Hunters Moor Neurorehabilitation Centre for the West Midlands - The Olive Carter Unit

Quality Report

135 Cateswell Lane
Hall Green
Birmingham B28 8LU
Tel: 0121 777 9343
Website: www.huntersmoor.com

Date of inspection visit: 27 - 28 September 2016
Date of publication: 04/05/2017

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

Summary of findings

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.

Overall summary

We rated the Olive Carter unit as Requires improvement because;

- Although the service operated safe medicines management; we found three unlabelled insulin vials and insulin pen. Insulin has a change of expiry date once it has left the fridge; dates were not documented on the insulin.
- The fridge in the clinic room was overstocked therefore blocking the fan and reducing the circulation of air to keep medicines cool. Not all staff knew how to reduce the temperature of the fridge in the clinic room. The fridge temperature was 16 degrees centigrade.
- Non-prescribed medication administered to patients did not include the patients' name. There were no recordings on the medication administration records of when patients had been given these types of medication.
- There were four areas of mandatory training that fell below 75% one of which was medication training at 67%. Training for bank staff also fell below 75% such as deprivation of liberty safeguards and Mental Capacity Act training which was 57%.
- Although care plans were up to date and recovery orientated not all showed patient participation.
- Patients were involved in discussions about their care and treatment, most care plans were signed but it was not clear whether the patient was offered a copy of their plan.
- Patients were not routinely invited to ward reviews they were able to give and receive feedback through their key worker.

However,

- The unit was clean with well- maintained furnishings. There was a range of rooms and facilities to support treatment and care. The service could also access facilities at the adjacent Janet Barnes unit.
- There were sufficient staffing levels to cover all shifts to safely support patient's observations. Staff had good understanding and development of skills in de-escalation techniques.
- There was a good range of skilled staff to deliver care and treatment to the patients. There was good multidisciplinary team working within the service that also extended to outside agencies.
- Staff were kind, patient and showed a good understanding of individual patient need.
- The NHS Safety Thermometer rated the unit as providing 100% harm free care to the patients. This was above the national average of 95%.
- There were good discharge plans in place that involved a range of professionals and consideration to aftercare treatment under section 117 of the Mental Health Act.
- Patients could personalise rooms and had access to keys therefore they could lock their rooms. There was access to snacks and drinks at any time.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury	Requires improvement 	

Summary of findings

Contents

Requires improvement

Olive Carter unit

Services we looked at Services for people with acquired brain injury

Summary of this inspection

Background to Hunters Moor Neurorehabilitation Centre for the West Midlands - The Olive Carter Unit

- The Olive Carter Unit is part of the Hunters Moor Residential Services limited and is in a residential area of Birmingham. The unit specialised in neurobehavioral rehabilitation for those with challenging behaviours including those whose rights are restricted under the Mental Health Act.
- The unit has been registered with the Care Quality Commission since 11 January 2011 to carry out the following regulated activities;
- Treatment of disease disorder or injury; Assessment or medical treatment for persons detained under the Mental Health Act 1983; Diagnostic and screening procedures.
- The last inspection was on 5 March 2014, action was needed in the following areas: co-operating with other providers; assessing and monitoring the quality of the service provision and records.
- The Olive Carter unit is registered to provide services for up to ten patients. As a specialist challenging behaviour unit, patients come from a very wide geographical area. The admission criteria identified individuals with severe challenging behaviour or mental disorder. On the day of the inspection there were eight patients two of which were detained under the Mental Health Act 1983. No patients were under Deprivation of Liberty Safeguards (DoLs). The service had made applications for urgent authorisations some of which had expired.
- The manager had been in post since 2015 and was not registered with the service at the time of our visit. The manager told us they had registered with the Care Quality Commission to complete the Disclosure barring service check (DBS). Following the inspection the manager provided evidence of posting the application form.

Our inspection team

Team leader: Sonia Isaac

The team that inspected the service comprised two CQC inspectors, a CQC pharmacy inspector, specialist advisor nurse and doctor and one expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

During the inspection, the inspection team:

Summary of this inspection

- toured the unit, looked at the quality of the environment and observed how staff were caring for patients,
- spoke with two patients who were using the service,
- spoke with the manager of the service,
- spoke with eight other staff members; including doctors, nurses and rehabilitation assistants,
- attended and observed a multi-disciplinary meeting,
- looked at six patient care and treatment records,
- carried out a specific check of the medication management, and
- reviewed a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

People whose family members were using the service completed the "share your experience" documents provided by the service. The majority of the feedback from families and carers were that they felt their family member was looked after by staff, supported and cared for. The response was neutral as to whether they would recommend the service to others. One person felt that management was difficult to speak to and did not communicate well with family members.

One Patient we spoke with felt staff were approachable and supportive.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **Inadequate** because;

- Although the service operated safe medicines management; we found three unlabelled insulin vials and insulin pen. Insulin has a change of expiry date once it has left the fridge; however dates were not documented on the insulin.
- Between May 2015 to April 2016 staff turnover was 22% on the Olive Carter Unit. This meant during this time five staff had left the service. The total percentage of sickness for permanent staff was 20%.
- The fridge in the clinic room was overstocked therefore blocking the fan and reducing the circulation of air to keep medicines cool.
- Non-prescribed medication administered to patients did not include the patients' name. There were no recordings on the medication administration records of when patients had been given the medication.
- There were areas of mandatory training that fell below 75% one of which was medication training at 67%. Bank staff had a low completion of mandatory training than permanent staff. Not all bank staff had completed all aspects of the mandatory induction this fell below 75% completion in areas such as moving and handling and fire safety.

However,

- The unit was clean with well-maintained furnishings.
- The unit operated appropriate gender separation with separate sleeping corridors and facilities for male and female patients.
- There were sufficient staffing levels to cover all shifts and observations to safely support patients. Staff had good understanding and development of skills in de-escalation techniques.
- Staff knew how to report safeguarding concerns, the training for all staff was above 75%.

Are services effective?

Good

We rated effective as **Good** because;

- Patients received comprehensive assessments following admission to the service.

Summary of this inspection

- There was good multidisciplinary team working within the service that also extended to outside agencies.
- All staff received regular supervision.
- Patients records were paper based, they were stored securely and all staff had access to them when required.
- In adherence to the Mental Health Act, staff consistently read patients their rights under section 132.
- The service considered consent and capacity issues, five applications were made for Deprivation of Liberty Safeguards within the service.

However;

- Bank staff completed less than 75% training for deprivation of liberty safeguards and Mental Capacity Act which was 57%.

Are services caring?

Requires improvement 

We rated caring as **Requires improvement** because;

- Patients
- Patients were not routinely invited to multi-disciplinary team meetings they were able to give and receive feedback through their key worker. Therefore they were not fully involved in discussions about their care.
- Although care plans were up to date and recovery orientated not all showed patient participation.

However,

- Staff were kind, patient and showed a good understanding of individual patient need.
- Patients gave feedback on the service through weekly community meetings. The service operated the friends and family tests questionnaires to receive feedback.
- Patients had access to one of two advocacy services. Advocates attended meetings with patients.

Are services responsive?

Good 

We rated responsive as good because;

- There were good discharge plans in place that involved a range of professionals and consideration to aftercare treatment.
- The unit had a range of rooms and facilities to support treatment and care. The service could also access facilities at the adjacent unit, Janet Barnes.

Summary of this inspection

- Patients could personalise rooms and had access to keys therefore they could lock their rooms. There were hot and cold drinks and snacks available to patients at any time.
- There were facilities to meet with relatives and other visitors.
- Patients knew how to make complaints, the unit displayed information concerning this. Patients were able to raise concerns with staff. The service responded to complaints and took action where there were shortfalls.

However;

- The therapy kitchen was also used as a staff kitchen which was not good practice.

Are services well-led?

Requires improvement

We rated well-led as **Requires improvement** because;

- The systems and processes around assurance where not robust enough as audits did not identify the issues with non-prescribed medication not being documented.
- Although staff audited fridge temperatures, no action was taken to resolve the increased temperature of the fridge in the clinic room.
- Patients were not completely involved in their care and care reviews staff competed clinical audits of care plans that indicated staff needed to include patient preferences.
- The service had low levels of completed training for bank staff.This meant that staff might not be sufficiently skilled to work with the complexities of the patient group.
- There was a high turnover of staff within the service. Staff absence including sickness was 20% from June 2015 to June 2016 and staff turnover was 22% between May 2015 and April 2016.
- The manager was awaiting the disclosure barring check to be returned therefore at the time of the inspection therefore the service did not have a registered manager.

However,

- Staff received regular supervision and appraisals.
- Staff gave feedback on the service through staff friends and family tests. Regular staff meetings also gave staff a forum in which to provide feedback on the service and raise any concerns or issues.
- The NHS Safety Thermometer rated the unit as providing 100% harm free care to the patients. This was above the national average of 95%.

Summary of this inspection

- The service showed commitment to development of the service. For example, the psychology team had obtained a research grant which would see the service develop into a research centre for students.

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.

- There were nine patients using the service, one patient was detained under section three of the Mental Health Act.
- The manager told us in house training was provided for staff in the Mental Health Act with yearly updates. We did not receive information on the data provided by the service for Mental Health Act training.
- Patients' records showed staff explained patients' rights under section 132 of the Mental Health Act and repeated these when necessary. This included explanation of the role of the Independent Mental Health Advocate and their right to appeal to a Tribunal and Managers' Hearing.
- There had been a Mental Health Act monitoring visit from the Care Quality Commission in September 2016, Although the service had failed to respond to our report following our previous visit in April 2015, we found the issues that had been identified at that time had now been resolved.
- Further issues identified in September 2016, and which required further action included;
- No records informing patients of the outcome of the Second Opinion Appointed Doctor's (SOAD) visit, and no information about the CQC role in reviewing complaints from detained patients was available.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We found assessments of capacity were both decision and time specific. Staff had clearly recorded the reasons for their decisions.
- Staff told us they had applied for authorisations for five patients under the Deprivation of Liberty Safeguards. The urgent authorisations had expired in some cases. However, staff showed good awareness of the ways in which patients were under continuous control and supervision. They understood that there was no legal authority to deprive these patients of their liberty.
- Staff training for Deprivation of Liberty Safeguards (DoLs) and the Mental Capacity Act were 100% for both level one and two training. Bank staff training rates were 57%.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	Inadequate	Good	Requires improvement	Good	Requires improvement	Requires improvement
Overall	Inadequate	Good	Requires improvement	Good	Requires improvement	Requires improvement

Notes

Requires improvement

Services for people with acquired brain injury

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

Summary of findings

We rated the Olive Carter unit as Requires improvement because;

- Although the service operated safe medicines management; we found three unlabelled insulin vials and insulin pen. Insulin has a change of expiry date once it has left the fridge; dates were not documented on the insulin.
- The fridge in the clinic room was overstocked therefore blocking the fan and reducing the circulation of air to keep medicines cool. Not all staff knew how to reduce the temperature of the fridge in the clinic room. The fridge temperature was 16 degrees centigrade.
- Non-prescribed medication administered to patients did not include the patients' name. There were no recordings on the medication administration records of when patients had been given these types of medication.
- There were four areas of mandatory training that fell below 75% one of which was medication training at 67%. Training for bank staff also fell below 75% such as deprivation of liberty safeguards and Mental Capacity Act training which was 57%.
- Although care plans were up to date and recovery orientated not all showed patient participation.
- Patients were involved in discussions about their care and treatment, most care plans were signed but it was not clear whether the patient was offered a copy of their plan.
- Patients were not routinely invited to ward reviews they were able to give and receive feedback through their key worker.

However,

- The unit was clean with well- maintained furnishings. There was a range of rooms and facilities to support treatment and care. The service could also access facilities at the adjacent Janet Barnes unit.
- There were sufficient staffing levels to cover all shifts to safely support patient's observations. Staff had good understanding and development of skills in de-escalation techniques.
- There was a good range of skilled staff to deliver care and treatment to the patients. There was good multidisciplinary team working within the service that also extended to outside agencies.
- Staff were kind, patient and showed a good understanding of individual patient need.
- The NHS Safety Thermometer rated the unit as providing 100% harm free care to the patients. This was above the national average of 95%.
- There were goo discharge plans in place that involved a range of professionals and consideration to aftercare treatment under section 117 of the Mental Health Act.
- Patients could personalise rooms and had access to keys therefore they could lock their rooms. There was access to snacks and drinks at any time.
-

Requires improvement

Services for people with acquired brain injury

Are services for people with acquired brain injury safe?

Inadequate

Safe and clean environment

- Cleaning records were up to date and signed. These showed regular cleaning took place.
- All ward areas were clean. The unit was in a reasonable state of repair with maintained furnishings. However it was slightly dull with limited pictures and furnishings, this was more apparent in the ladies' lounge. It was very sparse; there were no information boards, no books or magazines. There was one picture on the wall and an exercise bike in the corner of the room. One patient told us there was a TV in the female lounge however it was recently "Smashed up". Another TV was available in the main lounge area.
- We found some blind spots in the corridors. Staff completed daily health and safety checks for both patients and the environment. Some bedrooms were not ligature free however, all patients had been risk assessed and allocated rooms based on their level of risk.
- The service carried out environmental risk assessments, including ligature risks that were audited yearly. The last audit was completed 8 April 2016. All bedrooms had windows with privacy panels that allowed staff to observe, but also allowed patients privacy and dignity.
- The unit had segregated male and female areas. Staff were able to change the areas around to have an extra bedroom within either the male or female only areas. At the time of the inspection the male bathroom was undergoing repairs due to a leak. However, rooms had en-suite facilities, including showers.
- The clinic room was small but adequate. There was no room for a couch however patients could be examined in their bedrooms. The clinic was fully equipped with accessible resuscitation equipment that had been calibrated and checked each week.
- The fridge in the clinic room was unlocked; staff told us they were awaiting a new key. It was overcrowded and as a result the area in front of the fan was blocked. There were up to date temperature charts for fridge and clinic room temperatures. However on the 25 September 2016 the fridge temperature was recorded at 16 degrees up to and including the day of the inspection. We spoke to staff about this but they were unable to show us how to reset the fridge therefore it remained at 16 degrees. This meant that medicines would not be fit for purpose or safe for patient use at this temperature. We reported this matter to the unit lead for follow up.
- There was no seclusion room, as the service did not use seclusion. Discussions between the manager and senior managers had taken place concerning controlling aggressive behaviour which included transfers to local psychiatric intensive care units. The unit used low level holds and de-escalation techniques.
- Staff adhered to infection control principles including handwashing. The housekeeping manager was also the infection control champion. We viewed the last two completed audits dated 22 February 2016 and 22 June 2016. It was difficult to establish the overall score for the unit as they were grouped in specific areas. The score for these areas ranged from 89% to 100%. Action plans were established to address any outstanding issues highlighted from the audits.
- Alarms and call systems were in place. We saw staff responding promptly to calls throughout our visit. Alarm systems clearly identified which room a call was made from.

Safe staffing

- The unit had establishment levels of three qualified nurses and 18 rehabilitation assistants. The manager told us there were two vacancies for qualified nurses. They had recently filled these vacancies and staff were due to start at the end of October 2016. This would take them to their full complement of qualified staff. The unit needed two activity coordinators. One full time activity coordinator had recently been appointed and the other post was being recruited to.
- There was one nurse on duty during the day shift, supported by six rehabilitation assistants. This was in accordance with the services agreed staffing of one nurse per eight patients and one rehabilitation assistant per three patients. Bank and agency staff were used to maintain these ratios when required. The unit lead told us they had their own bank staff. They used the same agency staff to support familiarity with both patients

and the unit. We spoke to one bank staff member who had been working at the unit for several years and therefore was familiar with the unit, patients and other staff.

- Staff told us bank staff were mostly used to cover night shifts so that regular staff could cover the day shifts. The unit used agency staff when bank staff were not available. Staff said the rehabilitation assistants had been a stable group and that the turnover of staff had been quite recent. One staff member said there were some retention issues however the service was attempting to recruit full time staff. Information received from the service stated between May 2015 to April 2016 staff turnover was 22% on the Olive Carter Unit. This meant during this time five staff had left the service.
- Management told us they brought in additional staff depending on patient need and one to one support required. Staffing figures on a daily basis for rehabilitation assistants would be variable from five upwards. Therefore there were extra staff on duty to ensure patients who required regular observations and support were safely monitored and supported. We saw examples of this where patients required close monitoring.
- Information received from the service stated staff turnover was 30% between 1 June 2015 and 30 June 2016. The total percentage of sickness for permanent staff was 20%.
- Ward activities were rarely cancelled and only when the unit was short staffed or when there where challenges that would otherwise make the unit unsafe. One patient confirmed this telling us this occurred when there were staff shortages. Patients were informed in advance; staff apologised and gave reasons for the cancellation.
- The unit had sufficient medical cover. The consultants employed by the service attended on Tuesdays and Thursdays. This covered multi-disciplinary team meetings, urgent issues and ward rounds. Additional medical cover was provided by an out of hours GP service. We saw a proposal by a company to provide GP cover for a period of six months from 1 June 2016. This included GP cover, available seven days a week for advice and urgent visits for non-life threatening issues.

Assessing and managing risk to patients and staff

- Management explained that patients who experienced behavioural issues had individual behavioural management care plans. We observed discussions in the multidisciplinary team meetings when staff reviewed behavioural care plans. They discussed potential coexisting links to behaviour and medical issues.
- The unit deployed sufficient staff to carry out de-escalation when needed. The manager told us staff would use low level holds. Staff received training in conflict management and physical intervention through Maybo. This is an organisation specialising in advice and training on workplace violence, conflict management and physical intervention training. Staff told us they received theory sessions on site and practical training away from the unit off site. There was no information presented by the service for completed training for Maybo. The service also had a nurse who specialised in behaviour management, and who provided training to other staff.
- Staff we spoke with discussed the management of aggression and de-escalation techniques, they showed good understanding and awareness.
- Patients we spoke with felt the unit could be relaxing and calm most of the time and they felt safe.
- We found no evidence of any blanket restrictions. The door to the unit was routinely locked although staff shared the key code for the external door with informal patients, enabling them to leave without staff intervention. There were three notices explaining the rights of informal patients to leave the ward. Two of these were in very simple language; the third gave more details. These notices considered the communication needs of the patient group.
- There was a clear observation policy in place to manage and minimise individual assessed risks. Where risk was identified, additional staff were employed to provide one to one observation and support to ensure patients were safe and not a risk to themselves or other patients.
- The service had a “Searching of clients’ policy”, which was due to be reviewed in June 2016. This policy stated staff could search patients returning from section 17 leave, if there was a documented risk within the patient’s care plan such as alcohol abuse. Although informal patients did not have personal searches, staff did perform environmental searches of patients bedrooms if necessary.
- Staff had personal alarms. The unit lead explained that observations were not completed in isolation. Staff

completing 15 to 30 minute observations would also support staff completing one to one observations. We saw staff completing observations throughout the course of the inspection.

- Staff told us they had completed online training courses on social care TV, one had recently completed online training for medication. We viewed the training data for the service, which was separated in to permanent and bank staff. There were areas of training that fell below 75% first aid training 59% and medication training 67%. The service reported 0% completion of medication refresher training as five staff were non-compliant. We had further training figures submitted to us by the service this showed a further two areas below 75% for bank staff. This was brain injury awareness 65% and Dysphagia at 70%. Other mandatory training figures ranged from 76% to 100% completion.
- We saw that completed mandatory induction training for bank staff was less than 75%. Training such as moving and handling 43%, person centred care 57% and principles of care and confidentiality 57%. This meant that staff might not be adequately skilled to work within the patient setting. However management informed us that their policy stated bank staff were not used unless they had completed mandatory training. This was monitored by the service.
- Staff told us the service had a strict protocol for training, they allowed time for staff to complete training which was monitored by the human resources team.
- The service training figures for safeguarding was 100% for the formal annual refresher course and 76% for annual e-learning. For bank staff 71% had completed the annual e-learning refresher course.
- Management explained staff were trained up to level two for safeguarding adults. Managers would be trained up to level four. At the time of the inspection the unit lead was trained up to level two and the manager level three.
- We received four safeguarding alerts from the unit between the 5 June 2015 and 26 August 2016. The unit contacted the safeguarding team at the local authority as per their policies and procedures. The local authority also notified us of the safeguarding's and we were kept up to date on their progress by the service. Staff we spoke with were aware of how to raise safeguarding concerns. We saw that safeguarding policies were kept in the unit and staff told us they were also able to access it on the shared drive. Staff said they had recently completed safeguarding training but were unsure what level it was.
- We looked at the Medicine Administration Record (MAR) charts, of eight patients. Staff clearly recorded information of when prescribed medication was administered. There were clear systems in place for ordering and receiving medication. However we saw that there was an excessive amount of insulin in the fridge leading to overcrowding.
- All stock we checked was within its expiry date. However, we saw three unlabelled medicines in the clinic room; this could have resulted in the wrong medication being administered to a patient. The unlabelled medication was insulin vials and insulin pen removed from the patient's own boxes. Insulin has a change of expiry date once it has left the fridge; dates were not documented on the insulin.
- The unit operated homely remedies; this is non-prescribed medicine that is available over the counter at pharmacies. This includes medication for headaches, colds or occasional pain. Management told us that each patient had a homely remedies list developed and agreed by the GP. The stock of medicines identified would be kept by the service and only items recorded on the list would be used. However, documentation of the medication administered to patients did not include the patient's name and there were no notes on patient's MAR charts. Therefore staff were unable to know who had taken the medication or when. This could lead to patients being administered too much medication and is an unsafe practice.
- The service had a controlled drugs cupboard and staff completed stock checks and a record of the key holder. We saw recorded entries from December 2015 to September 2016 they were completed with double signatures. We checked two of the controlled drugs against the register; they were completed with correct quantity and expiry date. We looked at a further four controlled drugs all were within the expiry dates. Staff returned controlled drugs to the pharmacy for disposal and appropriate entries were made in the register.
- Medicine incident forms were available in the clinic room. Staff we spoke with said they informed the unit lead about any drug errors and completed the form. This was then sent to the manager and following investigation staff members may be required to

undertake a competency check. Staff gave an example of a recording error concerning medication. However they were not able to describe any systems or processes implemented or changed as a result of the error.
- Management informed us that any children visiting relatives on the Olive Carter Unit would use the family room in the adjacent Janet Barnes Unit.

Track record on safety

- There were no serious incidents recorded in the past twelve months.
- Staff were able to say how they would report drug errors and that they discussed errors after they had occurred. We saw medicine incident forms available in the clinic room, however there was no record of staff reporting the fridge temperatures as a safety concern.

Reporting incidents and learning from when things go wrong

- Staff knew what incidents they should report and how to report them. Staff told us they had forms to fill in that helped make it easier for them to report any incidents, Antecedent Behaviour Consequence (ABC) charts, for example, supported staff in recording and learning from incidents.
- The manager told us incident forms were looked at regarding possible causes of the incident. This included safeguarding, environmental issues or any patterns emerging with patients' behaviour. The incidents were discussed in the governance meetings where the team identified behaviour plans and training needs for staff.
- Following a training needs analysis it was identified that staff did not have the training to work with patients experiencing personality disorder. The manager said in house training would be provided.
- Staff received feedback from incidents that had occurred through various methods. This included handover, supervision unit meetings management meetings or training need analysis. We saw documented evidence in the team meeting on the 14 September 2016 of discussions concerning feedback from incidents. It was reported that there had been good feedback from staff on how incidents had been managed and the learning staff had achieved. We also observed discussions within the multi-disciplinary team meetings of incidents that had happened.
- The manager told us duty of candour was discussed with staff from incidents that had occurred. The incident forms used by the service did not include duty of candour. The manager stated the incident forms were being changed.
- We asked staff about their understanding of duty of candour. Although some staff did not know the terminology they were able to give good examples such as, apologising and explaining to patients if activities were cancelled.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- When the service received referrals they were discussed at the multidisciplinary team meeting. Staff were assigned to meet with the patients and completed initial assessments over the course of two visits. They provided feedback to the team and a decision would be made as to whether they were able to meet the patient's needs.
- We looked at six care records. We saw up-to-date risk assessments were present in the care plans we looked at. Comprehensive and timely assessments were completed after admission. Staff undertook a clinical assessment to assess patient needs.
- The care plans we looked at covered all areas of care and treatment. They were up to date and recovery orientated.
- Care records showed that physical examinations were undertaken and there was ongoing monitoring of physical health problems. There was good access to physical healthcare; including access to specialists when needed. Staff told us observations such as blood pressure and weight were completed every Sunday or more frequently when required. Patients were weighed regularly.
- Assessment and outcome tools such as Waterlow pressure ulcer risk assessments and hydration and nutrition was monitored in accordance with assessed risks.

Requires improvement

Services for people with acquired brain injury

- An unannounced inspection by the mental health act reviewer in September 2016 found patients' records included positive behavioural support plans. Staff had developed this to respond to challenging behaviour.
- All information needed to deliver care was stored securely. It was available to staff when they needed it and in an accessible form; including when patients moved between teams.

Best practice in treatment and care

- We saw guidance for the administration of 'as required' medicines were available for most medication but not all. This guidance provided information as to when it was appropriate to administer as required' medicine. It ensured that patients received their medicines in a consistent manner. This included medication for the management of anxiety such as Olanzapine and Lorazepam. However, the information for these medications was not available. This could have resulted in patients being given medication inappropriately.
- The UK Rehabilitation Outcome Collaborative (UKROC) measuring tool helped to show that the unit was treating people in the most effective manner. Clinical staff undertook audits of clinical notes, infection control measures and medication. Staff used baseline rating assessment / scales when assessing the patients' needs.
- We saw the status of patients documented on three patient charts. One patient was on section three of the Mental Health Act. The T3 form was attached and all medication corresponded to the chart.

Skilled staff to deliver care

- There was a good range of mental health disciplines and workers on the unit. In addition to nursing and rehabilitation support staff, the unit had access to other disciplines. This included occupational therapists, neuropsychiatrists, a rehabilitation consultant and behaviour specialists.
- New staff received an appropriate induction in to the service, including undertaking the Care Certificate where appropriate. We spoke with one new member of staff who was in the process of completing their mandatory training. They were awaiting further training specific to their role as part of the probationary period.
- The manager told us the training for rehabilitation assistants was a 12 week programme, during which there were three reviews. Staff completed a competency booklet and had a mentor to support them. This process was overseen by the training administrator to monitor progress. Qualified staff had an agenda for change programme that they completed. There was also preceptorship and assessors' courses that staff were joining at the Birmingham City University.
- Staff we spoke with said they received professional supervision and appraisals. One member of staff said they had supervision and one to ones with senior staff and management every two months. During the inspection we viewed the supervision matrix. We found gaps in supervision and employees who had left the service were still on the matrix. We spoke with the management who said supervision sessions took place once every two months. An updated supervision record was obtained following the inspection. It recorded from December 2015 that staff had received between four and five supervision sessions up to September 2016.
- Information provided by the service showed four doctors had been revalidated. A revalidation spreadsheet was on display in the staff office. The manager told us the clinical/group lead had the responsibility of monitoring revalidation for all staff.
- The service addressed poor staff performance promptly and effectively. Management gave an example of where a disciplinary procedure had been used. The outcome was performance management with a written warning, supervision was increased and training needs had been identified.

Multi-disciplinary and inter-agency team work

- There were weekly multi-disciplinary meetings. We attended one such meeting and saw it was patient and recovery focused. There were contributions by all attendees, including behaviour specialist, occupational therapist, nurses, consultant psychiatrist and the manager. Patients were not invited to attend this meeting however, their keyworker would provide feedback. There was no attendance by rehabilitation assistants.
- The manager told us community psychiatric nurses and social workers would attend the multi-disciplinary team meetings when invited. Social workers had also reported to the Care Quality Commission when they had attended the unit concerning safeguarding incidents.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Requires improvement

Services for people with acquired brain injury

- On the day of the inspection there were nine patients using the service, one patient was detained under section three of the Mental Health Act.
- The manager told us in house training was provided for staff in the Mental Health Act with yearly updates. We did not receive information on the data provided by the service for Mental Health Act training.
- Patients' records showed staff explained patients' rights under section 132 of the Mental Health Act and repeated these when necessary. This included explanation of the role of the Independent Mental Health Advocate and their right to appeal to a Tribunal and Managers' Hearing.
- There had been a Mental Health Act monitoring visit from the Care Quality Commission in September 2016, Although the service had failed to respond to our report following our previous visit in April 2015, we found the issues that had been identified at that time had now been resolved.
- Further issues identified in September 2016, and which required further action included;

No records informing patients of the outcome of the Second Opinion Appointed Doctor's (SOAD) visit, and no information about the CQC role in reviewing complaints from detained patients was available.

Good practice in applying the Mental Capacity Act

- Training records for permanent staff showed Deprivation of Liberty safeguards (DoLs) and Mental Capacity Act training (MCA) level one and two had 100% completion. This was for permanent staff. Bank staff had 57% completion for Mental Capacity the level one e-learning course. One bank staff had not completed level two which included training for Deprivation of Liberty Safeguards.
- Management explained Mental Capacity Act training formed part of the induction for new staff. Mandatory training was provided through e-learning and face to face. Staff told us patients' capacity was assessed regularly and reviewed every three months. The assessments were led by the neuropsychologist, behaviour specialist or psychologist. They had completed Mental Capacity Act and Mental Health Act training during their induction with refresher training.
- Management told us they had applied for authorisations for five patients under the Deprivation of Liberty Safeguards. The urgent authorisations had expired in some cases. However, staff showed good awareness and understood that there was no legal authority to deprive these patients of their liberty.
- Care plans showed capacity to consent to treatment had been considered for each patient. Assessments of capacity were decision and time specific and staff had clearly recorded the reasons for their decisions.

Are services for people with acquired brain injury caring?

Requires improvement

Kindness, dignity, respect and support.

- There were five male and three female patients on the unit.
- We observed several positive interactions by staff throughout the inspection. Staff showed patience and kindness in particular to one patient who was seeking to exit the unit. They used positive distraction techniques and were able to persuade the patient to return to the unit. We could see the patient responded to staff and appeared relaxed. Staff behaved respectfully and provided reassurance and support for patients.
- Patients told us staff were "Fantastic". If they needed anything staff would try and help. If they did not want to participate in activities they would try and encourage them to take part.
- One patient who was deemed to lack capacity was not able to communicate whether they had any family members. They had no change of clothing with them. The unit arranged a fund raising event to obtain funds to buy clothes for the patient.
- Staff showed a good understanding of the individual needs of patients. This was evident in multi-disciplinary teams, our discussions with staff, and in observing interactions with patients.

The involvement of people in the care they receive

- Some of the care plans we looked at were not goal orientated and at times prescriptive and showed little evidence of patient participation. It had been identified in the clinical notes audit of August 2016 that all care plans needed to include patient preferences. This had not been followed up.

Requires improvement

Services for people with acquired brain injury

- We saw evidence in three out of six care plans that patients had signed them. One patient told us due to a visual impairment staff read the care plan to them. The patient would not sign the plan if they did not agree with it. They felt staff understood the individual needs of the patient. The patient was offered a copy of their plan but had not received it at the time of the inspection. Other care plans we looked at were not signed and there was no documented explanations for this. There was no clear statement to show care plans had been offered to patients.
- Patients were not completely involved in their care and care reviews. We attended the multi-disciplinary team meeting where patients were discussed on alternate weeks. Staff told us patients were not invited to the meeting but were aware they were being discussed. Feedback was given via the patients' keyworker to both the patient and the multi-disciplinary meeting.
- One patient said they had never been invited to attend a ward review and did not see the consultant very often. They said if they had any information for the multi-disciplinary team they would notify the senior staff.
- There were two providers of advocacy services who attended the unit. Information was on display on a notice board and included an explanation of the role of an Independent Mental Health Advocate (IMHA). The manager said they would also attend specific meetings to support patients. One patient had no immediate family or carer support. The service was actively supporting this patient to access advocacy support by contacting the advocacy service.
- We saw evidence of community meetings taking place weekly where patients gave feedback about the service. Discussions took place about food, such as what they enjoyed or did not enjoy, and activities for the unit. Staff facilitated these meetings; one patient said patients also got involved with the process.

Are services for people with acquired brain injury responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

- The service had contracted beds; therefore the time between initial assessments to the onset of treatment would dependent on funding approval. The manager told us that when a referral was received for a potential admission, a clinical analysis was completed. This determined whether any of the patients were ready to be moved to either their new placements or return home. If they did not have any beds the referrer would be alerted. At the time of the inspection they did not have a waiting list.
- Patients always had access to a bed when they returned from leave.
- The Olive Carter unit admitted most patients from Birmingham and the Midlands area, and occasionally further afield.
- The service worked with patients and other agencies to plan discharges in a timely manner. We saw records of discharge planning and consideration of plans for aftercare under section 117 of the MHA. The unit involved a range of professionals, including the patient's care co-ordinator from their local area in discharge planning, which began early in the patient's stay. Staff told us this was because patients required a high level of support on discharge, and were sometimes a long way from their local area.
- The unit reported an average length of stay of 230 days between 1 June 2015 and 30 June 2016. From 30 June 2016 onwards the average length of stay was reported to be 170 days.
- The unit had one delayed discharge. The manager told us this was because a suitable placement could not be found to meet the patient's needs. The unit submitted information listing reasons for delayed discharges. This included, change of funding streams, delays with care packages and provision of equipment in the community.

Requires improvement

Services for people with acquired brain injury

- Patients could move from Olive Carter unit to Janet Barnes unit if their needs changed or as part of their rehabilitation process. The Janet Barnes unit was adjacent to the Olive Carter unit and separately registered. They also transferred patients to the Olive Carter unit if presented with challenging behaviour that could not be managed on the unit.

The facilities promote recovery, comfort and dignity and confidentiality

- There was a range of rooms and equipment to support treatment and care, including a well-equipped clinic room, and a therapy kitchen, though this was also used as the staff kitchen, which was not good practice. Management said aspects of the environment and structure of the unit did not offer itself to the service type. Such as the therapy kitchen. Access to other therapy rooms was available at the Janet Barnes unit.
- Patients were able to lock their rooms and staff had master keys if they needed to gain access.
- Patients could make phone calls in private and had access to their own mobiles.
- There were tidy gardens and a smoking area for use by patients.
- Patients' could make hot drinks and snacks at any time.
- Patients were able to personalise bedrooms. We saw one patient had put out pictures of their family and had some their own possessions on display.
- Patients told us regular activities were planned for the week and weekend. They were occasionally cancelled if staff were on sick leave. Patients were informed in advance and staff apologised. The unit had one activity coordinator with another recruited to start imminently. Activities included healthy eating club, nail art, knitting and arts and crafts.

Meeting the needs of all people who use the service

- We viewed the minutes of the community meetings from July to September 2016. Patients discussed how food could be improved. Patients gave suggestions of food they liked and asked for less rice-based foods. One of the patients told us the food was "fantastic" at the unit and there was a good selection. Staff made individual meals for patients if they did not like what was presented. There was a choice of food to meet dietary requirements of religious and ethnic groups.
- There was a variety of information available, including accessible information about treatments, local services, patients' rights, and on how to complain.
- We observed a language barrier with one of the patients and staff. The manager told us an interpreter attended the unit twice a week, and one of the staff members spoke their language. However in between these times staff found it difficult to communicate with them. We observed the patient in a confused and upset state. Staff tried to communicate to offer support, however the patient became agitated and aggressive towards them. We spoke to the manager about this. They said prior to admission a request was made for funding for interpreters. They currently had funding for eight sessions. Access to interpreters for the Mental Health Act such as understanding patient rights and capacity assessments was not an issue.
- The unit had a female only lounge and a multi faith / quiet room that patients could use. Both rooms were quite sparsely furnished. The multi faith room had a computer and did not offer any therapeutic or religious properties. Management told us access to church or faith centres was assessed and care planned for patients.
- There were day lounges as well as individual bedrooms, where patients could meet with families and others.
- One patient told us they knew how to complain and had recently made a complaint. They said actions were taken and they were kept informed during the process.

Listening to and learning from complaints

- There was a clear complaints policy. The manager told us complaints were investigated. Meetings with patients or patient's relatives and staff took place and reports were prepared. Feedback was given to the complainant at various stages and overall outcomes provided. Feedback for staff happened at team meetings. We saw evidence of the provider responding to a complaint from a relative. The letter highlighting the concerns raised in the complaint and what they had put in place to prevent the issue reoccurring.
- Staff were clear on how to respond to complaints. The unit had received five formal complaints from April 2015 to July 2015. Four of the complaints were upheld and one partially upheld, no referrals were made to the ombudsmen. Two of the complaints concerned missing property, another poor care and poor communication.

Requires improvement

Services for people with acquired brain injury

The outcomes included retraining staff, purchasing wash baskets and replacing missing property such as hearing aids. This showed the service was responsive to complaints.

Are services for people with acquired brain injury well-led?

Requires improvement

Vision and values

- The service aimed to empower people to access and benefit from occupational, social and educational pursuits. To achieve full participation and inclusion in community life. The service had an ethos based on integrity, transparency, compassion and positivity. Although staff did not verbally convey their understanding of the aims it was displayed in the way in which they worked with the patients.
- Staff were aware of senior staff in the organisation. The manager said senior staff had visited the unit. The governance manager regularly attended. Staff and patients were positive about the manager. They said he was approachable and present on the unit.

Good governance

- Information provided by the service stated there was a 22% turnover of staff in the past twelve months. There was 20% staff absence, including sickness, in the past twelve months.
- Overall mandatory training for permanent staff was above 75% however, not all staff had completed medication training which was 67%. Bank staff did not achieve the same rates as permanent members of staff. Mandatory training and induction for bank staff such as person centred care was 57%, Fire safety 28%, emergency first aid course 14% and Mental Capacity Act level one 57%.
- Medication management was audited however there were some issues with homely remedies not being documented. This was not identified in the audits.
- Some over ordering of insulin led to overcrowding in the fridge. This meant that patients were at an increased risk of receiving medication that was not otherwise kept at the correct temperature.
- There was a sufficient number of staff of the right skill mix to cover shifts. The service used bank or agency staff to ensure one to one observations were implemented safely, and that there was sufficient nurse cover on all shifts.
- The service completed audits in all areas of service delivery to improve services for the patients they supported. We viewed samples of clinical, medication and infection control audits. The audits outlined any issues identified and were communicated to staff in meetings and through supervision. Information collated from the audits was discussed at monthly governance meetings. There were also monthly key performance targets for areas such as falls, urinary tract infections (UTI) safety thermometer and reportable incidents
- The manager had sufficient authority and administrative support.

Leadership, morale and staff engagement

- At the time of the inspection the manager had recently applied for the disclosure barring service check (DBS). Therefore the service did not have a registered manager. Following the inspection we obtained evidence from the manager of the application form being sent. It was acknowledged the length of time the DBS checks were currently taking.
- A staff survey was completed in July 2016. The majority of staff reported they would recommend the Olive Carter unit as a place to work. Staff were able to have their say on the delivery of care, what was good about working at the service and improvements that could be made.
- We did not see or hear of any evidence of bullying and harassment. The manager said the whistle blowing policy was now called “Freedom to speak out”, which staff were aware of. There was one grievance brought by a member of staff which was concluded in August 2016. This involved lack of communication between staff and senior staff concerning an interview. Staff we spoke with said they felt able to raise concerns with the line manager if necessary. In the staff survey some staff felt that complaints raised with the senior management team were not always followed up.
- The manager said staff morale had improved and was good within the unit. The service had invested in staff with training which assisted to build morale. The service provided away days for staff. The managers and therapy leads had away days every six weeks. However

management explained that as the rehabilitation assistants were a large group and it was difficult to get everyone to an away day together, they could not have as many structured away days as other staff.
- We saw very positive teamwork and mutual support amongst all staff.
- There were staff meetings which staff could contribute ideas. We viewed the minutes of the staff meetings. There was a discussion concerning poor attendance at staff meetings. It was decided that the meetings would be added on at the end of training sessions to encourage attendance.
- Managers told us they felt supported in their role by senior managers and they could be contacted by phone.
- Supervision and appraisals for staff were taking place regularly. Senior nurses, staff nurses and senior rehabilitation assistants completed supervision sessions within their discipline. The manager told us they received supervision regularly and were offered suitable management training. The service learnt from complaints, and made changes to the service as a result. Safeguarding alerts had resulted in suitable actions.
- Staff followed safeguarding mental capacity and consent procedures.

Commitment to quality improvement and innovation

- The manager stated the service was about to become a research unit and would be seeking to have research students. The psychology team had recently received a research grant and had developed a new tool that assessed positive and negative behaviours. It would provide quicker support for staff and patients.
- The unit received a safety thermometer certificate for September 2016. The NHS safety thermometer assessed 100% of patients were receiving harm free care. The national goal was 95%.
- We saw the risk register contained historical and current issues such as parking facilities at the unit. The ligature risk assessment was on the risk register due to the high risk patient group they had at the unit. The fire door was also on the risk register as it was easy to open and was a risk of patient absconding. The unit required new magnetic fire doors. Ligature risks were updated and additional parking spaces had been allocated.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure all patients' own medication is labelled and has the correct amended expiry dates on insulin vials.
- The provider MUST ensure that all patient own medication administered to the patient is recorded on the medicine administration chart.
- The provider MUST ensure that staff are trained in monitoring the temperature of the refrigerator and are clear on what actions to take if temperatures are above the safe limit.
- The provider MUST ensure that the fridge is not over stocked which prevent the fan from circulating cool air.
- The provider MUST ensure care plans show the involvement of patients and reflects their preferences.
- The provider MUST ensure that care plans reflect whether patients' has been offered and given a copy of their care plan

Action the provider SHOULD take to improve

- The provider should ensure that all staff including bank staff completes mandatory training and induction in a timely manner.
- The provider should ensure that all bank staff completes deprivation of liberty safeguard and Mental Capacity Act training.
- The provider should ensure outcomes of the Second Opinion Appointed Doctor (SOAD) are communicated to the patient and documented.
- The provider should display information about the role of the Care Quality Commissions role in reviewing complaints.
- The provider should ensure that all staff receives training for personality disorder as identified in the training needs analysis.
- The provider should ensure that the training kitchen is entirely for patient use and is not also used as a staff kitchen.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care. Care plans did not reflect patients' participation or preferences. There was no documentation of whether patients had received a copy of their care plan. Regulation 9 (1) (c) 3 (a) (b)

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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The fridge recording in the clinic room was above 16 degrees. Staff were not aware how to reset the temperature. The fridge was over stocked with medication preventing the fan from circulating cool air Staff did not document on the medication administration records when patients had been administered non-prescribed medication. Insulin vials did not have the patients name or expiry dates. Regulation 12 (2) (e) (g) (c)

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.