach of regulation 15(1)(a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider failed to establish and operate an effective system for identifying, receiving, recording, handling and responding to complaints. **This was a breach of regulation 16(2)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to employ proper systems to ensure that they could monitor and improve the quality and safety of the service. Audits were either incomplete or not done at all. **This was a breach of regulation 17(2)(a)** The provider failed to keep an accurate, complete or contemporaneous record of the care and treatment of the patient or decisions taken in relation to that care and treatment

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 17(2)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not deployed sufficient numbers of staff to keep the patient safe at all times. **This was a breach of regulation 18(1)** The provider did not provide any formal supervision or support to any of the staff at the service. The provider failed to ensure that all staff at the location had appropriate skills, training and experience to undertake their duties and meet the needs of the patient. **This was a breach of regulation 18(2)(a)**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider failed to establish and operate effective recruitment procedures in Schedule 3 of the Health and Social Care Act 2003 (HSCA). The provider had not conducted adequate checks on the employment history of staff. The provider had not conducted sufficient checks on a volunteer who was sometimes in sole charge of a patient. **This was a breach of regulation 19(1)(2) and (3)**