Elysium Healthcare (Acorn Care) Limited

The WoodHouse Independent Hospital

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
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

The WoodHouse Independent Hospital provides services for patients with a learning disability or autism in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service is specialist in providing care for individuals with autism and forensic histories.

We inspected the hospital because we received information of concern about the safety and quality of the services. We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering how we carried out this inspection. Therefore the inspection focused on specific areas of the following key questions:

- Are services safe?
- Are services well-led?

We carried out an unannounced responsive inspection and visited the location on 8 October 2020 during the night shift and again on 14 October during the day shift.

We focused on specific areas of the safe and well-led key questions. We did not rate the service at this inspection as we were looking at specific concerns. This meant that not all areas within each key question were reviewed or reported upon and therefore we did not gather enough information across the whole service to re-rate it.

We identified the following areas of concern:

- Staff did not always follow infection control policies and procedures and the units were not always clean. The provider did not act in a timely manner to respond to concerns raised on our first visit to minimise the potential risk posed to patients through a lack of staff adherence to these measures.
- The units did not always have enough nursing staff who knew the patients to keep them safe from avoidable harm. Staff told us that patients were not always able to access time outside of the unit to access fresh air and staff were not always able to take their break.
- Staff did not always follow the provider's policy on carrying out observations.
- Staff told us that they did not always feel valued, respected and supported. They did not always feel able to raise concerns without fear of retribution. Staff told us managers were not always visible or approachable.
- Governance processes did not always work effectively at unit level. There were not robust processes in place to provide assurances of the quality of care that patients receive.

However, we also found:

- Staff followed good practice with respect to safeguarding and minimised the use of restrictive practices. The service managed patient safety incidents well and recognised and reported incidents appropriately.
- Leaders had the knowledge and experience to perform their roles and had a good understanding of the services they managed.

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
Wards for people with learning disabilities or autism	Inspected but not rated	We carried out an unannounced responsive inspection and visited the location on 8 October 2020 during the night shift and again on 14 October during the day shift. We focused on specific areas of the safe and well-led key questions. We did not rate the service at this inspection as we were looking at specific concerns. This meant that not all areas within the key questions were reviewed or reported upon and therefore we did not gather enough information across the whole service to re-rate it. We received information of concern about the safety and quality of the service.

Summary of findings

Contents

Summary of this inspection

Background to The WoodHouse Independent Hospital

The WoodHouse Independent Hospital is an independent mental health hospital provided by Elysium Healthcare (Acorn Care) Limited. The hospital provides services for patients with a learning disability or autism in a range of small, bespoke units and cottages. The service offers assessment, treatment and rehabilitation placements, individualised and intensive packages of care and step down to community-based services. The service is specialist in providing care for individuals with autism and forensic histories; including sexual offending, highly complex and severe challenging behaviour. The service has recently refurbished Hawksmoor unit and reopened the unit to provide care and treatment to female patients. It provides care for up to 39 male and female patients under 65 years old who have learning disabilities or autism.

The WoodHouse Independent Hospital comprises of eight units located on a rural site in Cheadle, Staffordshire:

- Hawksmoor, female, three beds, locked rehabilitation with self-contained apartments;
- Lockwood, male, eight beds, locked rehabilitation unit;
- Farm cottage, male, three beds, open rehabilitation house;
- WoodHouse cottage, male, three beds, open rehabilitation house;
- Moneystone, male, eight beds, autism complex/ challenging behaviour unit;
- Whiston, male, four beds, autism complex/challenging behaviour self-contained apartments;
- Highcroft, male, four beds, autism rehabilitation unit;
- Kingsley, male, four beds, autism complex/challenging behaviours self-contained apartments.

The WoodHouse hospital is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.

At the time of inspection, there was a registered manager in place. The registered manager left their post shortly after the inspection.

We most recently carried out a comprehensive inspection at The WoodHouse Independent Hospital in February 2020, we rated it as requires improvement overall. We rated caring and responsive as good and safe, effective and well-led as requires improvement. We removed the hospital from Special Measures and issued the following requirement notices:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 11 HSCA (RA) Regulations 2014 Need for consent
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance

You can read our findings from our all of our previous inspections by selecting the 'all reports' link for The WoodHouse Independent Hospital on our website at: www.cqc.org.uk.

How we carried out this inspection

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.

Summary of this inspection

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to improve:

- The provider must ensure that staff adhere to infection control principles in line with the provider's policy and national guidance. (Regulation 12)
- The provider must ensure that staff working at the service adhere to the provider's policies and procedures.(Regulation 17)
- The provider must ensure that there are robust audits in place to monitor and improve the quality of care, with clear actions where appropriate. (Regulation 17)
- The provider must ensure that there is a robust system in place for staff to raise concerns, including verbal and written, without fear of retribution. (Regulation 17)

Action the provider SHOULD take to improve:

- The provider should ensure that medicines are dispensed following good practice guidelines. (Regulation 12)
- The provider should ensure that all units are clean and well-maintained. (Regulation 15)
- The provider should ensure that there are robust systems in place to ensure that staff working during a night shift are appropriately undertaking their roles. (Regulation 17)
- The provider should ensure that staffing levels do not prevent patients access to time outside of the unit to access fresh air. (Regulation 18)
- The provider should ensure that staff working are able to take uninterrupted rest breaks in line with the providers policy and working time regulations. (Regulation 18)
- The provider should ensure that managers are visible and approachable for both staff and patients and staff know who their Freedom to Speak Up Guardian is.
- The provider should consider communicating lessons learned to all staff in a clear and timely manner.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Wards for people with learning disabilities or autism

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Wards for people with learning disabilities or autism safe?

Inspected but not rated

This was a focused inspection responding to specific areas of concern. Therefore not all areas within safe were reviewed or reported upon. At this inspection we found:

- Not all units were clean, well-furnished or well maintained. During our out of hours visit, we found Kingsley and Moneystone units were not always appropriately clean or well maintained. On Kingsley unit there were boxes of dirty personal protective equipment stacked on top of one another at the donning station.
- Staff did not always adhere to infection prevention control procedures. Some staff were observed not wearing personal protective equipment or not wearing it appropriately. Some staff were observed not following the principles of social distancing in handover meetings or sanitising their hands on entry to the unit or frequently while working on the units.
- The service did not always have enough nursing staff who knew the patients to keep patients safe from avoidable harm. We found one nurse having responsibility for three units at one time. Staff told us there was not always enough staff to take patients outside for fresh air if their level of observation increased, as there were not enough staff on the unit. Staff reported that they were not always able to take a break as there was not always enough staff to facilitate this.
- We found indicators that staff may have been sleeping during their night shift. The provider did not have clear processes in place to monitor that staff working during a night shift were appropriately undertaking their roles.
- Staff did not always follow good practice when storing medicines. On Highcroft Unit, medicines were dispensed and stored in paper cups, stacked on top of one another in a locked cupboard.
- Staff did not always follow the provider's policy in relation to carrying out observations. Staff were responsible for carrying out observations at set times but told us there were occasions when observations were recorded retrospectively. We found omissions in observation recording during our out of hours visit. The provider did not have an audit programme in place for monitoring the recording of observations.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information in both paper based and electronic format.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and when things went wrong, staff apologised and gave patients honest information and suitable support.

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

Inspected but not rated

Wards for people with learning disabilities or autism

Inspected but not rated

This was a focused inspection responding to specific areas of concern. Therefore not all areas within well-led were reviewed or reported upon. At this inspection we found:

- Leaders did not always have the skills and were not always visible in the service or approachable for patients and staff. Staff told us that they did not find managers approachable or have confidence in their ability.
- Staff did not always feel respected, supported and valued by managers. They did not always feel able to raise concerns without fear of retribution. Staff gave us examples of where they had raised concerns and there had been no action or feedback received. Staff were not aware of who the Freedom to Speak Up Guardian was.
- Managers did not have appropriate oversight of governance; they did not take appropriate action when staff raised concerns, they did not always carry out effective audits with clear actions where appropriate and they did not have processes in place to ensure that staff adhered to infection prevention control measures.
- Lessons learned were not always shared with all staff in a timely manner.
- Leaders did not always actively engage staff in local quality improvement activities such as audits.

However:

- Leaders had the knowledge and experience to perform their roles and had a good understanding of the services they managed.
- Unit teams had access to the information they needed to provide safe and effective care.
- Staff told us that they felt supported by members of the multi-disciplinary team; in particular, the psychology team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Staff were not always adhering to the providers policies and procedures There were not robust audits in place to monitor and improve the quality of care, with clear actions where appropriate. There was not a robust system in place for staff to raise concerns, verbally or written, without fear of retribution.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Following the inspection, an urgent Notice of Decision to impose conditions on the provider's registration was issued under Section 31 of the Health and Social Care Act. Staff did not always adhere to infection prevention control procedures. Some staff were observed not wearing personal protective equipment or not wearing it appropriately. Some staff were observed not following the principles of social distancing in handover meetings or sanitising their hands on entry to the unit or frequently while working on the units. Not all units were clean, well-furnished or well maintained. During our out of hours visit, we found Kingsley and Moneystone units were not always appropriately clean or well maintained. On Kingsley unit there were boxes of dirty personal protective equipment stacked on top of one another at the donning station. The provider did not act in a timely manner to respond to concerns raised on our first visit to minimise the potential risk posed to patients through a lack of staff adherence to these measures.

Inactive