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	Inspected but not rated
Are services safe?	**Inspected but not rated**

Summary of findings

Overall summary

This was an urgent focused inspection, due to concerns we had around the safety of patients within the service and the care they were receiving. The focus of the inspection was on the assessment and management of patient risk.

This inspection was not rated.

We found that:

- The service was not safe. It did not have enough staff to provide care for the patients. Staff did not manage risk well. Permanent and agency staff did not have the same level of training to ensure they could work together to restrain a patient.
- Risk assessments had been completed but were not reflective of patient risk or up to date. For example, we found these to either not reflect incidents that had occurred before the assessment or had not been updated following incidents. There was no evidence that the multi-disciplinary team had met to review and discuss newly presenting patient's risk.
- Staff did not know about risks to each patient and how to act to prevent or reduce risks. Staff did not have access to consistent risk documentation for example, briefing documents contained conflicting advice on the risk's patient presented with.

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	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Eleanor

Eleanor Independent Hospital provides care and treatment for up to 36 patients.

At the time of the inspection there were nine 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.

Linden ward –Linden ward is a rehabilitation ward for women with a primary diagnosis of mental illness, it has 10 beds. Linden ward had opened the week of the inspection with patients transferring from Cavendish ward which was now closed.

The service had previously been inspected on 21, 22 April and 5 May 2021 and was rated requires improvement. At that time 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 further inspected on 12 May 2022 and was rated as inadequate in safe, caring and well led. 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. At this point, we served a notice of proposal to cancel the providers registration. This meant that patients were being discharged and the provider subsequently notified us that they were voluntarily closing the hospital.

This inspection was an urgent focused inspection, due to the ongoing serious concerns we had around the safety of patients within the service and the care they were receiving.

What people who use the service say

We spoke informally to patients during our on-site inspection They told us they did not think there were enough staff. Patients told us they were often told to wait for a member of staff to be available if they required some assistance.

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.

During the inspection visit, the inspection team:

Summary of this inspection

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with eight staff members; including doctors, nurses, and health care assistants
- attended and observed two handover meeting
- looked at five care and treatment records
- 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.

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	Inspected but not rated	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Safe

Inspected but not rated

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

Inspected but not rated

Safe and clean care environments

All wards were safe clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. On the last inspection, Oriel ward had an out of date ligature assessment, this had now been updated. Cavendish ward was no longer in use and the service had reopened Linden ward after a refurbishment. The ligature assessment for Linden ward was up to date.

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

Patients had moved to Linden ward from Cavendish ward. Linden ward was newly refurbished and was clean and modern. Oriel ward was also clean and tidy. At the last inspection concerns had been raised about food being left in kitchen areas and bedrooms cluttered with belongings. Kitchens were now clean and bedrooms were no longer cluttered.

Staff wore personal protective equipment (masks) following provider guidance.

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 from the 1 July to 22 July 2022 prior to our inspection. We found that the provider was still reliant on agency staff to provide registered nursing cover. During the month of July, the service had used three registered nurses on the night rota and two of those were agency staff. On six nights out of 22 there was no permanent member of nursing staff on duty. On the day shift we found there were three permanent nursing staff with four agency nursing staff being used.

Since the last inspection there had been a reduction in the number of agency nursing staff being used to cover shifts and those now on the rota worked a regular shift pattern.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

On the morning of our inspection there were three registered nurses', one on Linden and two on Oriel. Two were agency and one a permanent member of staff.

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. During July the service had used 47 bank or agency staff compared with 22 permanent staff. 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.

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. For example, on the morning of our inspection Linden ward had one agency nurse, four agency healthcare assistants and one permanent healthcare assistant for eight patients. There were four patients requiring one to one observation, meaning there was no staffing capacity to support a patient who needed increased clinical observations.

Another example was on Oriel ward, where we found two nurses (one agency) and five healthcare assistants (three agency) on shift.

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.

Mandatory training

We reviewed the staff training spreadsheet for the service. Since the last inspection permanent staff trained in physical interventions had increased from 39% of staff to 61.9%. The provider target was 90%.

Immediate life support training had increased from 66% to 100%.

We looked at agency staff records and saw that none of the staff had restraint training. This meant that if a patient required restraining, there was not enough numbers of staff trained in restraint available on the wards to carry out restraint safely.

However; staff had mostly completed and kept up to date with their mandatory training. Training figures above the provider target of 90% were met in a number of areas including data protection, fire awareness, equality and diversity. However, first aid and basic life support was at 66.67%. Overall compliance for mandatory training was 76.74%.

Managers monitored mandatory training and alerted staff when they needed to update their training. We could see that the provider had ensured the number of staff completing mandatory training had increased since the last inspection.

Assessing and managing risk to patients and staff

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

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Assessment of patient risk

Since the last inspection patients had been assessed for risk. We reviewed five patient records. However, risk assessments in clinical files were not up to date and did not contain all patient incidents. The risk assessments were not reviewed regularly, including after any incident.

However, when incidents had been added to patient's risk assessments, there had not been updated summaries, formulation or calculation of risk included. There was no evidence that the multi-disciplinary team had met to review and discuss patients' risk.

The recording of incidents, within daily records, risk assessments and the reporting of those incidents to external agencies was not always comprehensive and in some cases was not recorded. For example, there had been two incidents involving one patient in July 2022 where hospital treatment had been needed, these had not been incident reported and were not included in the risk assessment.

It was not clear how staff used the risk assessments to continually assess risk. The handover sheet dated 21 July 2022 did not reflect a handover where risks had been discussed. It contained conflicting information on the assessment of risk and contained information about risk which had not been acted upon.

One patient was noted to be on 15-minute observation levels but on another part of the handover sheet under "What is the issue" they were noted to be nursed on continuous observation.

Another patient was noted to have a pair of scissors in their possession, there was no information about what actions staff had taken in response to this incident.

Within a patient care record, it was recorded the patient had disclosed suicidal ideation to a health care assistant and was offered reassurance. However, there was no information in the record in terms of any intent or plans the patient may have. There was no review by a nurse, or a doctor recorded, and no assessment of risk was undertaken.

Management of patient risk

Staff did not always know about any risks to each patient. We observed staff handovers on both wards. The nurse on nights gave a verbal briefing to staff. The information given revolved around how the patient had been over night. Staff were not told what individual patient observation levels were or what risks were associated with that patient.

We had concerns about the skills and knowledge of staff on duty in relation to the patients they were caring for. Staff undertaking observations were not provided with important information they needed to keep patients safe and provide the care they needed. Only one patient had information about how the patient liked to interact with staff and that they were happy to hold hands but did not like other physical contact.

All staff members undertaking one to one observation with patients did not know the individual risks relating to the patient they were supervising. When asked staff told us they were there to prevent self-harm, however they had no personal knowledge of patient.

Staff were unable to tell us what may trigger a patient they were observing to self-harm, how they may self-harm and what actions/interventions they should take to reduce the risk of them self-harming.

For some staff, the only information they had about the patient was the observation sheet with the patients' initials.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

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.

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.

We examined the providers incident recording system. 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. Incidents were not always reported effectively or in a timely manner.

We found incidents recorded that had not been reflected in the risk assessment and we found incidents recorded but there was no record of those incidents in the patients file. For example, one patient had two incidents (one of which was a ligature) recorded on the hospital incident recording system but we could find no recording of either incident within the daily notes.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that: • The service was not safe. It did not have enough staff to provide care for the patients. Staff did not manage risk well. Permanent and agency staff did not have the same level of training to ensure they could work together to restrain a patient. • Risk assessments had been completed but were not reflective of patient risk or up to date. For example, we found these to either not reflect incidents that had occurred before the assessment or had not been updated following incidents. There was no evidence that the multi-disciplinary team had met to review and discuss newly presenting patient's risk. • Staff did not know about risks to each patient and how to act to prevent or reduce risks. Staff did not have access to consistent risk documentation for example, briefing documents contained conflicting advice on the risk's patient presented with.