# Olive Eden Hospital

## Quality Report

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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** | **Good** |
| Are services safe? | **Good** |
| Are services effective? | **Good** |
| Are services caring? | **Good** |
| Are services responsive? | **Good** |
| Are services well-led? | **Requires improvement** |

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

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

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

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

# Summary of findings

## Overall summary

We rated Olive Eden Hospital as requires improvement because:

- Whilst patients had a number of risk assessments in place, these were not always reviewed or updated following an incident. Staff were recording incidents of restraint but these did not include the length of time restraint was used.
- There was a lack of proper management of patients' care records, incidents and informal complaints. Patient care records and information was not kept in a consistent or accessible way. Patient needs and how these were being met were not clear in multiple care plans, files and records. The was a lack of clarity in data collected and overall analysis around incidents.
- Discharge plans were not all detailed, personalised or person centred. The extent to which patients achieved their goals linked to their discharge plans were not clear.
- Patients had mixed views about their activities. Whilst a programme of activities was in place for each patient, there was variable feedback from patients about their level of satisfaction with activities.
- Family members expressed dissatisfaction about the handling and response to their informal complaints regarding their relative's care and treatment. Informal complaints records were not easily accessible. There was no effective system in place to ensure informal complaints were addressed in a timely manner.

However:

- The provider had made improvements to ensure that they managed medicines safely.
- We observed a good standard of cleanliness throughout the service.
- There were sufficient staff and an appropriate skill mix. There were enough staff to ensure patient safety.
- Staff were made aware of incidents and debrief discussions provided staff with opportunities discuss and learn from incidents in team and one to one meetings.
- Staff regularly monitored patients' physical health and patients accessed the GP, dentist, optician and chiropodist on a regular basis.
- Patients had access to psychological assessments, their individual behaviour was monitored and they had positive behaviour support plans in place. There was a strong multidisciplinary team (MDT) who were available to patients when they needed.
- All staff had completed the corporate induction prior to commencing full duties. Staff had regular supervision and the majority had annual appraisals. Staff completed mandatory and specialist training in relation to the needs of patients using the service.
- All the documentation relating to the Mental Health Act for the detained patients was available to view and in good order. Patients had a record of their consent to care and treatment in place and their rights explained to them on admission and routinely after.
- Patients were supported to make decisions and where they lacked capacity, there were procedures in place to enable best interest decisions to be made. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was mandatory and staff showed good awareness of the principles.
- Patients said staff were kind, caring, understanding and supportive. We observed that staff had developed a good rapport with patients and understood their individual needs. Staff treated patients with dignity and respect and provided practical and emotional support. There were positive interactions between staff and patients.
- There were a sufficient range of rooms and outside and quiet areas where people could go and engage in activities. Patients were permitted to smoke in outside areas.

# Summary of findings

- There had been changes among senior management in the past five months, including a new area manager and operations director who were reviewing systems and procedures aimed at improving the service. All staff said they had good support from the manager who knew the needs of patients well and was improving the outcomes for patients using the service.
- Quality monitoring through processes such as audits were identifying areas of improvement and these were mostly being followed through. Collation of incidents, use of physical intervention and formal complaints was provided. This enabled trends across the service and areas of improvement to be identified. However, there was not a robust system to manage informal complaints.

# Summary of findings

## Contents

Good

# Olive Eden Hospital

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

# Summary of this inspection

## Background to Olive Eden Hospital

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

## Our inspection team

The team that carried out this inspection consisted of two CQC inspectors, a CQC inspection manager, a CQC assistant inspector, a pharmacy inspector, a nurse specialist advisor and a Mental Health Act reviewer.

## Why we carried out this inspection

We inspected this service as part of our on-going 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 information that we held about the location and asked a range of other organisations for information. During the inspection visit, the inspection team:

- carried out a tour of the ward environment, looked at the quality of the premises and observed how staff were caring for patients
- spoke with four patients that were using the service
- reviewed the care and treatment records of patients of all seven patients
- spoke with five relatives of patients using the service
- spoke with the management of the service including the registered manager, area manager and director of operations
- spoke with 13 other members of staff including psychiatrists, assistant psychologists, nurses, assistant occupational therapist and rehabilitation facilitators
- carried out a specific check of the medicines management in the service
- received feedback from commissioners of the service and care coordinators of patients in the service
- carried out a Mental Health Act review of the statutory documents of three patients detained under the Mental Health Act
- looked at a range of policies, procedures and other documents relating to the running of the services

# Summary of this inspection

## Information about Olive Eden Hospital

Olive Eden Hospital is registered with the CQC to provide, treatment of disease, disorder or injury, assessment or medical treatment for persons detained under the Mental Health Act and diagnostic and screening procedures.

At the time of our inspection a registered manager was in post. There have been four previous inspections at Olive Eden Hospital. The most recent inspection was in February 2015. At that time, Olive Eden Hospital was found to be non-compliant in the area of management of medicines. We found the service was compliant with the management of medicines at this inspection.

## What people who use the service say

The patients we spoke with had mixed views of the hospital. Three patients told us there were not always enough structured activities and they were sometimes bored. Two patients also said that they were anxious about their discharge arrangements.

Four patients we spoke with said they liked staff and were satisfied with the care they received.

Patients said that staff were supportive and understood their individual needs. Patients reported that staff used one to one sessions with them to listen to their needs and offer advice when appropriate.

# 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?

Good

We rated safe as **good** because:

- Staff were made aware of incidents and debrief discussions provided staff with opportunities to discuss and learn from incidents in team and one to one meetings.
- There had been a significant reduction in behavioural incidents in recent months, which staff linked to effective working between the nursing and support staff and the multidisciplinary team. The majority of staff had completed training on physical interventions and had improved their skills in de-escalating situations where patients were distressed.
- There were sufficient numbers of staff and an appropriate skills mix. There were enough staff to ensure patient safety.
- At the last inspection in February 2015 the provider was given a compliance action for not having appropriate arrangements in place to manage medicines safely. At this visit we found medicines were well managed on the site.

However:

- While staff recorded incidents of restraint, they did not always record the method and length of time restraint was used so that restraint could be monitored to ensure it was carried out in an appropriate and safe manner.
- Some staff were not clear on the provider's seclusion policy.
- Individual risk assessments relating to the risk of self-harm using a ligature point needed to be reviewed.
- Whilst patients had a number of risk assessments in place, these were not always reviewed or updated following an incident. Risk assessments were inconsistently recorded.

### Are services effective?

Good

We rated effective as **good** because:

- Patients' health records showed patients had annual health checks and accessed the GP, dentist, optician and chiropodist on a regular basis. There was evidence that patients' physical health was monitored and they had regular contact with health professionals.
- Records showed examples of good, recovery-orientated practice.
- Patients had access to psychological assessments, their behaviours were monitored and they had positive behaviour

# Summary of this inspection

support plans in place. There was a strong multidisciplinary team (MDT) who patients said were available to them when they needed. Input from the psychology team played an important role in review meetings and the development of patient care and recovery plans.
- Actions decided at multi-agency and care programme approach (CPA) reviews had been followed through.
- There was a robust recruitment procedure in place and all staff had completed essential recruitment checks prior to staff taking up employment.
- All staff had completed the corporate induction prior to commencing full duties. Staff had regular supervision and the majority had annual appraisals. Staff completed mandatory and specialist training in relation to the needs of patients using the service.
- All the documentation relating to the Mental Health Act for the detained patients was available to view and in good order. Patients had a record of their consent to care and treatment in place and their rights explained to them on admission and routinely thereafter.
- Patients were supported to make decisions and where they lacked capacity, there were procedures in place to enable best interest decisions to be made. The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was mandatory and staff showed good awareness of the principles

However:

- Patients' needs and how these would be met were not clear in the multiple care plans, files and records.

## Are services caring?

Good

We rated caring as **good** because:

- Patients said staff were kind, caring, understanding and supportive. We observed that staff had developed a good rapport with patients and understood their individual needs. Staff treated patients with dignity and respect and provided practical and emotional support. There were positive interactions between staff and patients.
- Patients said they could talk to staff and said they would listen. Staff offered patients reassurance when they presented with particular needs or concerns.

However:

# Summary of this inspection

- While families were invited to attend reviews, relatives gave mixed feedback about their relationship with the service. A number expressed different levels of dissatisfaction with communication from the hospital.
- Patients had access to advocacy support. They had regular opportunities to provide feedback about their service through regular community and one to one support meetings.
- Staff understood patients' needs and patients participated in their care planning meetings.

## Are services responsive?

Good

We rated responsive as **good** because:

- There were a range of rooms where people could engage in activities and patients felt there were enough quiet areas they could go to. Patients had access to outside space in a small outdoor garden area. Patients were permitted to smoke in outside areas.
- Patients had a choice of food to meet their dietary requirements. For example, staff helped to prepare one patient's preferred traditional meals at least twice a week. Menus were developed with feedback from the patients in regular community meetings.
- The hospital was on one ground floor and suitable for people requiring disabled access. All the patients had seen an occupational therapist for an assessment to see if there was a need for adjustments to meet their individual needs.
- Key documents including care plans were provided in formats accessible to patients. The speech and language therapist had provided guidance to staff about how to communicate with individual patients.
- Spiritual support for patients was available to individuals who wanted this input.

However:

- Discharge plans were not all detailed, personalised or person centred. The extent to which patients achieved their goals linked to their discharge plans were not clear.
- Patients had mixed views about their activities. Whilst a programme of activities was in place for each patient, there was variable feedback from patients about their level of satisfaction with activities.
- Whilst formal complaints were addressed in a robust manner, family members expressed dissatisfaction about the handling and response to their informal complaints regarding their relative's care and treatment.

# Summary of this inspection

## Are services well-led?

Requires improvement 

We rated well-led as **requires improvement** because:

- There was no evidence that policies and procedures had been reviewed and updated where necessary to ensure staff carried out their duties and responsibilities in line with current guidance.
- The provider had not ensured that there were systems and processes in place to maintain accurate, consistent and accessible patient care records.

However:

- Staff knew how to use the whistle-blowing process and to report any concerns. Staff reported a good culture of team working and mutual support and the satisfaction of working in a supportive environment.
- There were no reported cases of bullying or harassment.
- All staff said they had good support from the manager who knew the needs of patients well and was improving the outcomes for patients using the service.
- Staff knew and agreed with the organisation's aims and values. They were aware of the importance of treating patients with respect and dignity and having an individualised approach to the treatment and care of patients.
- There had been changes in senior management in the past five months, including a new area manager and operations director who were reviewing systems and procedures aimed at improving the service.
- Quality monitoring through processes such as audits were identifying areas of improvement and these were mostly being followed through. Collation of incidents, use of physical intervention and formal complaints was provided. This enabled trends across the service and areas of improvement to be identified. However, there was not a robust system to manage informal complaints.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

- The provider had systems in place that showed adherence with the Mental Health Act (MHA) so that patients' rights were protected. One patient was subject to section 3 of the MHA and two were subject to section 37/41.
- Whilst MHA training was not mandatory for all staff, the provider's data showed that 50% of staff had received training in the MHA.
- Patients had a record of their consent to care and treatment in place.
- Where a patient had requested the input of a second opinion doctor, their decision was clearly recorded in the patient's file.
- Patients had their rights explained to them on admission and routinely thereafter. Two patients said they were told about their rights and their medication had been discussed and agreed.
- MHA administrator within the organisation provided advice and support regarding the implementation of the MHA. All the documentation relating to the MHA for the detained patients was available to view and in good order.
- There was evidence of effective processing of tribunal requests and of the receipt and scrutiny of section papers.
- There were regular MHA audits to ensure the MHA was being applied correctly.
- There were notices with information about the Independent Mental Health Advocacy service on the units. The service could be contacted by staff and patients directly during visits or by telephone on the publicised number.

## Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had systems in place that showed adherence to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).This meant patients' rights were appropriately protected.
- The MCA training completed by 91% of staff was mandatory. Staff showed a good awareness of how to apply the principles and this was reflected in their practice. Staff had access to the MCA and DoLS policies and procedures when they needed.
- One patient was subject to an authorised DoLS and three others had been assessed and were waiting for the outcome.
- Patients had MCA assessments completed on a decision-specific basis. Assessment forms documented where the multi-disciplinary team and family had been consulted. Mental capacity assessments had been completed in areas including finance, medicine management and community access to determine if patients could make informed decisions.
- Patients were supported to make decisions and where they lacked capacity, steps were taken to make decisions in their best interests.
- If staff needed advice about the MCA including DoLS, they could ask the MHA manager and MHA assistant within Sequence Care or consult the responsible clinician.
- There were arrangements in place to monitor adherence to the MCA through an audit completed by the MHA manager on at least a three monthly basis.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Wards for people with learning disabilities or autism | Good | Good | Good | Good | Requires improvement | Good |
| Overall | Good | Good | Good | Good | Requires improvement | Good |

Good

# Wards for people with learning disabilities or autism

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires improvement |

## Are wards for people with learning disabilities or autism safe?

Good

### Safe and clean environment

- There were ligature points that could pose a risk to patients throughout the service. The service had completed an environmental ligature risk assessment. This identified the areas of risk in the hospital. These were mitigated by patients having an individual risk assessment although some of these needed to be reviewed. There were higher levels of observation where needed and building work to reduce potential ligature points in patients' bedrooms where needed. There was no ligature cutter in one of the units which meant patients could have been put at risk in the event of an incident involving self-harm. This had been identified in a previous audit but action had not been taken to replace the ligature cutter. The provider ensured a ligature cutter was in place by the end of the inspection.
- There was a treatment room with a medicines cupboard, emergency resuscitation equipment checked regularly and a first aid kit. We noted the first aid kit contained steroid washes that were out of date.
- The service was clean. Hand gel dispensers were placed at hospital entrances. Signs in bathrooms reminded people of hand washing procedures. Staff competed quarterly infection control audits, however some actions had not been completed in the October 2015 audit and were carried over to the next audit in March 2016. This included the cleaning and removal of mould in certain areas and missing netting and curtains in bedrooms.
- Environmental risk assessments were completed by the quality assurance health and safety manager in the organisation.
- A pin point alarm system was located in the corridors. Staff in both units were provided with portable alarms linked to this system which identified the location of staff member who needed help. Patients had access to nurse call buttons in their rooms.

### Safe Staffing

- At the time of our inspection there were two whole time equivalent (WTE) qualified nurses employed by the provider and three part-time qualified nurses. There were twenty WTE nursing assistants called rehabilitation facilitators. There were four rehabilitation assistant vacancies and two nurse vacancies. There had been 360 shifts covered by bank or agency staff during the three months since February 2016.
- The provider used a tool to calculate minimum staffing levels to ensure that all the shifts had a suitable number of qualified and unqualified staff to ensure patient safety. The tool considered the current and historical risks to the patients, their activities and staff training requirements. It also included the procedure to be followed if staffing levels needed to be increased to ensure patient safety. Staff felt these numbers were sufficient.
- There was at least one nurse on duty at all times and a minimum of six to eight nursing assistants on the day

shifts and five but often six or more at night. There were usually two team leaders on each shift. The registered manager was a mental health nurse who said they could occasionally provide cover if a nurse was not available.

- No new members of staff were being recruited as vacancies arose. The hospital relied on the use of bank or agency staff to ensure safe staffing levels. This was due to the provider's plans to make changes to the registration of the service. In the past 12 months there had been a high staff turnover of 25%. Patients, relatives and key stakeholders mentioned this as potentially impacting on the consistency of care. However most of the bank or agency staff had previously been employed as permanent staff and were familiar with the service and patients. This helped to minimise the impact on patients as a result of the changes.
- The multidisciplinary team (MDT) reviewed and agreed the observation levels for each patient based on their individual needs. Records showed that observation levels were regularly assessed, monitored and adjusted.
- Staff including the rehabilitation facilitators and qualified staff were present in communal areas of the ward. Each patient had a named worker with whom they met regularly for key-working sessions. Staff each worked three shifts a week and were available to talk with patients during their shifts. Staff said they always had time for one to one sessions.
- Patients had access to leave and regular activities. These were rarely cancelled due to staff shortages. Rehabilitation facilitators and MDT staff told us this was a well-staffed hospital and having time to spend with patients was one of the positive aspects of working there. We observed one patient going out with two staff to the park, others going out with staff to shops and another patient spent the morning having their hair done by a member of staff.
- The majority of staff (87%) had completed training on physical interventions which included restraint. Staff told us physical interventions were not routinely used. There were always enough trained staff to carry out physical interventions if needed.
- Medical cover for the service was provided by two part-time consultant psychiatrists. They were also available on-call out of hours to respond to any emergencies. Patients were also registered with a GP.
- An on-going training programme was in place and most staff were up to date with mandatory training. There were 13 mandatory training courses completed by 91% of staff. Areas of mandatory training included safeguarding, emergency first aid, fire safety, learning disability, mental health and dementia awareness, nutrition and hydration, physical health and diabetes. A staff training schedule was in place and showed that courses were due for renewal between one to three years.
- We reviewed nine staff files. All staff had evidence of satisfactory references having been obtained prior to staff commencing employment. Disclosure and barring service (criminal records) checks had been obtained for all staff and probationary assessment records were completed.

**Assessing and managing risk to patients and staff**

- There was no seclusion room on site. The provider's seclusion policy stated that any supervised confinement of a patient in a room may amount to seclusion. It included confinement of a patient in their bedroom (with the door open or closed) or confinement in any other room. The policy stated any seclusion would be treated in accordance with the Code of Practice to the MHA. Nursing staff and a member of the multi-disciplinary team said if patients were agitated or deemed as high risk to themselves or others, they could be redirected to a low stimulus area, such as the garden or lounge or go out for a walk. This also included their bedrooms if they needed. The provider told us that staff redirected patients using distraction methods to escort them to quiet areas; that patients were never prevented from leaving an area, whether this is a communal space or their bedroom, and that patients often had capacity and understanding to recognise the risk and agree with staff that it would be appropriate to go to their room or another safe area.

  However, there was inconsistent feedback from staff as to whether patients could come out of their rooms and how long they were kept there. We were told by some staff that doors were never locked to patients' rooms and patients could come out if they wished, whereas other staff told us that there had been multiple occasions in previous months where one patient was not able to leave their room once directed there until it was sufficiently safe for them to do so. This suggests a risk of de-facto seclusion that would not be reviewed as

required by the MHA Code of Practice. Records did not record the length of time patients were taken to go in their bedroom or whether the patient agreed to go if they were informal.

- There had been 26 incidents of restraint used in the six months prior to the inspection. Where staff had restrained a patient, this was documented on incident forms. Incidents of restraint were recorded on accident and incident (AIR) forms. We looked at two incident forms and these did not state the length of time the patient was held during the restraint to show that it was carried out in a safe and appropriate manner. Staff had received training and were clear that they did not use face down (prone) restraint.
- Staff used verbal de-escalation in the first instance with patients and physical interventions were always used as a last resort. Patient files included an analysis of individual behaviour triggers and the de-escalation techniques that worked best for each person. Patients had positive behavioural support plans.
- Recognised risk assessment tools were used throughout the service. These included the short term assessment of risk tool (START) and the accident, incident (AIR) risk assessment tools, completed before and at the end of a shift for any intervention with a patient. In one patient's file there was a form describing an incident that took place with another patient. We found no reference to this incident in the other patient's risk assessment. One patient's file did not contain an initial risk assessment.
- The kitchen and front door was locked due to the specific needs of individuals. The provider had applied for and was waiting to hear the outcome of the DoLS applications for these individuals and one DoLS had been authorised Individuals had access to the kitchen and going out with staff support. Whilst it was recognised that these were restrictive practises, they had been done with the best interests of patients.
- There were policies and procedures in place to use when carrying out patient observations. Records documented where additional staff were provided for patients who required increased levels of support.
- The MDT worked well together to improve their skills in the positive behaviour support of patients. All staff said incidents of patient on patient assaults had significantly reduced in the past few months and this was evident in figures which showed that the number of incidents had halved since October 2015. Incidents were reported by staff and analysed by the assistant psychologist to identify trends for each patient.
- Olive Eden Hospital reported the use of oral medicines only for rapid tranquilisation. An isolated incident of the use of rapid tranquilisation for one patient was clearly documented in their care records. This included events that led up to this need and further actions taken by staff to monitor and protect the individual.
- Patients we spoke with told us they felt safe. Ninety one per cent of staff had undertaken safeguarding adults training. In a recent team meeting staff were reminded that they could access the provider's policy and procedure to keep their knowledge and skills updated. This defined the different types of abuse and actions to take if abuse was suspected. Staff knew how to recognise abuse, for example, one staff said they would look for patients who may be withdrawn and any changes in behaviour around certain people. Staff were able to identify the local safeguarding authority. Managers said that they would discuss potential safeguarding issues with the local authority safeguarding team where needed. In all the reported incidents of suspected abuse a referral had been made to the local authority safeguarding team.
- Patients had their medicines when they needed them. We saw appropriate arrangements for obtaining, recording, administering and correctly storing medicines. Medicine administration records (MAR) were clear, accurate and fully completed. There were detailed medication treatment plans for each patient. Staff had information to help them make decisions about 'as and when required' medicines and patients received these safely. Medicine audits were carried out on a weekly and monthly basis to monitor the quality of medicines management.
- Children were not allowed on the locked units, however safe procedures were in place for children who visited the service. A room was available for family use in the front of the building outside but away from the main hospital.

**Track record on safety**

- There was one serious incident in the last 12 months before the inspection.

Good

# Wards for people with learning disabilities or autism

**Reporting incidents and learning from when things go wrong**

- Incidents were a standing item on the monthly management meeting.
- All staff we spoke to were aware of the procedures for incident reporting. Incident reporting involved the completion of a handwritten form stored in the patient's care records and safeguarding folder. We found staff had completed incident forms for the majority of incidents, although we found a number of incidents staff noted in patients' care records or risk assessments that did not have a corresponding incident form. It was not clear whether staff had reported these as incidents as the paper records were very disorganised. The provider had sent reportable incidents to the Care Quality Commission (CQC).
- Incidents were reported to the operations manager, as per the provider's policy. The sample of incidents we looked at appeared to have been dealt with in an appropriate manner.
- Staff were made aware of incidents in handovers by the manager or the nurse in charge. One member of the multidisciplinary team told us they attended handovers after any incident and talked with staff in debriefing discussions. They said this had been very good in helping staff to understand the triggers behind incidents and find alternative ways to work with people and de-escalate their behaviours. Other staff said these debriefs were very helpful and constructive in finding alternative, more effective ways of working with people. There were further opportunities for reflective practice in team and one to one meetings.

## Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

- The seven patients each had comprehensive assessments of their needs. Each patient had had an initial comprehensive assessment and on-going reassessments of their mental and physical health needs.
- Patients' health records showed patients had on-going monitoring of their physical health and regular access to health services such as the GP, dentist, optician and chiropodist and annual health checks.
- Care plans were very detailed but some were generic in nature with variable inclusion of patients' views. The majority of the care plans were personalised. There was a section in each patients' care plan where they could write their own views in the first person. The 'my life story' document in some patient care records contained personal information. Patients had an accessible care plan summary that included pictures to represent each care plan.
- Patients' records documented individual key work sessions with staff, which generally occurred on a fortnightly basis. However sometimes the frequency of these varied, such as weekly and monthly for the same patient and the reason for this was not recorded. Records showed some examples of good, recovery-orientated practice. For example, one patient completed a daily reflective diary describing their routines and activities and how they were feeling.
- Multiple files and care plans led to some confusion about what patient's needs were and where key information about their needs information was stored. Patients had multiple files containing paper care records. One file contained the patient's general information, care plans and risk assessments; the second had clinical information and incident forms and the third, information about the patient's health. For example the day to day progress notes and the doctors' summaries were not consistently located in the same place. CPA documentation was largely absent and we were told there was also an electronic file for patients and that not everything was printed off and placed in the paper files.

**Best practice in treatment and care**

- Medicines were prescribed within recommended dosage ranges and compliant with guidance from the national institute of health and care excellence (NICE).

Patients had access to psychological assessments and therapies aligned with guidelines from NICE. Weekly comparative behaviour data analysis provided evidence of the improved outcomes of on-going psychological and therapeutic input. Therapy was provided by the qualified and assistant psychologists and consultant psychiatrists. Therapists focused on functional analysis, psychological assessments and the use of positive behaviour reinforcement methods, such as the use of reward charts. Positive support behavioural plans documented triggers, psychological support needs and a positive, proactive approach to care. Patients had access to a support and discussion group held fortnightly facilitated by the assistant psychologist which patients said they found useful to them. Continual therapeutic monitoring and analysis fed into care planning and treatment reviews.

- There was evidence of proactive working and close attention being paid to the physical health of patients with community health professionals. A GP came to the unit once a month or as requested, including the same day if needed. Plans were individualised to patients' needs, for example, one patient had an epilepsy treatment plan, which had been reviewed and updated. Patients' health records evidenced that staff took their vital signs weekly. However, there was no clear indication how this was escalated should patients' vital signs change to a level of concern.
- Patients identified as having nutrition and hydration needs had detailed care plans that outlined their dietary needs and how to meet them. Pictorial dietary care plans had been developed for some patients and there was access to a pictorial recipe folder. The issue of one person's diet who had particular complex needs was addressed in their care plan. They were on a waiting list to see a dietician and staff had done training in relation to management of this condition and worked collaboratively with the individual and others involved in their care. Speech and language therapy input was available for people with swallowing difficulties.

**Skilled staff to deliver care**

- The staff working in the hospital said the multidisciplinary team (MDT) were a strong and visible team. The MDT consisted of two consultant psychiatrists who were responsible clinicians, each working one day per week with attendance at monthly meetings, two assistant psychologists, one part-time occupational therapist (OT) working 10 hours a week, an OT assistant and a part-time qualified speech and language therapist (SALT). The provider had recruited a senior speech and language therapist who was available to staff across all sites. They supervised the SALT at the hospital. The provider had recruited a full-time occupational therapist who was still in the process of completing their induction. The assistant psychologists worked under the guidance and support of a clinical psychologist. The clinical psychologist visited staff and patients at the hospital at least once every two weeks. They worked reflectively with staff on topics linked with the therapeutic and behavioural needs of patients. The area manager said if it was needed there were more consultant psychiatrists in the organisation who could be contacted. Staff said this was rarely needed.
- Ninety per cent of staff had supervision. Staff said they could access advice and support when they needed. Team meeting records showed staff being actively encouraged to book their supervision. MDT staff had their own regular supervision arrangements in place and were satisfied with their clinical supervision and therapeutic and group in-house meetings. Some staff told us they had annual appraisals, while others were in progress.
- All staff had completed the corporate induction prior to commencing full duties. This included the care certificate standards.
- Staff said they had improved their knowledge and skills from taking specialist courses. Training certificates showed a wide range of relevant non-mandatory training available and taken by staff in related topics, including learning disability awareness and training specific to the needs of individual patients, such as percutaneous endoscopic gastrostomy (PEG) feeding, autism awareness, managing personality disorder and Prader-Willi Syndrome. The manager and members of the MDT trained staff in areas such as positive behaviour support. Most staff (87%) had completed training on positive behaviour support in order to minimize the use of physical interventions. Staff were reminded in team meetings to ensure they completed training recommended for them.

- Over the past 12 months, the provider had used their disciplinary procedure with one staff member where poor performance was an issue. Generally staff performance issues were addressed through on-going supervision.

**Multidisciplinary and inter-agency team work**

- The multidisciplinary team (MDT) meeting took place once a month. The responsible clinicians provided the medical input to these meetings. All patients were discussed at the MDT and this included a review of their progress and any changes to their care plans. Incidents that occurred were reviewed and plans formulated for how to manage patients with increased support needs.
- Handovers took place between staff twice daily at shift changes. This provided an opportunity for staff to be updated with any changes in patients' care needs, observation levels and other essential information, including any incidents that had occurred during the previous shift. Staff told us there were also lots of information shared by email to ensure staff who were not working were updated on their return.
- Patients had been admitted from across London and funded by different clinical commissioning groups. We spoke with a range of social and health care professionals and commissioning managers. Some of those we spoke with expressed concern that communication was not always timely or responsive and could in some ways be improved. Whilst we could not find evidence of instances where communication was poor, we found records of discussions and decisions made during care plan and care programme approach (CPA) reviews that were attended by relatives and multi-agency professionals.

**Adherence to the MHA and the MHA Code of Practice**

- The provider had systems in place that showed adherence with the Mental Health Act (MHA) so that patients' rights were protected. One patient was subject to section 3 of the MHA and two were subject to section 37/41.
- Whilst MHA training was not mandatory for all staff, the provider's data showed that 50% of staff had received training in the MHA. Staff showed a good understanding of the MHA Code of Practice and guiding principles.
- Patients had a record of their consent to care and treatment in place.
- Where a patient had requested the input of a second opinion doctor, their decision was clearly recorded in the patients file.
- Patients had their rights explained to them on admission and routinely thereafter. Two patients said they were told about their rights and their medication had been discussed and agreed.
- MHA administrator within the organisation provided advice and support regarding implementation of the MHA.
- All the documentation relating to the MHA for the detained patients was available to view and was mostly in good order.
- There was evidence of effective processing of tribunal requests and of the receipt and scrutiny of section papers.
- There were regular MHA audits to ensure the MHA was being applied correctly.
- There were notices with information about the independent mental health advocacy service on the units. The service could be contacted by staff and patients directly during visits or by telephone on the publicised number.

**Good practice in applying the MCA**

- The provider had systems in place that showed adherence to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).This meant patients' rights were appropriately protected.
- The MCA training completed by 91% of staff was mandatory. Staff showed a good awareness of how to apply the principles and this was reflected in their practice. Staff had access to the MCA and DoLS policies and procedures when they needed.
- One patient was subject to an authorised DoLS and three others had been assessed and were waiting for the outcome.
- Patients had MCA assessments completed on a decision-specific basis. Assessment forms documented where the multi-disciplinary team and family had been

consulted. Mental capacity assessments had been completed in areas including finance, medicine management and community access to determine if people could make informed decisions.

- Patients were supported to make decisions and where they lacked capacity, steps were taken to make decisions in their best interests.
- If staff needed advice about the MCA including DoLS, they could ask the MHA manager and MHA assistant within Sequence Care or consult the responsible clinician.
- There were arrangements in place to monitor adherence to the MCA through an audit completed by the MHA manager on at least a three monthly basis.

## Are wards for people with learning disabilities or autism caring?

Good

### Kindness, dignity, respect and support

- Staff interacted with patients in an unhurried way and responded to their needs and requests in a way that was kind, caring and respectful. We saw that staff provided patients with practical and emotional support when they needed. Records of care showed that staff offered patients reassurance when they presented with particular needs or concerns. Staff monitored changes in the presentation or needs of patients. Records showed staff worked with patients until they appeared calm and settled. Minutes of a team meeting showed that staff were reminded to be aware of their voices and to use the right tone of voice when talking with one patient in particular as well as with other patients.
- Patients and staff had developed a good rapport with each other. One patient told us there was nothing staff could do better in their view. Another said one staff in particular was really nice. Patients told us they felt able to talk to staff and that staff do listen. One patient's family also spoke highly of members of the multidisciplinary team. A care coordinator we spoke with told us that two of their patients were very settled at Olive Eden Hospital. They said they had formed very good relationships with one nurse in particular. We saw one staff dancing with a patient and another dressing a patient's hair. Staff recorded a shift plan that was agreed with the patients and included the activities they wanted, so that all the staff knew what had been agreed.
- Staff respected patients and sought to understand and take into account their needs and wishes. Patients attended a relationships group every two weeks run by the psychologist. Patients and staff said the group was going well and had been running successfully for two years. Patients said they looked forward to it and staff said it gave the group a chance to explore personal matters and to meet socially with other patients which was helpful for their social integration.
- Staff respected the privacy and dignity of patients.

### The involvement of people in the care they receive

- Patients were actively involved in planning their care. Progress with goals was discussed in one to one sessions and therapy meetings. Patient views were used to develop the positive behavioural support plans. Patients attended their care plan meetings where possible.
- Most patients told us they had received copies of their care plans but one patient's care plans did not indicate whether they had received a copy. Staff had documented on another patient's care records that they were unable to sign their care plan due to their learning disability. Those who could not read had been given their care plans in an accessible form.
- Advocacy services were provided and two patients had their own advocates. The advocate had recently visited and spoken with patients outside the hospital. They were planning a fortnightly visit to the hospital. A record of their visit showed they had asked patients how they wanted to be supported and explained the different ways support was available. They gave examples about how patients could make themselves heard and planned to speak with individuals.
- Families gave mixed feedback to us about their relationship and communication with staff at Olive Eden Hospital. One family member said staff worked well with their relative and were happy with the level of contact. However three others gave varying and some gave negative feedback. This included their views not being taken on board or not being kept informed about care

arrangements. Care plans and patient records documented contact with relatives, their views and their involvement in patients' care. The manager identified herself as being the main contact for carers who was always available to discuss their concerns. Records showed that relatives were invited to care review meetings.

- Patients were able to give feedback on their service through twice weekly community meetings. We reviewed the minutes from the previous two months and saw that on average four patients attended each week. Issues discussed included activities, a review of the menu and business relating to the daily running of the service. For example, patients had requested the removal of the television in one lounge to create a quiet space and we saw in the lounge that staff had removed the TV. The manager told us staff had now ordered another TV as patients recently said they wanted the TV back. Staff supported individual patients to maintain activities that were culturally appropriate to them. Patients were not involved in recruiting staff during the time of this inspection. However plans were being developed for two patients to be involved in training staff about how they wanted staff to support them.
- The last patient survey was completed in March 2015. The provider stated they were in the process of gathering patient views at the current time. The provider was unable to show how the feedback and involvement of patients had resulted in changes or improvements to the service as a whole.

## Are wards for people with learning disabilities or autism responsive to people's needs?

(for example, to feedback?)

Good

### Access and discharge

- Admissions were managed through a referral process from placing authorities. The length of stay for patients at the hospital had varied from less than a year to four years. The provider said they were planning to change the registration of the service and type of service provided. Consequently, the hospital was closed to new admissions and the provider was looking to discharge the remaining patients. The timeframe for closure was uncertain until discharge arrangements were confirmed and suitable alternative provision found for all patients, which staff were actively exploring.
- The bed occupancy was at 50% and gradually winding down in this transitionary period of change.
- While patients had a "future discharge" plan in place, these were generic and not all personalised . They did not state specific actions the provider was taking to facilitate each persons discharge within given timescales. For example, one patient's discharge plan the section where they could give their view was blank. It was not clear how well patients were meeting their goals in relation to preparing for their discharge either now or in the future to a non-hospital environment. Relatives' concerns and feedback centred around the uncertainty, lack of clarity and communication around patients' length of stay and their discharge plans. However we saw records of liaison with relevant key professionals, including care-coordinators, commissioners and the Ministry of Justice required to authorise the leave arrangements for certain patients.

### The facilities promote recovery, comfort, dignity and confidentiality

- There were sufficient rooms where patients could engage in activities and patients said they felt there were enough quiet areas they could go to including several spacious lounges. Patients said they were satisfied with the environment and they had fair size bedrooms and enough storage space. There were two additional rooms outside of the main unit that could be used flexibly. Parts of the flooring in two of the lounges were in need of refurbishment. The maintenance contractor had produced a document three months before the inspection which detailed the areas of work and actions required. This included the replacement of flooring and furniture in some parts of the premises, decoration and converting the office to a functioning kitchen. This work now needed to take place.
- Patients could use their own mobile phones or make calls. There were also handheld phones available to patients and they could use these to speak in private in their bedrooms.

- Patients had access to an outside space in a small outdoor garden area. They were permitted to smoke in outside areas.
- Patients told us their food was satisfactory. Staff supported patients to prepare culturally specific foods. Patients had the opportunity to cook food of their choice as part of their occupational therapy programme. Details of daily menus and healthy eating were available in communal areas. Menus were developed with patient feedback from regular community meetings. Some staff had national vocational qualifications in food preparation and handling and prepared freshly made food. Pictorial menus were displayed on the units and individual pictorial menus were available in patients' files.
- Patients had access to drinks and snacks 24 hours a day with staff support.
- Bedrooms were personalised by patients with pictures and personal effects. Patients were assisted to tidy their rooms where necessary and regular deep cleans took place as part of the housekeeping schedule.
- Lockable drawers were available for patient use in their bedrooms for secure storage of their possessions.
- Activities included cooking, creative arts, watching films and yoga therapy once every two weeks. The manager said they were exploring other activities such as Zumba. External activities were arranged based on individual interests. They included walking, visits to the library, cinema or other local areas of interest, horse grooming, bowling and swimming. Activities were discussed and agreed as part of the patient's one to one meeting and two weekly community meetings. Patients were supported to go out with two staff members if they needed. However patients had mixed views about their satisfaction with their activities. Some gave positive comments, that activities were good and that staff took them out. Other patients said they felt bored and wanted more structured regular activities and to be able to have internet access. Each patient had their own individual activity time table, which staff said took place, possibly at flexible times to fit in with staff availability.

**Meeting the needs of all people who use the service**

- The hospital was single storey and suitable for people requiring disabled access. All the patients had seen an occupational therapist so adjustments could be made based on their individual needs if needed.
- Key documents including care plans were provided to patients in formats accessible to them. The manager told us staff had internal access to a service which could translate information into other languages if needed. The speech and language therapist had provided guidance to staff about how to communicate with patients with particular communication needs, including the use of pictorials and objects of reference. We saw information in easy read formats displayed around all parts of the hospital including, patients' rights, local services, advocacy, community meetings and a guide on how to complain.
- Patients had a choice of food to meet their dietary requirements, for example staff helped to prepare one patient's culturally appropriate meals at least twice a week.
- Spiritual support for patients was available to individuals who requested this. Patients attended local places of worship with staff support where required.

**Listening to and learning from concerns and complaints**

- There was evidence complaints were documented, appropriately investigated and actions taken to appropriately address the issues raised by the individuals. One informal complaint was raised at a care and treatment review and this was partially upheld. Improvements were made in line with actions generated from this review. One complaint was not upheld. We saw a response letter had been provided to the complainants with full explanation provided about the outcomes and actions taken to address the issues raised in the complaint.
- Where concerns were raised in formal meetings such as CPA meetings these had been recorded including actions taken. However three out of four relatives we spoke with told us there had been a number of times each when they had raised concerns about the care of their patient family member and they were not satisfied with the response they had received from the hospital. In their feedback they said they did not feel their concerns were taken on board or had been adequately

addressed; they felt dismissed by senior staff and disappointed by a lack of any response to concerns they felt were of a serious nature about the care of their family member, including the approach of individual staff. The relatives said they had made their concerns clear but had not raised formal complaints. The records of these verbal concerns were not clearly recorded and so it was not possible to see how these had been followed up.

- Leaflets on how to complain were displayed in the entrance to the hospital. Patients told us they knew would speak to the doctor or other staff if they had a complaint. We saw in their files they had each been given information on how to complain and staff said they would support patients to make a complaint if they wished to do so.
- Staff were able to describe the procedure for registering complaints from patients and how they would support them to do so.
- Staff said they discussed complaints as a team so they could learn from the issues raised.

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

Requires improvement

### Vision and values

- Most staff we spoke to knew and agreed with the organisation's aims and values. Members of the MDT team were in favour of the organisational plans to transfer patients, de-register the hospital, and to re-establish it as a specialist residential care home. They felt that the staff were particularly skilled in supporting the client group they proposed to work with.
- Staff members described the principles of treating patients with respect and the importance of an individualised approach to the care of patients, in line with the organisational values.

### Good governance

- A system of audits were in place throughout the year to assess the safety and quality of the service. These covered ligature risks, infection control, medicines, health and safety. These identified actions which needed to take place. However some of these actions had not been followed through. For example some individual ligature risk assessments had not been updated and a ligature cutter had not been replaced when identified as missing until during the inspection when pointed out. Some actions identified in the October 2015 infection control audit were still outstanding in the March 2016 audit. There was a lack of proper management of patients' care records. Patient care records and information was not kept in a consistent or accessible way. Information in the safeguarding folder containing documentation of mixed types, for example records of incidents, accidents and safeguarding were stored together and difficult to access. We found one patients file had documents relating to another patient.There was no effective system to identify and analyse the number and nature of informal complaints and what action was taken.
- New processes were being developed and introduced to improve the quality monitoring of the service. The quality and safety board monitored the quality of services across all the provider locations. The operations director said management had begun to take a 'deep dive' approach around specific issues identified for improvements. In April this was medication management and compliance with mandatory training which produced changes to practice in both areas. The current KPI reporting format and procedure had recently changed to be completed on a weekly rather than monthly basis. This information was analysed every month. The area manager had begun making weekly visits to look at the overall performance of the hospital .
- Monthly meetings which the Olive Eden manager attended allowed the operations director to raise shared issues noted as a consequence of the key performance monitoring information. A new quarterly full senior team meeting had been arranged. This aimed to bring all operational, senior management personnel and directors together to discuss issues around clinical governance, review serious untoward incidents, trend analysis and personnel issues.
- The provider quality and strategy plan for 2016 had identified four objectives for further improvements planned to the quality monitoring of the service.

Good

# Wards for people with learning disabilities or autism

- All staff said they had good support from the manager who knew the needs of patients well and was working to improve the outcomes for patients.
- Policies and procedures were in place. As these were dated in early 2015 it was not clear if they had been reviewed and updated with any changes. We found in some areas of practice the manager showed gaps in their knowledge and understanding of organisational policies and procedures and that they might benefit from further support and training to assist with their managerial responsibilities.

**Leadership, morale and staff engagement**

- There had been a lot of change at a senior management level in the organisation with a completely new senior leadership team in the last 12 months. There was a review of systems and procedures which had led to staff feeling unsettled. This had caused a high turnover of some staff while their roles and employment conditions were being reviewed. Staff spoke positively about the leadership team despite this and said they were visible, supportive and accessible when needed.
- We received feedback from staff at the hospital and other stakeholders that there had been a high turnover of staff and high usage of bank and agency staff. This had some impact on patients in terms of the quality and consistency of care. The sickness rate had been three per cent during three months since February 2016. The provider confirmed the turnover rate had been 25% in the past 12 months. However we also received feedback from staff and relatives that there had been an improvement in staff turnover in the last two months.
- There were no reported cases of bullying or harassment.
- Staff knew how to use the whistle-blowing process, were encouraged to read the whistleblowing policy and report any concerns. Staff told us they felt able to raise concerns.
- The morale of staff was good. We spoke to a range of staff from different disciplines and all described feeling good about working in the service and the care they provided for the patients. Staff talked about having satisfaction in seeing progress among patients and having job satisfaction.
- Staff had benefitted from promotion through training and opportunities to assist with their leadership development. All staff received emails from the provider with information about other services and job opportunities.
- We saw that communication was transparent between staff and patients and patients said they were openly able to raise their concerns with staff.

**Commitment to quality improvement and innovation**

- The provider was not involved in any research or national improvement programme. The consultant psychiatrist and operations manager were exploring accreditation schemes to recommend to the company board. These included accreditation for inpatient mental health services (AIMS) provided by the Royal College of Psychiatrists and the accreditation scheme of the British Institute of Learning Disabilities.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

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

### Action the provider SHOULD take to improve

- The provider should ensure patient risk assessments are reviewed or updated following incidents and also in terms of potential self-harm using a ligature point.
- The provider should ensure that when restraint is used, it is accurately recorded to ensure it is carried out in a safe and appropriate manner and can be reviewed afterwards.
- The provider should ensure that staff understand the organisation's seclusion policy and procedures.
- The provider should evidence that policies and procedures are reviewed and updated where necessary to ensure staff carry out their duties and responsibilities in line with current guidance.
- The provider should review the arrangements around individual patient's activities, taking into account patients' views.
- The provider should continue to review how they work with relatives and carers to ensure they are fully informed and involved where appropriate in decisions about care.
- The provider should have an improved system to record, address and learn from informal complaints.
- The provider should ensure the manager has access to the correct information on site in order to effectively manage the service.
- The provider should ensure patient discharge plans are clearly identified and progress towards their discharge goals are recorded.
- The provider should ensure that care plans and other patient records are improved so that essential information can be located and they are easy for staff to use.

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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider had not ensured that there were systems and processes in place to maintain accurate, consistent and accessible patient care records.<br><br>**This was a breach of regulation 17(1)(2)(c)** |