Eleanor EHC Limited

Eleanor

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

Eleanor Independent Hospital provides care and treatment for up to 34 patients.

At the time of the inspection there were 14 patients at the hospital.

The wards we visited were:

Oriel ward – a rehabilitation ward for women primarily diagnosed with personality disorder which has nine beds.

Cavendish ward - Cavendish ward is a rehabilitation ward for women with a primary diagnosis of mental illness, it has 10 beds.

This inspection was carried out urgently as a focused inspection, due to concerns we had around the safety of patients within the service and the care they were receiving.

Our rating of this location went down. We rated it as inadequate because:

The service had previously been inspected in April 2021 and was rated required improvement.

The service did not have a registered manager at the time of our inspection and the controlled drugs accountable officer was detailed as someone who had left the service some time ago.

The service was not safe. It did not have enough staff to provide care for the patients. Staff did not manage risk well.

We had significant concerns about the medicine's management at the hospital. We found many errors including prescribing, recording, and dispensing of medicines.

Staff did not develop meaningful care plans and risk assessments which meant staff were often working from out of date or incorrect information. The risk assessment process was flawed in that various formats were used at one time, this meant staff were not working with the most up to date and effective methods to manage and reduce risk.

The hospital was not caring. Patients and carers told us that patients were not at the forefront of their own care. Patients told us that staff were on their mobile phones, talking in different languages to the ones they used and did not know the reasons they were in hospital and how to help them.

The service was not well-led, there was no registered manager at the time of our inspection. The provider lacked oversight of the service provided at the hospital. The governance processes did not ensure that ward procedures ran smoothly.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Contents

Summary of this inspection

Background to Eleanor

Eleanor Independent Hospital provides care and treatment for up to 34 patients.

At the time of the inspection there were 14 patients at the hospital.

The provider was registered to provide the following regulated activities:

Diagnostic and screening procedures

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

Treatment of disease, disorder, or injury

The wards we visited were:

Oriel ward – a rehabilitation ward for women primarily diagnosed with personality disorder which has nine beds.

Cavendish ward - Cavendish ward is a rehabilitation ward for women with a primary diagnosis of mental illness, it has 10 beds.

What people who use the service say

We spoke informally to patients during our on-site inspection and spoke to patients formally as part of the Mental Health Act reviewer visit the week before our inspection. They told us the following:

All patients we spoke to told us that staff were not available to support and help them when they needed it.

Patients we spoke to raised concerns about staff texting and talking on their personal mobile phones instead of engaging with patients.

Patients also reported that some staff would speak in a different language to the one they used whilst on the ward.

For patients that were in on increased observations, they reported that staff often fell asleep whilst sat outside their bedrooms on night shifts.

Patients told us that staff often did not understand their individual needs and would not know what items they needed to remove from patients to prevent them harming themselves, this left patients feeling anxious and unsafe.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location including information discussed at provider engagement meetings.

Summary of this inspection

We conducted the inspection out of core business hours (in the evening). During the inspection visit, the inspection team:

visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients

spoke with patients who were using the service

spoke with other staff members; including doctors, nurses, and occupational therapy staff

attended and observed one handover meeting

looked at eight care and treatment records

carried out a specific check of the medication management on both wards; and

looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

The service must ensure that there are enough suitably skilled and experienced staff to care for patients (Regulation 18)

The service must ensure that they are adhering to working time directives and ensuring that staff have adequate days off over a 14 day period (Regulation 18)

The service must ensure that ligature risk assessments are completed on time and are available for ward staff (Regulation 12)

The service must ensure that patient risk assessments are up to date, not duplicated in various formats and reflect the current risks for the patient (Regulation 12)

The provider must ensure that medications and equipment are stored, checked and maintained appropriately (Regulation 12)

The service must ensure that patients are actively involved in their care and make efforts to ensure the patient fully understands their care and treatment plan (Regulation 9)

The service must ensure that governance processes are in place to effectively monitor operations across all areas (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Inadequate	Not inspected	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Caring	Inadequate
Well-led	Inadequate

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

Safe and clean care environments

All wards were not safe clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not complete and regularly update thorough risk assessments of all wards. On arrival at the inspection visit on 12 May 2022, we requested the ligature risk assessments for Oriel and Cavendish ward. Staff did not know what these were and were unable to locate them. We were provided with a copy of the ligature risk assessment for both wards the following day by email. Cavendish ward's ligature risk assessment was dated 2019 and had not been reviewed before the ward reopened following refurbishment and a changed patient group. Oriel Ward had a ligature risk assessment that was due to be reviewed in February 2022 and this had not been completed. However, the review had been booked in by the provider on the 10 May prior to our inspection and was due to take place on the 16 May. The ligature risk assessment file on Cavendish ward was empty and although permanent staff had access to the electronic version via the shared drive, agency staff did not have computer access so would not have been aware of or able to assess the risks of the environment. The ward was heavily reliant on agency staff to ensure safe staffing numbers.

Staff could not observe patients in all parts of the wards, parabolic mirrors were used to mitigate blind spots.

The ward complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and were able to call for assistance if needed.

Maintenance, cleanliness, and infection control

Ward areas were not always clean. On both wards there were lots of food on the dining room floor. Some bedrooms contained belongings piled high almost to the ceiling and window ledges were also completely covered. We were therefore not assured that these rooms were adequately cleaned on a regular basis. The light fittings on Oriel ward contained lots of dead flies. The wards were well maintained, well-furnished and fit for purpose for the most part. However, in the lounge on Cavendish ward, the curtains were hanging down at the windows. The door to the garden on Oriel ward had no handle on the outside, subsequently patients were locked out once the door closed and had to go around the building to another door to get back in.

Staff wore personal protective equipment (masks) as per provider guidance.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. We reviewed the duty rotas for the four weeks prior to our inspection. We found that the provider was heavily reliant on agency staff to provide qualified nursing cover. There was only one permanent qualified nurse on Oriel ward who worked nights and four on Cavendish ward, two on days and two on nights. During April 2022, there were 21 different agency qualified staff that worked at the hospital. Many of these only worked one or two shifts, so were not regularly booked. A small number of agency qualified nurses were working a considerable number of days in a row. One member of staff worked 17 out of 19 days in April. Another agency qualified nurse had worked eleven nights in a row prior to the day of our inspection and they were then booked to work another eight nights after this. We raised this immediately with the provider. We were not assured that the provider had sufficient oversight of the duty rota to manage staff who were working too many hours. There were three shifts where there was no qualified nurse on duty on one or both wards. On the evening of our inspection there was no qualified nurse booked to work on Cavendish ward, the qualified nurse from Oriel came up to take the handover and a qualified nurse arrived later in the shift.

The service had high vacancy rates at the time of our inspection. There were six qualified nurse posts that were unfilled. The provider told us that these posts had been recruited to and that three staff were awaiting the induction process.

The service had high rates of bank and agency nursing assistants. Although managers attempted to request staff familiar with the service, this was not always the case. We reviewed the duty rota for the four weeks prior to our inspection. We found that there was often more agency staff than permanent staff working on each shift. Although some agency staff were working regular shifts there were many that were not.

We reviewed allocation sheets for the four weeks prior to our inspection. We saw that agency staff were often put straight onto patient observations following a handover on their first shift on the wards. This meant that they did not have time to familiarise themselves with the ward and more importantly the patients, including what their risks were and how these were managed. The allocation sheets showed many examples of staff staying on close observations with patients for up to six hours without a break. The allocation sheets showed no evidence of new staff shadowing someone on their first shift, they were often placed onto security or observations straight away. The allocation sheets were piled up on the desk in both ward offices, we asked for the last four weeks and staff struggled to locate them. There were days missing and some were dated back to 2021.

The service did not have enough staff to keep people safe. Although managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift and could adjust levels according to need. The service was significantly reliant upon the use of bank or agency staff to staff the wards. We

reviewed the duty rotas for the six weeks prior to our inspection, and found that on many shifts agency staff outnumbered regular staff. On some shifts there were no regular staff and on three shifts there was no qualified nurse on duty. Patients did not have regular one- to-one sessions with their named nurse, most patients we spoke to did not know who their names nurse was. Patients that we spoke to told us that staff did not have time to sit and talk to them. They told us that staff did not know them well enough and there were new staff every day, this made it difficult for them to build a rapport with staff and they felt like they were repeating information to lots of different people. Many of the patients at the hospital had experienced significant past trauma and therefore, required consistent staffing that allowed them to form trusting and therapeutic relationships within order to support them in their recovery. Although we saw evidence of some leave taking place in patients records, patients told us that ward-based activities were often cancelled due to lack of staff time (staff time taken up by patients requiring higher levels of observation).

Handover records were basic and did not give important information about patients, especially to new staff who did not know the patients. We observed a handover on both wards during our inspection visit. We found the handover information to be brief and it did not give details about patient's individual risks or the reasons why they required higher levels of observations.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

We reviewed the staff training spreadsheet for the service. It was difficult to understand if the training figures were accurate as many staff on the training spreadsheet did not appear on the staffing rota and some staff who had left the service remained in the figures. Furthermore, the hospital had low numbers of permanent staff in post and was heavily reliant on agency staff. Due to the fact the provider did not train the agency staff, it was difficult to ascertain what their level of training was.

Training records for physical interventions showed that only 39% of staff were in date for this training against the provider target of 90%. The staff training plan showed 12 staff from the hospital were booked to complete this training in June 2022. Additionally, as most staff on shift were from agency, it was not clear what level of physical intervention training they had received and if this was the same as permanent staff at the hospital were using.

Immediate life support training was at 66% which meant that only four out of the six staff identified for this training were in date.

However; staff had mostly completed and kept up to date with their mandatory training. First aid was at 83%, infection prevention was at 86% and control and PREVENT was at 89% against the provider target of 90%.

Managers monitored mandatory training and alerted staff when they needed to update their training. We could see how the provider had identified courses that were falling below their target and booked staff on.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Assessing and managing risk to patients and staff

Staff did not assess and managed risks to patients and themselves well.

Assessment of patient risk

Staff did not complete risk assessments for each patient on admission/arrival. The risk assessments were not reviewed regularly, including after any incident. We reviewed eight patient records. We found that in six of these risk assessments had not been reviewed this year. We saw evidence of incidents occurring during in this time. We found that there were various risk assessments in patient files. We saw risk assessments from previous placements and an NHS Trust remained in the patient folder. This meant there was a risk that staff could inadvertently use an old or out of date risk assessment when caring for patients. Some patients only had a risk assessment from their previous placement and not one from when they arrived at Eleanor.

Management of patient risk

Staff did not always know about any risks to each patient and did not always act to prevent or reduce risks. Some staff we spoke to did not know the names of the patients they were caring for as this was one of the first times they had worked at the hospital or on the ward. Staff were not given the information they required to manage patient risk and keep them safe; handovers were brief and observations forms did not tell staff why patients required a certain level of observations. Staff often spent many hours on close observations with patients without any information to tell them why and what risks they were observing for. Patients told us that staff did not know about their history and that they had to repeat their history to several staff each day, this increased their anxiety and therefore risk levels.

Staff did not identify and respond to any changes in risks to, or posed by, patients. We saw that risk assessments were not reviewed following incidents, even when the incidents had required an admission to an acute hospital for the patient.

Although staff training was up to date in safeguarding adults, staff did not always show a sound understanding of how to protect patients from abuse and report this appropriately.

We saw several examples of patients who we had significant safeguarding concerns about following our inspection. For one patient, we raised a safeguarding with the local authority to look into their care and treatment. Patients were not safeguarded from harming themselves and several patients had significantly harmed themselves whilst at the hospital, on increased observations. Despite this, patient's risk assessments and care plans did not reflect the risk the patient posed to themselves, and similar incident had happened more than once as a result of records not clearly indicating risks for staff to monitor.

Staff access to essential information

Staff did not have easy access to clinical information, agency staff who were predominantly working on the wards did not have access to the electronic incident reporting system. This meant that incidents often went unreported or were added later by permanent staff.

Patient notes were not comprehensive, all patient files we reviewed were large and disorganised. We found several risk assessments in all eight patient files we reviewed, some were incomplete, and others were not kept up to date. Care plans were out of date and some patients did not have any care plans at all. There were piles of paperwork on the desk

in both ward offices, these contained paperwork such as allocation sheets and observation records. This meant that if staff needed to look back on what had happened on a particular date it would have been very difficult to find. We requested the allocation sheets for the four weeks prior to our inspection and staff struggled to locate them all and several were missing. These should have been used to inform patients care plans and risk assessments in order for staff to be able to care for them in a safe way. However, they were not stored securely, and staff could not locate them easily.

Medicines management

The service did not safely prescribe, administer, record and store medicines.

We reviewed ten medicines charts during our inspection. Six from Oriel ward and four from Cavendish ward.

We found examples of medicines not signed for by a prescriber, including controlled drugs. One patient had been prescribed morphine but there was no signature to say who had prescribed this, the medicine had been given on 17 occasions by staff.

For two patients' allergies had not been recorded, one of these resulted in a near miss when a patient was transferred to an acute hospital and the medical team were not informed of the allergy. Despite this, the allergy had still not been recorded on the patient's drug card.

We saw nine examples of patient's medication being given incorrectly. This included too many doses of medication in a day, medications being given more frequently than prescribed, medicines being dispensed late and medicines being given alongside other medicines when it was indicated this should not happen.

Staff did not review the effects of each patient's medicines on their physical health according to NICE guidance. We found five patients who were prescribed high dose antipsychotic therapy. Due to the risks this carries, the Royal College of Psychiatrists set out guidance for prescribing and monitoring of this type of treatment. The key recommendation from the Royal College of Psychiatrists is that any prescription of high dose antipsychotic medication should be an explicit, time-limited individual trial with a distinct treatment target. We found there was no monitoring taking place for these patients. Monitoring should include regular ECGs, specific blood tests, blood pressure pulse and temperature monitoring and monitoring of side effects. We found that none of the five patients whose records we reviewed had an ECG in their file, the medicine chart did not note that the patient was on high dose antipsychotic therapy. We did not see any evidence of regular blood tests taking place and monitoring of physical health, primarily blood pressure, pulse and temperature was sporadic. There was no guidance on how to monitor high dose antipsychotic therapy in any of the medicine records.

We found three examples of medicines that had been altered without a signature of the prescriber and medicine that had not been stopped when there was an indication it should have been.

Track record on safety

The service did not have a good track record on safety.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Staff did not always recognise incidents and subsequently did not always report them appropriately.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The majority of staff on most shifts were agency staff. Not all agency staff had access to the online incident reporting system that the provider used. Therefore, incidents were often reported late due to the need to wait for permanent staff to access the system. We picked up on several incidents in patients records that constituted a safeguarding concern and in turn should have been notified to the CQC. This was not always happening and, in some cases, was reported but the seriousness of the incident was not conveyed, this was particularly the case for some incidents of self-harm. Risks were not updated in key documents when incidents occurred and therefore, the management plans to reduce the risk of these happening again were not completed.

There was little evidence that changes had been made as a result of learning from incidents. Since incidents were not always reported effectively or in a timely manner. There was a lack of evidence to provide assurance that patients and their families had been involved in debriefs and investigations. Although staff were open when something went wrong, the fact that some incidents were not formally reported meant that that window of opportunity was missed. Relatives we spoke to told us that communication from the hospital was poor and that they struggled to find out key information about their loved one's care and treatment.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Inadequate

Kindness, privacy, dignity, respect, compassion, and support

Staff did not always treat patients with compassion and kindness. Due to the lack of permanent staff on both wards, staff often did not understand the individual needs of patients and were therefore unable to support patients to understand and manage their care, treatment, or condition.

We carried out a Mental Health Act monitoring visit to the hospital the week before our inspection. During this visit we spoke to three of the six patients on Oriel ward. All patients we spoke to told us that staff were not available to support and help them when they needed it. They told us that they did not get one to one time with staff and most of the patients did not know who their named nurse was. Patients we spoke to raised concerns about staff texting and talking on their personal mobile phones instead of engaging with patients. Patients also reported that some staff would speak in a different language whilst on the ward. For patients that were in on increased observations, they reported that staff often fell asleep whilst sat outside their bedrooms on night shifts. Patients told us that staff often did not understand their individual needs and would not know what items they needed to remove from patients to prevent them harming themselves, this left patients feeling anxious.

Involvement in care

Staff did not involve patients in care planning and risk assessment.

We reviewed eight patient records. The care plan review forms were blank and there was no evidence of patient involvement in reviewing care plans. One patient had a care plan stating they could not have access to the kitchen, this was written in 2021 and there was no evidence on the care plan that it had been reviewed. The kitchen was open on the day of our visit.

Involvement of families and carers

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not always inform and involve families and carers appropriately.

We spoke to two carers as part of our inspection. They told us that communication from the hospital was poor and that they often had to chase information several times. They told us that the ward telephone often went unanswered and they received no regular updates about their relative's care and treatment. However, relatives did comment that when significant changes were made, for example the detention status was reviewed, they were informed, and rights were explained.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Inadequate

Leadership

The hospital did not have a registered manager at the time of our inspection. There had been a high turnover of managers at the hospital over recent years and this had contributed to a lack of stability in the leadership of the hospital.

Governance

Our findings from the safe key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

The governance structure was not effective and there was a lack of oversight from the provider. There were not effective systems and processes established to ensure that the quality and safety of the unit was assessed, monitored, and improved.

Key audits were not effective in identifying issues and furthermore, they were not used by staff to make improvements for the future. We found a long list of problems in relation to medication and risk assessments; the provider had not previously recognised these issues in their own internal audit processes.

Management of risk, issues, and performance

Teams did not always have access to the information they needed to provide safe and effective care and used that information to good effect.

Agency staff (who made up a large portion of the staff on duty each shift) did not have access to incident reporting systems. This meant that incidents went both unreported and were often reported late.

We saw that the review of incident forms was not always used to ensure patient safety and reduce the risk of incidents reoccurring. For example, we saw incidents where patients had significantly self-harmed or absconded from the hospital, and this was not immediately flagged as a safeguarding concern, in some cases it was not even incident reported just noted in the daily records. We did not see any evidence of debriefs taking place to support patients and staff following an incident. We did not see trends or themes in incidents being discussed within the teams to reduce future occurrences**.**

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Information management

Patient records were not kept up to date, there was conflicting information stored in one file and there were often several different risk assessments for the same patient in varying formats.

We found that staff had not always made notifications to the Care Quality Commission as required. We found three examples of historic incidents that should have been reported to safeguarding and subsequently CQC which were not.

Patient records were kept in the office on each ward. During our inspection we found that the office desk was piled high with patient records that needed to be filed away. Staff had no system in place to organise this information and when we asked for specific dates and times it was very difficult for the staff to search through these piles to find them, some were never found.

Engagement

During our Mental Health Act visit prior to the inspection, patients told us they did not feel that staff engaged them in their own care. Patients felt that staff did not know them personally and did not understand their illness and the care they needed to support them with this. Patients told us that staff did not spend one to one time with them and with the high use of agency staff, patients often felt the need to keep repeating their concerns to new people.

Carers we spoke to told us that communication from the hospital was poor. They explained that they would struggle to gain feedback about their loved one's care. They were not asked for feedback on the service.

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.