Constance House 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	Requires improvement
Are services safe?	Requires improvement
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.

Overall summary

CQC previously inspected Constance House in August 2015. At the last inspection, the service received an overall rating of good.

At this inspection we rated safe as requires improvement and well-led as requires improvement. Therefore, we have rerated the service as requires improvement overall.

Summary of findings

We found the following issues that the service provider needs to improve:

- The provider had made a decision not to address any environmental concerns until it had made a decision about the future of the service.
- The premises were not safe for patients. Ceramic tiles had been removed from the wall. This left the sharp, hard edges of the other tiles exposed.
- The premises were not clean. Carpets throughout the hospital were severely stained. In one patient's flat, there were stains on the walls.
- The provider had not reported a safeguarding concern to the local authority safeguarding team. The service had not sent any notifications of abuse or allegations of abuse to the CQC since September 2016 even though an incident of abuse had occurred.
- The provider did not investigate serious incidents and complaints in detail, which meant that patients may have been significantly affected in some way and that opportunities where missed to learn from incidents and complaints and reduce the likelihood of reoccurrence.
- The provider did not have effective governance systems in place to assess, monitor and improve the quality and safety of the service. The provider had not addressed recurring issues identified in audits of cleaning and environmental safety. The provider did not have a local risk register that reflected concerns raised by the staff.

However, we also found the following areas of good practice:

- Staff produced comprehensive positive behaviour support plans for each patient. These plans clearly identified the triggers for patients' challenging behaviour and details of how staff should respond.
- Staff knew patients very well. They understood patients' routines, rituals and indicators of increased risk and could respond by reassuring patients before situations escalated
- Staff were trained in de-escalation techniques and used verbal de-escalation before physical interventions. Physical interventions involved a minimal use of force. Staff did not use seclusion or rapid tranquilisation.
- There were sufficient staff on duty at all times. Staff spoke positively about their experience of working at the service and found the hospital manager to be supportive and approachable.
- The provider had systems to ensure staff were up to date with mandatory training. Staff received regular supervision and annual appraisals.

Summary of findings

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Summary of this inspection

Background to Constance House Hospital

Constance House Hospital is part of Sequence Care Limited.

Constance House is an independent hospital situated in Enfield, North London. It provides care and treatment for up to 11 female patients with learning disabilities, along with autism, mental disorder or challenging behaviours. At the time of our inspection, there were four patients. One patient was on leave and staying with their family. One patient was detained under the Mental Health Act.

The CQC previously inspected Constance House in August 2015. At the last inspection, the service received an overall rating of good.

Our inspection team

The inspection team comprised of two inspectors, an expert by experience and a specialist advisor with a professional background in nursing for people with learning disabilities.

Why we carried out this inspection

Sequence Care Limited submitted a request to change the regulated activity at Constance House to residential care without nursing in January 2017. The CQC was unable to approve this request as there was no registered manager in post at the time. The provider withdrew the application.

In July 2017, the provider informed us it intended closing Constance House Hospital by the end of 2017. The hospital had not accepted any new patients since November 2016. At the time of the inspection, the provider was seeking alternative placements for the remaining patients.

We carried out this inspection to ensure that patients who remained at the services were safe and the service was well-led whilst the provider made decisions about the future of the hospital.

How we carried out this inspection

During this inspection, we focussed on two of the five key questions (are services safe, effective, caring, responsive and well-led?). We specifically looked at the two key questions:

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

During the inspection visit, the inspection team:

- visited the hospital site and looked at the quality of the environment and observed how staff were caring for patients
- spoke with one patient in depth and spent time with two other patients at the premises to observe their interactions with staff
- spoke with the registered manager and the deputy manager
- spoke with two nurses and two support workers
- spoke with three commissioners
- spoke by telephone with the consultant psychiatrist and chief operating officer for Sequence Care Ltd
- looked at the treatment records of all four patients
- looked at a range of policies, procedures and other documents relating to the running of this service.

Summary of this inspection

What people who use the service say

One patient told us they felt safe at the service and that staff were always available to help them. They said they felt involved in decisions about their care and treatment. They said that staff were very caring. They also said they enjoyed the independence of having their own flat. This meant they could decorate their rooms in the way they wanted to. The patient enjoyed going shopping and having their own kitchen.

Another patient found it difficult to talk to us. However, we saw good interaction between staff and the patient. At times, everyone was smiling and laughing. Staff supported the patient with recreational activities and more practical tasks, such as laundry. Staff were polite throughout, offering gentle support and encouragement.

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?

Requires improvement

We found the following issues that the service provider needs to improve:

- The premises were not safe. A number of ceramic tiles had been removed from a wall leaving the sharp, hard edges of the other tiles exposed.
- Some areas of the building were not clean. There were stains on the carpets throughout the hospital. In one flat, there were stains on the walls. The water cooler presented a risk of contamination.
- The provider had not reported a safeguarding incident to the local authority safeguarding team.
- The provider did not investigate serious incidents in detail. This meant there was little evidence of staff identifying learning and making changes after incidents in order to reduce the chances of the incident happening again.

However, we also found the following areas of good practice:

- Staff completed a risk assessment for each patient when they were admitted and updated these assessments throughout the admission.
- Staff completed comprehensive personal behaviour support plans for each patient. These plans included details of triggers that increased the risk of challenging behaviour and details of how staff should respond, including a list of authorised interventions.
- All staff were trained in de-escalation techniques and always used verbal de-escalation before employing physical interventions.
- Staff kept detailed records of all incidents of challenging behaviour. These records were analysed by the assistant psychologist in order to track any changes in patients' behaviour over time.
- There were sufficient staff at all times to care for patients

Are services well-led?

Requires improvement

We found the following issues that the service provider needs to improve:

- The provider had made the decision not address issues with the environment whilst it was deciding the future of the service.

Summary of this inspection

- The provider had failed to identify environmental risks in sufficient detail. The service did not maintain a register of risks that were specific to the location.
- The systems in place to assess, monitor and improve the quality and safety of the service were not effective.
- The provider had not carried out detailed investigations after serious incidents and complaints in order to identify the impact for patients, ensure learning from these and that improvements were made as a result.
- The provider had not notified CQC or the local authority safeguarding board of a safeguarding incident.
- While the provider had completed audits on cleaning and environmental safety the issues identified in the audits had not been addressed. The provider had not addressed the poor levels of cleanliness and maintenance in some areas of the hospital.

However, we also found the following areas of good practice:

- Staff spoke positively about their experience of working at the hospital and found the hospital manager to be supportive and approachable.
- The manager had a good understanding of all the patients.
- The provider had systems to ensure staff were up to date with mandatory training. Staff received regular supervision and annual appraisals.
- The provider had systems in place for monitoring and managing challenging behaviour.

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	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement
Overall	Requires improvement	N/A	N/A	N/A	Requires improvement	Requires improvement

Requires improvement

Wards for people with learning disabilities or autism

Safe	Requires improvement
Well-led	Requires improvement

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

- The hospital comprised of two buildings. The main building had eight bedrooms with en-suite facilities situated over three floors. The main building also housed a communal area with a dining space and an area for patients to watch television together. An additional building at the rear of the property housed three large open-plan flats; two of which were used by patients at the time of the inspection. The service kept the building locked at all times.
- Staff assessed the environment for potential risks. The service completed risk assessment of potential ligature points in May 2017. However, the assessment was generic, stating that coat hangers, door handles, shelves and brackets were all potential ligatures points. The audits did not list specific ligature points or state the location of these. This meant that staff may not be aware of potential ligature risks for each patient and be able to reduce the risk of self-harm. We raised this with the manager. In response to our concern, the manager requested a review of the ligature assessment by their health and safety consultant.
- Staff carried out risk assessments of the environment. An independent fire risk assessor completed a fire risk assessment in June 2017. This assessment identified action that the service needed to take. The manager produced a detailed action plan setting out how they were addressing this. Fire response equipment was available throughout the building. Each patient had a personal evacuation plan. This showed how staff should support the patient to leave the building in an emergency.
- There were blind spots throughout the hospital. The service had installed convex mirrors to improve sight lines. Staff mitigated risks caused by poor visibility by undertaking enhanced observations of patients assessed to be at risk of harm.
- The service planned for emergencies. Staff wore personal alarms. When staff activated an alarm, a sign lit up on each floor to show where the member of staff had activated the alarm.

Maintenance, cleanliness and infection control

- Some areas of the building were not clean. There were stains on the carpets throughout the hospital. In one patient's flat, there were stains on the walls. The wooden fixture around the water cooler was chipped and dirty, with mould starting to appear. This presented a risk of contamination. Staff updated basic cleaning records each day.
- The premises were not well maintained and not safe. A number of hazards within the premises posed a risk to patients. During our first visit, we found exposed screws on a kitchen unit, a light that was flickering continuously and exposed wires on a broken light switch. We also found two empty bedrooms were unlocked and used to store broken furniture and plastic sheeting. We raised this with the manager at the time and they acted promptly to address these concerns. However, on our second visit we found a number of ceramic tiles had been removed from a wall leaving the sharp, hard edges of the other tiles exposed. This was in an area of the premises used by a patient who had self-harmed by banging her head in May and July 2017. This patient had also pulled a tile from the wall in June 2017 and attempted to use the tile to break a window in the kitchen door.
- The service carried out infection control audits. The infection control audit for May 2017 provided advice on how the service could improve practice in cleaning body fluids reducing the of risk of food contamination and waste disposal. The service had implemented these recommendations.

- The service had systems in place to ensure staff maintained standards of food hygiene. The kitchen displayed information on basic food safety and hygiene. Staff recorded the kitchen fridge and freezer temperatures daily. These temperatures were within the correct range. Food in the fridge had date stickers. All food was within the date stated on the sticker. The kitchen was clean. Staff completed a daily cleaning schedule for the kitchen.

Clinic room and equipment

- The clinic room was equipped with oxygen and a defibrillator. A first aid kit was fully stocked. All items were in date. Staff signed a record to show they checked the first aid kit and emergency equipment once a week to ensure it was fit for purpose.
- The service had a pulse oximeter, weighing scales and a blood pressure machine. This equipment was clean. Staff signed a record to confirm they checked this equipment once a week.

Safe staffing

Nursing staff

- The service employed four nurses. Three nurses were permanent members of staff. The service employed the other nurse as part of the hospitals 'bank' of staff who worked shifts when required. The service also employed 25 health care assistants.
- The number of patients at the service had declined since November 2016, meaning that the staffing number on each shift had reduced. Therefore, the service had not needed to use agency staff for some time and only used bank staff occasionally.
- The service allocated staff to each shift according to the number of patients and the level of observations required. During our inspection, two patients required two members of staff to provide observations, care and treatment. The service allocated a further member of staff to the other patient. In addition, a nurse managed the shift, providing a total allocation of six members of staff. This reduced to four members of staff during the night shift.
- The service assigned at least one nurse to each shift.
- The manager could adjust the staffing level according to patients' needs. For example, the manager allocated additional staff to escort patients to hospital appointments. The hospital employed a driver to take patients on trips. The driver was additional to the allocated nursing and health care assistant numbers.
- The service provided an induction for bank staff to ensure they were familiar with the hospital.
- The level of staffing allowed patients to have plenty of time with staff. Staff were always available to facilitate outings and activities. There were always enough staff to carry out physical interventions if necessary.

Medical staff

- There were no doctors based on site. A consultant psychiatrist attended once a week and was available by telephone at other times. The patients' GP provided assistance with physical healthcare. In an emergency, the service contacted the emergency services.

Mandatory training

- Staff completed mandatory training. This included attending courses on safeguarding, physical interventions, emergency first aid, medication and the Mental Capacity Act. Staff also completed online training on food safety, health and safety, infection control and fire prevention. Overall, staff in the service had undertaken 91% of the training that the service had set as mandatory.

Assessing and managing risks to patients and staff

Assessment of patient risk

- We looked at three patient risk assessments. Staff completed a risk assessment for each patient on admission. Staff updated this throughout the admission. Each patient had a recent risk assessment in place.
- Staff used a recognised risk aggregation tool that scored each risk in order of severity. Assessments included the patient's risk history, triggers and management plans for each specified risk.

Management of patient risk

- Staff produced positive behaviour support (PBS) plans for each patient. These plans gave details of how staff should manage each patient's risks. Positive behaviour plans also included a list of approved interventions that

staff could use when the patient became agitated. For example, the PBS plan for one patient authorised the use of assertive commands, touch support and escorting the patient.

- Staff identified changes in risk behaviour. Patients' risk assessments recorded any change or improvement in their risk behaviour. Staff updated risk assessments to reflect this.
- Staff followed procedures for observing patients at risk of harm. At the time of the inspection, two patients were on two-to-one observations due to their high risk. We looked at the records of patient observations for the last week. Staff had completed comments on each patient every hour.
- The service kept the kitchen door locked in order to protect patients from possible harm. However, staff facilitated supervised access to the kitchen for patients, at any time.
- Informal patients could leave at any time and could be supported to do so. At the time of the inspection, two patients were informal. The service had a sign at the front door in a pictorial format explaining that patients could leave at will if it was safe to do so.

Use of restrictive interventions

- Staff used verbal de-escalation to address challenging behaviour in the first instance. Staff used physical interventions as a last resort. Patient files included an analysis of individual behaviour triggers and the de-escalation techniques that worked best for each person. For example, staff had recorded using proactive engagement methods with a patient to reduce their agitation, including supporting the patient to access the community.
- There had been no incidents of staff using restraint of a patient in the 12 months prior to the inspection. Staff used touch support and redirection to assist patients. Staff recorded incidents of physical contact on accident and incident forms. We looked at two incident forms for July and August 2017. These detailed the type of contact used. It also specified how many staff were involved. For example, during one incident a patient received two-person touch support and was redirected back to their bedroom by two staff.
- Staff recorded incidents of challenging behaviour. Staff recorded incidents of patients displayed challenging behaviour. In response to challenging behaviour, staff used de-escalation techniques and redirected the patient to their bedroom if they needed to.
- The service did not have seclusion facilities. There were no recorded incidents of seclusion at the service in the last six months. The deputy manager said they did not seclude patients in their bedrooms or other rooms within the building.

Safeguarding

- The service had a policy on safeguarding adults. The policy included a flow chart showing the procedure that staff should follow when reporting allegations of abuse. The service displayed easy read information of safeguarding on the noticeboards for patients to receive information on protection from abuse.
- Ninety percent of staff had completed mandatory training on safeguarding. Staff were aware of the need to report all allegations of abuse to the nurse in charge. Staff gave examples of how they protected patients from abuse by discussing risks with patients. However, there were no records of the service reporting incidents to the local authority safeguarding team. When looking at patient records, we found there had been an incident in June 2017 involving a patient assaulting another patient that staff should have reported to the local safeguarding team. The service had informed patients' care co-ordinators that incidents had taken place but not the local authority, as required by the policy and pan-London safeguarding arrangements.
- Staff gave examples of how they worked with care co-ordinators to develop care plans to keep patients safe. The service worked closely with care co-ordinators to arrange further placements for patients that would ensure the patients' safety.
- There was sufficient staff and quiet areas at the premises to ensure that visits from children could be carried out safely.

Staff access to essential information

- Staff used paper files for patient care and treatment records. All patient records were kept in a locked staff office. This meant that all staff had access to the information they needed and this was accessible to agency staff.

Requires improvement

Wards for people with learning disabilities or autism

- All staff could update patient records when they needed to.

Medicines management

- The service followed good practice in medicines management. The service commissioned a pharmacy service to visit once a month to deliver and dispose of medicines. Staff completed a medicines administration record for each patient showing the dates and times on which they had administered medicines to patients. No patients were receiving high doses of anti-psychotic medicines at the time of the inspection.
- Staff carried out physical health checks of patients once a month. This involved checking the patient's weight and blood pressure. If a patient required additional health checks, staff would support them to visit the GP.

Track record on safety

- The organisation had a policy for investigating incidents. The policy stated there was a need for all incidents to be investigated fully and impartially. Between May and July 2017, four incidents had been classified 'amber', indicated a higher level of seriousness that required investigation. However, the service had not carried out any formal investigations during the year before the inspection and these four incidents had not been investigated.
- The service maintained an accident and incident log. This showed there had been 10 incidents in May, nine in June and 12 in July. Of these 31 incidents, 11 involved assaults on staff, nine were incidents of self-harm and four involved patients damaging property. The service had classified four incidents as 'amber' and 27 as 'green.' There had been one incident of a patient assaulting another patient.

Reporting incidents and learning from when things go wrong

- Staff reported all incidents that should be reported. Staff recorded all day-to-day incidents on a standard form. Records included details of each incident, the triggers to the patient's behaviour, the action taken by staff and the outcome of staff interventions. There had been 139 incidents reported at the service in the three months prior to the inspection. Incidents typically involved patients becoming aroused and agitated. The assistant psychologist analysed the data from these forms and produced reports for the manager. Reports showed that between May-July 2017 one patient had 103 incidents recorded, 44 of these were in May. Another patient in the same period had 22 incidents of physical interventions recorded, with the common triggers being home leave and their needs not being met immediately.
- The service recognised it duty of candour towards patients and their families. Staff routinely notified the patient's family and care co-ordinator whenever they were involved in an incident.
- While staff analysed data from incident forms, there were no detailed investigations into any incidents, including serious incidents. Records did not include any findings or conclusions about the incidents that had taken place. This meant that learning was not identified and changes were not made to improve the quality of the service.
- Staff discussed incidents in handover meetings. However, staff did not discuss clinical matters in the monthly team meetings. This meant that there was no opportunity for staff to share what had been learned from incidents and discuss improvements that could be introduced.
- Staff involved in incidents attended debriefing sessions shortly after. Staff recorded these sessions, including details of what happened and what staff learned from the incident. However, staff learning from incidents was limited to stating that staff needed to be more alert and able to identify any triggers. There was no consideration of how staff could be supported to be more alert and better able to identify triggers.

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

Requires improvement

Leadership

- The service manager was a qualified nurse with experience in a number of management roles. They had been in their current role for six months. They been a registered manager at other services since 2011.
- The manager had a good understanding of the service they managed. They knew the names of all the patients and had a good understanding of each patient's individual needs. The manager explained that their priority in ensuring a high quality service was to support

patients to address challenging behaviour and self-neglect within a caring environment. This involved employing staff who demonstrated caring attitudes, assessed risks and managed these using positive behaviour plans. The manager also talked about the importance of enabling patients to pursue their interests and supporting patients to sustain close relationships with their families.

- The manager was visible in the service and approachable for staff and patients. The manager managed both Constance House and another service nearby. The manager visited Constance House at least three times each week to attend handover meetings, provide supervision, attend team meetings, support staff and respond to specific incidents. Staff could contact the manager by telephone at other times during the week.
- The manager had completed leadership training and specific training on mentoring and safeguarding. The service encouraged staff to complete National Vocational Qualifications in Health and Care levels two to four. The service also encouraged staff to gain experience in other nearby services run by Sequence Care Limited.
- Senior managers at Sequence Care Limited had made the decision not address issues with the environment until it had made decisions about the future of the service.

Vision and Strategy

- Staff understood the provider's values and applied this to their work. Sequence Care stated that it aimed to empower people to achieve their personal goals and independence through providing personalised, holistic care. Staff applied this to their work by having a good understanding of individual needs, providing care and support to meet these needs and supporting patients to have overnight visits to families.
- The senior management communicated these values to frontline staff. For example, the newsletter for staff, patients and carers included positive stories about how specific patients had made progress towards independence through personalised positive behaviour plans.
- Staff had an opportunity to contribute to discussions about the strategy for their service at monthly team meetings. Staff were aware that changes were taking place as the service had not accepted any new patients since November 2016. Staff were also aware of plans to move all current patients to alternative placements. A member of the organisation's board of management said that a consultation with staff about the future of the service was about to begin.
- Staff could explain how they worked to deliver high quality care. For example, they said they used minimal restraint and did not use rapid tranquilisation. Instead, they managed behaviour by getting to know the patients very well. They understood patient's routines, rituals and indicators of increased risk and could respond by reassuring patients before situations escalated. Staff were not aware of any budgetary restrictions on their ability to provide care.

Culture

- Staff spoke positively about their experience of working at the hospital. Staff acknowledged that supporting patients presenting challenging behaviour could be difficult but they felt supported, respected and valued in carrying out their roles.
- Staff found the manager to be approachable and felt able to raise concerns without fear of retribution.
- The service had a whistleblowing policy and procedure. The organisation had not assigned a specific person that staff could report concerns to. However, the policy stated that if staff did not want to approach their manager, they could approach a more senior person in the organisation. No one had raised a whistleblowing concern in the 12 months before the inspection.
- Managers dealt with poor performance when needed. During the 12 months before the inspection, three employees had failed their probationary period and not been confirmed in post. Poor performance was managed by setting objectives for employees and measuring their performance in relation to these targets. The organisation's human resources department provided support to managers.
- The staff team worked well together. A communication book enabled staff to leave messages for each other about changes to shifts and other logistical matters. Staff attended debriefing sessions after incidents.
- Staff appraisals included conversations about career development and how it could be supported. In particular, staff were encouraged to gain experience of working in other services.

- The provider promoted equality and diversity. Almost all nurses and health care assistants were from minority ethnic groups. There were no male care staff at the service due to the needs of patients. The service promoted career progression for all staff.
- The staff sickness rate was 2.1%. Staff sickness and absence were below the average for health and social care services.
- Staff had access to support with physical and emotional health needs related to their employment through the occupational health department.
- The service operated a staff recognition scheme. Every three months, the manager nominated an employee for a staff recognition award. Nominations had been made for overall performance, exceptionally good team work, very good attendance and advocating for patients. Employees who achieved an award received shopping vouchers.

Good Governance

- The board of Sequence Care Limited provided overall governance. The manager of the service met with other managers across the organisation every two months to share information and discuss operational matters.
- The service had systems in place to assess, monitor and improve the quality and safety of the service but these were not always effective. The service did not sufficiently assess risks to the environment. This meant that staff had not identified and recorded all ligature anchor points. Some areas of the hospital were not clean and, in some area, large ceramic tiles had been removed from the walls. However, the service demonstrated good governance in the management of staff and care for patients. Staff had completed mandatory training and received regular supervision and appraisals. The service held regular team meetings that were well attended by staff. The provider was taking positive action to replace institutional restrictions. For example, staff prepared patients' meals individually and involved patients in cooking whenever possible. This meant that patients could choose what to eat and have their meals whenever they wished to. Staff supported patients to make overnight visits to their families. Patients were also able to leave the accommodation, visit local shops and pursue their interests whenever they wished.
- The service made statutory notifications to CQC in relation to incidents involving the police and deprivation of liberty safeguards. However, the service had not provided notifications in relation to an allegation of abuse that involved incident of a patient assaulting another patient. There were no records of staff making safeguarding referrals to the local authority.
- The organisation's policy on formal investigations did not provide clarity in which incidents managers should investigate. The service had not investigated of four incidents that staff had rated as 'amber.' During the 12 months before the inspection, there had been a number of complaints by a parent of a patient. While the service kept records of emails concerned with these complaints, there was no evidence of investigations taking place or conclusions being reached. The meant the service failed to identify learning from incidents and make improvements to the quality of the service.
- Staff undertook regular audits to monitor staff compliance with requirements for administering medication, health and safety, environmental safety and deprivation of liberty safeguards. However, we found the service did not take action to address the concerns that were identified. For example, three consecutive environmental audits between April and July 2017 identified concerns about the lift being unpredictable, door closers not responding to fire alarms and deep cleaning not taking place. The service had not addressed these concerns.
- Staff understood the arrangements for working with other teams. The service worked closely with commissioners and care co-ordinators to monitor each patient's progress and plan future placements. Care co-ordinators usually visited each month. The staff contacted the care co-ordinator if their patient had been involved in any incidents.

Management of risk, issues and performance

- Sequence Care Limited maintained a risk register. The majority of the ten entries on the register related to corporate risk and were not specifically relevant to Constance House.
- During our interviews, the concerns of staff focussed on the needs of patients. Staff were not aware of the risk register. Staff said that, occasionally, their work could be very demanding. For example, if more than one patient was presenting challenging behaviour. The risk register did not reflect the risks that this presented.
- The service had plans in place for emergencies. Each patient had their own personal evacuation plan. This

meant staff knew how to support each patient to leave the building in an emergency. The service would employ agency staff if sufficient permanent staff were not available.

Information management

- The service had systems to collect data. As a small hospital, these systems, such as records of incidents and accidents, were straightforward and were not over-burdensome to frontline staff.
- The service maintained patient records in paper files. The staff had access to sufficient information technology to communicate by email, produce well-presented documents and analyse data.
- We found evidence of two incidents of allegations of abuse, involving a patient assaulting other patients that had not been reported.

Engagement

- Staff, patients and carers had access to up-to-date information about the service through the organisation's website and a newsletter.
- The service tried to hold community meetings for patients but these had been unsuccessful. As an alternative, staff spoke to individual patients on a regular basis about their experience of being at the hospital. There were no specific records of these meetings. The service maintained regular contact with carers and routinely invited carers to care programme approach meetings. There were no specific consultations with carers.
- Patients and carers had not been involved in the decision about the future of the hospital. Decisions had been made entirely by the board of the organisation that owned the hospital without consultation with staff, patients or their families. Members of the board did not visit the hospital on a regular basis.

Learning, continuous improvement and innovation

- The service was not involved in any research or national audits. There were no specific innovations or quality improvements taking place.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the premises are safe. The provider must ensure there are no exposed sharp, hard edges to wall tiles that could injure patients.
- The provider must ensure the premises are clean.
- The provider must ensure that all safeguarding incidents, such as abuse and allegations of abuse, are reported to the local authority and the Care Quality Commission
- The provider must ensure that incidents are investigated and that findings and used learn and improve services.
- The provider must ensure that concerns and shortfalls identified during audits are addressed and improvements made.
- The provider must ensure it has effective governance systems in place assess, monitor and improve the quality and safety of its services at the hospital.

Action the provider SHOULD take to improve

- The provider should fully investigate complaints about the service, identify learning and make improvements to the quality of the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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 **The premises were not safe to use.** **Ceramic tiles had been removed from a wall leaving exposed hard, sharp edges. This put service users at risk of avoidable harm.** **This was a breach of regulation 12(1)(2)(a)(b)(d)**

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes in place to prevent abuse to service users were not effective.** **The provider had not reported all safeguarding concerns to the local authority safeguarding team. An incident of a patient assaulting another patient had not been reported.** **This was a breach of regulation 13(1)(2)(3)**

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 15 HSCA (RA) Regulations 2014 Premises and equipment **The hospital premises were not clean.** **Carpets throughout the hospital were severely stained. There were stains on the walls.** **This was a breach of regulation 15(1)(a)**

This section is primarily information for the provider

Requirement notices

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 17 HSCA (RA) Regulations 2014 Good governance **Systems in place to assess, monitor and improve the quality and safety of the service were not effective.** **The service had not carried out any formal investigations into serious incidents, which meant there were missed opportunities for learning and reducing the risks of reoccurrence. Concerns identified during regular audits were not always addressed.** This was a breach of regulation 17(1)(2)(a)(b)(f)

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 18 CQC (Registration) Regulations 2009 Notification of other incidents **Specifically the provider had not notified the CQC of abuse or allegations of abuse in relation to a service user.** This was a breach of regulation 18(2)(e)

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.