Oakwood House

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

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

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

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

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

Summary of findings

Overall summary

We rated Oakwood House as requires improvement because:

• The service did not have safe systems in place to protect people from the risks of poor medicines management. We found examples of patients being at risk of receiving incorrect doses.

• The provider had not ensured that the capacity of patients to consent to decisions was appropriately assessed in all cases. Some patients had not had their capacity to consent to a specific decision assessed appropriately.

• Not all patients had been fully assessed.

• Not all equipment being used by the service was suitable for the purpose they were being used for.

However

• The provider had recently improved its systems to assess, monitor and improve the quality and safety of the services provided. However, this was not yet fully embedded.

• Staff were caring towards patients and most patients and relatives told us they felt the standard of care was good. However, some language staff used was paternalistic.

• The service had a comprehensive multi-disciplinary team. Staff from all backgrounds felt they were able to input into the development of plans for patients.

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** 	This report describes our judgement of the quality of care provided within this core service by Care + Ltd. Where relevant we provide detail of each location or area of service visited. Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Care + Ltd and these are brought together to inform our overall judgement of Care + Ltd.

Summary of findings

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Summary of this inspection

Background to Oakwood House

Oakwood House is a nine bedded neuro-disability rehabilitation unit based in Barnehurst in South East London. It provides care to males and females. It has been registered with CQC since December 2013 to provide the following services: assessment or medical treatment for persons detained under the 1983 Act, caring for people whose rights are restricted under the Mental Health Act, physical disabilities, treatment of disease, disorder or injury, caring for adults under 65 years, caring for adults over 65 years. CQC has not inspected it previously.

There were eight patients at the hospital on the day of the inspection. A further patient was admitted during the course of the inspection.

Our inspection team

Team Leader: George Catford, Care Quality Commission.

The team that inspected the hospital consisted of five people: an inspection manager, two inspectors, a pharmacist inspector and a doctor who specialises in neuro rehabilitation.

Why we carried out this inspection

We inspected this hospital as part of our planned, comprehensive hospital inspection programme.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about these services and asked a range of other organisations for information.

During the inspection visit, the inspection team:

• Interviewed the registered manager, the deputy manager, and the consultant psychiatrist.

• Spoke with or interviewed 14 other members of staff including the administration manager, a housekeeper, a music therapist, nurses, an occupational therapist, a psychologist, rehabilitations assistants, a physiotherapist, and a speech and language therapist.

• Spoke with four patients who were using the service.

• Spoke with four relatives / carers of patients.

• Observed interactions between staff and patients using the service, including observing the support given to patients at lunchtime.

• Attended a clinical team meeting.

• Reviewed the care records of seven patients.

• Reviewed the prescription and medical administration charts for eight patients.

• Looked at policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

We spoke with four patients. Three of them were positive about Oakwood House. We spoke with four relatives of patients. They were all positive about the care provided by Oakwood House.

Most people told us that they felt staff were nice and were caring towards them or their relative. They told us that the staff were good at responding to their physical health needs. Most people told us they were involved in decisions about their care and understood what their goals were. One person felt they did not always get the support they needed from staff and had to wait.

When we asked patients and their relatives/carers which areas could be improved, we received the following suggestions:

- The laundry could be quicker
- People would like more outings into the community
- More staff would improve the support people received
- It would be nice to be supported by a carer of the same gender during personal care.

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:

• The service was not managing the medication for people in a safe manner. Staff had not always completed the medication administration records correctly.

• The hospital did not have a female only lounge.

• The therapy room did not have a sink. This meant it would be hard for staff to manage the risks of infection control.

• The patient alarm system was not being used consistently.

• The service did not have a formal policy or plan for medical emergencies including seizures.

• Staff were not aware of where all of the equipment required in an emergency was stored.

• The service did not have any ligature cutters.

• The service was using 'time outs', which involved people spending time in their rooms. The use of this was not monitored centrally and there was no policy in place detailing when it should be used. The safeguards were not in place to ensure people were not sanctioned inappropriately.

• Staffing was adequate to meet the needs of patients, although staff expressed the opinion to us that they felt under pressure due to the high needs of patients.

• Staff were aware of how to report incidents and these were investigated. However, the service was not monitoring trends in incidents to identify potential learning.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

• Staff were not always assessing all the needs of patients. In the files we reviewed some assessments had not been completed.

• The service did not clearly demonstrate how it followed potentially relevant guidelines in the development of its model of care.

• Staff were not always assessing patients' capacity to make a specific decision when it may have been appropriate to do so.

However:

Summary of this inspection

• The hospital had a comprehensive multidisciplinary team. Staff from different professional backgrounds felt able to express their professional opinion.

• The management have recently improved the system for ensuring staff receive formal supervision sessions.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

• The language used on signage was sometimes paternalistic

• The service had collected some feedback from patients. However, it had not yet done this regularly.

However:

• Patients and relatives told us they felt the staff were caring and respectful to them. Staff we observed supporting people treated them in a respectful manner.

• We found that people were usually involved in the development of their care plans, although some plans we reviewed did not clearly record this.

Are services responsive?

Good

We rated responsive as good because:

• Staff sought to respond to patients' individual needs. Staff provided a wide range of activities to support people.

• Culturally specific food was provided.

• The service sought to support people with their spiritual needs.

• Complaints were responded to, although the responses could be more detailed.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

• The service did not have an effective system in place to ensure that it met the standards.

• Audits and quality checking were not being completed on a regular basis.

• Staff had not completed risk assessments and associated plans for all patients.

• Staff had not ensured they had assessed a person's capacity to make a decision appropriately.

• Monitoring of the environment had not identified that staff were unaware of where emergency equipment was held.

Summary of this inspection

• There were limited audits with regards to quality. Where these had been undertaken, for example in medicine management, they had failed to identify failings.

However:

• The service had undertaken many recent improvements, including introducing new systems for monitoring the service.

• Management were keen to improve the quality of the service.

• Most staff were happy working at the service, although some staff felt under pressure.

Detailed findings from this inspection

Mental Health Act responsibilities

• At the time of the inspection there was no patient who was subject to the Mental Health Act (1983).

• There was a notice displayed on the door informing informal patients of their rights.

• Information on advocacy services was displayed on the notice board in the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

• We found variation in the application of the Mental Capacity Act (2005). The provider must ensure that appropriate and decision specific capacity assessments are completed whenever they are required.

• The staff at Oakwood house varied in their knowledge of the MCA. Some staff we spoke with demonstrated a very strong understanding of when an assessment may be required, although others were less clear.

• Three patients were subject to deprivation of liberty safeguards to restrict their liberty.

• Staff had completed some good examples of capacity assessments. For example, one person there was a clear capacity assessment/best interests decision making process recorded regarding refusal to eat soft diet. Family involvement was recorded and a plan had been put in place following the best interests meeting.

• However, we also found other examples which were not decision specific. For example, one patient was receiving their medication covertly. Although a Mental Capacity Act assessment dated September 2014 was on their file, this did not refer to medicines or their being covertly administered.

• For another patient, the notes recorded examples of the person being restricted from leaving, but they were not subject to the Mental Health Act or deprivation of liberty safeguards authorisation. This meant there had been deprived of their liberty without the necessary legal framework to protect them.

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Inadequate

Our findings

Safe and clean ward environment

• The hospital did not have a female only lounge. There were nine single bedrooms, none were en-suite. Males and females were not segregated. There were three bathrooms, these were not single gender. CQC now expects that a service of this type would be single gender guidance.

• Most patients were wheelchair users. The hospital was wheelchair accessible. There was a lift to enable people to access the upper floors.

• The hospital was clean. A housekeeper worked every day and followed a schedule to ensure each area of the hospital was clean. Cleaning equipment was available for them to use.

• Patients were examined on the bed in the ground floor therapy room. There was no sink in this room. This could present an infection control risk. This room had frosted windows, although these did not afford full privacy.

• The clinic room was not well organised. The defibrillator and oxygen were held separately in building. When we spoke with staff they were unaware that oxygen masks with tubing were not being held in oxygen bag or where they were. The designated medication nurse alone had access to the room where oxygen was stored. This could compromise on speed and delivery of care in an emergency.

• The service had completed an environmental risk assessment in March 2015.

• The service did not have any ligature cutters. Some patients at the hospital had an identified suicide risk. The failure to have proper ligature cutters available for staff could put people at risk of injury.

• Staff told us they could get specialist equipment if they needed it and that management were very responsive to any requests for equipment.

• There were no nurse call buttons/alarms in bedrooms, although patients are given a portable alarm to wear around their neck or on their wrist. Not all residents were observed to be wearing these during our inspection. Patients were able to access bedrooms during day, which was not always observed by staff. This meant patients could be at risk of injury.

Safe staffing

• There were adequate staff to ensure people were safe. However, some staff and patients expressed the opinion that they felt staff were under pressure due to the high needs of the patient group.

• The service has a nurse working on all shifts. In addition there would be three rehabilitation assistants during the day and two at night. If extra staff were required for 1:1s these were booked.

• On the day of the inspection five rehabilitation assistants working. Three supporting all the patients, one escorting a person in the community, one on 1:1.

Requires improvement

Services for people with acquired brain injury

• In April 2015 there were 4.2 (whole time equivalent) qualified nurses and 10.5 (WTE) rehabilitation assistants, with a vacancy for 0.2 (WTE) qualified nurses and 2.5 (WTE) rehabilitation assistants.

• When we spoke with patients and their relatives they told us that staff were very caring, but they felt they were under pressure due to their numbers. Some people felt they had limited opportunities to access the community due to staff numbers

• The service has a staffing bank. If they could not source a staff member through this they would book agency staff. In the three months prior to April 2015 140 shifts had been filled by bank or agency staff. There were two shifts which they had been unable to cover.

• Staff received an induction before working on the ward.

• Staff sickness was low. In the previous 12 months sickness had been under 1%.

• Nursing handovers are completed daily.

• Staff had received their mandatory training. This included training on managing violence and aggression.

Assessing and managing risk to patients and staff

• Management of medications was unsafe. We looked at the medication administration records for eight patients at the hospital, audits and records relating to medicines, medicines held in the hospital and their storage, the medication policy for Oakwood House and talked to the manager and nurses. Some patients were not receiving their medicines as prescribed and some patients were at risk of receiving an incorrect dose of medicine as changes to patients' doses were not accurately recorded on the medication record by the prescriber.

• For three patients we found that their medication had either been incorrectly recorded or administered. The medication record for one patient recorded that a medication should be administered twice a day. The administration record had only been signed once daily. For a second patient, an increase in the patient's medication had been recommended, but this had not been administered. For a third patient, the dose prescribed was not recorded on the administration record and the patient was at risk of receiving an incorrect dose.

• Although staff had undertaken some audits of medications, these had been infrequent and had not identified any of the problems with the medication charts our inspection found.

• The service did not have a formal policy or plan for medical emergencies including seizures. The consultant had identified this as a need because staff had not always responded appropriately in emergencies.

• Staff had recorded that they had restrained people three times in the last year. Staff were trained in managing aggression. The service was using 'time outs', where people would spend time in their rooms, if they continued to be disruptive following two warnings. The use of this was not monitored centrally and there was no policy in place detailing when it should be used and the safeguards were not in place to ensure people were not sanctioned inappropriately.

• Personal protective equipment, such as gloves, was available for staff to use whilst supporting people with the personal care needs. Staff were observed to use this appropriately.

• Staff were trained in safeguarding. Staff we spoke with understood safeguarding and when to report a concern. There was no named safeguarding lead. However, all staff spoken to said they would speak to the nurse in charge or the manager regarding a safeguarding concern.

Track record on safety

• The service had reported five serious incidents requiring investigation in the last year. These were all the incidents are related to Type 4 (allegations, or incidents, of physical abuse and sexual assault or abuse).

• These had been reported and investigated by the service. We reviewed two of these investigations. In both the allegation had not been upheld.

Reporting incidents and learning when things go wrong

• The service had an incident form, which staff had to complete when there was an incident. The manager would then review these forms and decide on any appropriate response.

Requires improvement

Services for people with acquired brain injury

• Staff were aware of the need to report incidents. All staff were able to describe the incident reporting process and give examples of incidents which had occurred. Staff said they received information about incidents in handover sessions.

• The manager kept a file of incidents. The documentation in here showed incidents were reported and post incident actions were identified and change implemented. However, the service was not reviewing trends in incidents to see if any further learning could be identified.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Requires improvement

Our findings

Assessment of needs and planning of care

• We reviewed the nursing assessments in five patient records. We found variation in the quality of these. Some assessments were completed to a high standard, with appropriate plans put in place. For example, one person had a specific care plan regarding their dysphagia developed with the speech and language therapist. However, staff had not consistently completed the assessments fully. For example, for one person the assessments had not been completed for mobilisation, sleeping or communication. For a second patient there was no assessment of their social needs.

• We reviewed four records to assess the medical input regarding people's physical health. These showed the consultant physician had reviewed all four patients regularly. Where appropriate, referrals had been made to other services. However, in one file we noted that a note had been made for the psychiatrist to follow up a review of anti-depressants for a patient. The notes did not record whether this had been undertaken.

• In the four patient notes we reviewed for their medical involvement, only one had a face-to-face interview and mental state examination with the consultant psychiatrist recorded during their admission. Although, the consultant was involved in discussions at clinical team meetings, the notes did not clearly demonstrate how they were directly monitoring the mental health of patients on an ongoing basis.

Best practice in treatment and care

• There are currently no specific NICE (National Institute for Health and Care Excellence) guidelines with regards to brain injury rehabilitation. When we spoke with the consultant he noted he was working with colleagues to develop consensus guidelines with regard to the patient group. However, it was not clear how other potentially relevant guidelines, such as the NICE guidelines on stroke neuro rehabilitation, or the Royal College Physicians / British Society Rehabilitation Medicine joint guidelines on brain injury neuro rehabilitation, were informing the current model of care provided.

• Data was being collected on outcomes in terms of HoNOS (Health of the Nation Outcome Scale). However, there was limited evidence recorded of how these scores were being used.

• We reviewed four files with regards to their development of goals. In none of the files was it clearly recorded what the goal was and what the outcome of this would be. For example, when this goal was achieved a conversation with regards to discharge planning would be triggered.

• The psychologist undertook neuro-psychological assessments using orientation logs and cognitive logs. These were then used with other assessments in the development of individualised plans for each patient.

• Physical healthcare was monitored by a physician who attended once a week. The service also had access to a local GP.

Skilled staff to deliver care

• The provider had recently introduced a new system to ensure staff received formal supervision sessions and an annual appraisal. In evidence provided before the inspection only 15% of staff had undertaken an annual appraisal. At the inspection nearly all staff had completed the appraisal.

• Staff had recently started receiving more regular supervision sessions.

Requires improvement

Services for people with acquired brain injury

• Some specialist training had been arranged for staff, such as a session planned regarding personality disorder, but not all staff had received this yet. The service should ensure that staff receive specialist training in the needs of the patient group and how to support this,

• The psychologist ran a weekly reflective practice session for the rehabilitation assistants. This gave staff an opportunity to reflect on the challenges of the role. Rehabilitation assistants we spoke with told us they appreciated this session.

• Where appropriate, members of staff, such as the psychologist, were receiving professional supervision from supervisors external to the organisation.

Multi-disciplinary and inter-agency team work

• The hospital had a comprehensive multidisciplinary team (MDT) to support patients. The team included a physiotherapist, an occupational therapist, a psychologist, a consultant in rehabilitation who attended weekly to monitor patients' physical health, a consultant psychiatrist, nurses, a speech and language therapist, and a music therapist once a week.

• The team had a weekly clinical meeting, where the whole MDT met. We observed this meeting, which was facilitated by the consultant. There was a clear open dialogue, with different specialities able to raise concerns and contribute to the care plan.

• Staff from different specialities told us they felt their professional opinions were respected and they were able to contribute to patients' care plans.

• The nursing team had a twice daily handover, between shifts. There was also a daily therapy handover, where any issues from the previous day were discussed.

• Care co-coordinators were invited to review meetings.

Adherence to the MHA and MHA code of practice

• At the time of the inspection there were no patients subject to the Mental Health Act.

• The consultant, who acted as the responsible clinician when patients were subject to the mental health act, was also the owner of the hospital. The Mental Health Act Code of Practice (updated 2015) 39.4 states that "…where a patient is to be admitted to an independent hospital and the doctor providing one of the medical recommendations is on the staff of that independent hospital, the other medical recommendation must be given by a doctor who is not on the staff of the independent hospital".

• There was a notice displayed on the door informing informal patients of their rights.

• Information on advocacy services was displayed on the notice board in the service.

Good practice in applying the MCA

• The staff at Oakwood house varied in their knowledge of the Mental Capacity Act. Some staff we spoke with demonstrated a very strong understanding of when an assessment may be required. Others were less clear.

• Staff were not able to describe how recent case law relating to the Mental Capacity Act, such as the "Cheshire West" judgement, impacted on their practice.

• Four patients were subject to deprivation of liberty safeguards authorisations which provided them with legal protection while they were being deprived of their liberty

• We found variation in the application of the Mental Capacity Act. Staff had completed some good examples of capacity assessments. For example, for one person there was a clear capacity assessment/best interests decision making process recorded regarding refusal to eat soft diet. Family involvement was recorded and a plan had been put in place following the best interests meeting.

• For one patient, the notes recorded examples of the person being restricted from leaving, but they were not subject to the Mental Health Act or an authorisation according to the deprivation of liberty safeguards. This meant there was a risk this person may have been deprived of their liberty without the protection of a legal framework.

Are services for people with acquired brain injury caring?

Requires improvement

Our findings

Kindness, dignity, respect and support

• We spoke with four patients. Three of them were positive about Oakwood House. We spoke with four relatives of

Requires improvement

Services for people with acquired brain injury

patients. They were all positive about the care provided by Oakwood House. Most told us that they found staff to be caring and respectful of them. Comments included "staff are nice and helpful" and "very caring staff […] they know how to deal with X [their relative]"

• Staff we observed interacting with patients were kind and considerate of their needs. At lunchtime people who required support with eating received this help.

• When we observed the clinical team meeting, staff demonstrated a good knowledge of the patients' personal history, background, and the social and cultural context of their presentation. Staff demonstrated an open-mindedness of this without prejudice.

• However, some language used on signs displayed was not always respectful of patients and was paternalistic. For example, one poster noted "No demanding staff attention, especially if the member of staff is working with another patient – it is important for everyone to turn take." It also noted that "Breaking these rules will result in two warnings will be followed by a time-out period of 20 minutes to be spent in your room."

The involvement of people in the care they receive

• Each person had an information folder in their room. This included a copy of their care plan if they wished to have it. The patient guide and information on the complaints procedure were also included.

• We reviewed the care plans for five patients. There was variation in the involvement of people in the development of these. Staff had clearly taken effort to involve patients in the development of some plans. For example, for one patient with limited communication skills, it was recorded they had signed to agree. However, in some plans it was not clear if they reflected the views of the patient, as this was not recorded.

• When we spoke with relatives they told us they were invited to be part of reviews. However, in the notes we reviewed it was not clear how families had been formally involved in these, especially with regard to future discharge.

• The hospital held house meetings about once a month. The meetings included discussions with regard to food choices, activities available, and the ongoing management of the hospital.

• Information on advocacy services was displayed in the unit.

• The service had completed two patient satisfaction surveys in the last year. One asked about food specifically; the other survey was a general survey. The manager had identified the need to increase feedback from patients in the running of the hospital.

Are services for people with acquired brain injury responsive to people's needs?
(for example, to feedback?)

Good

Our findings

Access, discharge and bed management

• The service received referrals from a wide catchment area. Prior to admission the patient would be assessed to ensure they met the criteria for the service.

• The provider also had two other services, for people with lower levels of needs. Patients could be transferred to one of these services if required.

• Staff had not clearly planned discharge throughout a patients stay at the hospital. In the files we reviewed clear goals to move towards discharge had not been identified.

The ward optimises recovery, comfort and dignity

• There was limited space on the ward. This meant that if a patient wished to have privacy they would need to go to their bedroom.

• The hospital had a garden, which patients could access.

• Patients were able to personalise their bedrooms with their own possessions.

• The service had a regular activities programme. Activities included creative writing, art group, and music therapy. A theatre group also visited to perform plays. However, there was limited therapy at the weekend.

• On the day of our inspection, patients were being supported to undertake visits to the local community.

Meeting the needs of all people who use the service

Requires improvement

Services for people with acquired brain injury

• Most patients in the hospital used wheelchairs. The building was wheelchair accessible and had a lift to access the upper floor. The service had recently bought a car Staff had been trained in transferring people to the car to enable them to access the community more regularly.

• Staff sought to support people to meet their spiritual needs. For example, one person was being supported to attend the local church.

• The provider sought to provide culturally specific food where possible. It had recently completed a survey regarding the food options.

Listening to and learning from concerns and complaints

• People knew how to complain to the service. Information was displayed on how to complain in the main lounge. The service also provided information to people as part of their pack, which was kept in their room.

• The service displayed information on advocacy services, to support patients if they needed any support in raising a concern.

• The service had received eight complaints in 2014 and three in 2015. The subject of these varied and there was no clear theme. We reviewed the file for complaints and saw that these had been responded to promptly and people had received written responses where appropriate. However, in some cases the responses were short and did not give a full explanation of the investigation undertaken. The service should ensure that all complaint responses give a full explanation of the investigation undertaken.

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

Requires improvement

Our findings

Vision and values

• The service had a wide ranging multi-disciplinary team and staff we spoke with felt they were able to express their professional opinion.

• The consultant noted he was working with colleagues to develop consensus guidelines with the regard to the patient group. However, it was not clear how other potentially relevant guidelines were informing the current model of care provided.

Good Governance

• The service did not have an effective system in place to ensure that it met the standards.

• The hospital had recently employed an external consultant to develop their governance system. This person had developed an action plan and a number of improvements had been made, such as the development of clinical governance meetings, which had been introduced just before the inspection, and improvements in the uptake of supervision.

• However, there were a number of areas where concerns had not been identified.

• Staff had not completed risk assessments and associated plans for all patients.

• Staff had not ensured they had assessed a person's capacity to make specific decisions appropriately.

• Monitoring of the environment had not identified that staff were unaware of where emergency equipment was held.

• The system for auditing medicine handling was not robust. In 2015 there had been one audit. This identified issues and action taken, for example a missing photograph on the medication chart for identification, but did not check the accuracy of the medication records. The hospital's policy stated that audits should be carried out monthly but the manager said that none had been done in January, February or April 2015.

• There was limited auditing of outcomes or quality being undertaken. In the previous six months to the inspection the only audits completed were a medication audit, a documentation audit, a patient satisfaction survey and a food satisfaction survey. This meant there was limited opportunity for staff to identify where improvements could be made.

• All staff had been undertaken disclosure and barring service checks.

Leadership, morale and staff engagement

Requires improvement

Services for people with acquired brain injury

• Most staff we spoke with were positive about working at the hospital and felt well supported. However, some staff told us they felt under pressure and that it was hard to raise concerns.

• Staff had not completed a feedback survey.

• Staff team meetings were not happening regularly. Some staff told us they would appreciate these being more regular.

• The sickness rate amongst staff was under 1%.

• The registered manager left the service shortly after our inspection visit. We were informed the consultant psychiatrist was managing the service until a new manager was appointed.

Outstanding practice and areas for improvement

Outstanding practice

Good Practice

• The service had a comprehensive multi-disciplinary team with staff from a wide range of disciplines relevant to neuro-disability rehabilitation.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that staff:

• Assess the capacity of patients to consent to decisions and record these assessments in all cases.

• Fully assess the nursing and care needs of all patients.

• Are aware of where emergency equipment is stored. Appropriate equipment, such as ligature cutters should be made available.

• Manage medications safely. Patients were not receiving their medicines as prescribed and some patients were at risk of receiving an incorrect dose of medicine because staff did not accurately record changes to patients' doses on the medication record.

• It develops a policy regarding its use of 'time outs' to ensure people are not sanctioned inappropriately.

• Put in place an effective system or process to assess, monitor and improve the quality and safety of the services provided.

• There is a female only lounge.

Action the provider SHOULD take to improve

The provider should ensure that:

• The system for using personal alarms is clear.

• All responses to complaints give a full explanation of the investigation undertaken.

• Staff receive specialist training in the needs of the patient group and how to support this.

• Staff continue to receive regular formal supervision.

• It clearly demonstrates how it follows relevant guidelines in the development of its model of care.

• Staff are clear on how to respond to medical emergencies.

• Staff do not use paternalistic language when writing signage.

• It reviews trends in incidents to see if any further learning could be identified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment for patients who were unable to consent because they lacked the capacity to, was not always in accordance with the Mental Capacity Act (2005). We found examples where a patient's capacity to consent to a decision had not been assessed appropriately. The provider was failing to meet regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not assessed all the risks to the health and safety of service users of receiving care and treatment or ensured that care and treatment was provided in a safe way for patients. It had failed to ensured that all patients had been fully assessed for all risks and plans put in place to mitigate these risks. The provider was failing to meet regulation 12 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Not all premises and equipment used by the service provider was suitable for the purpose for which they were being used or appropriately located for the purpose for which they were being used. The service did not have any bespoke ligature cutters. The oxygen was kept separately to the emergency equipment.

The provider was failing to meet regulation 15 (1) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not have an effective system or process to assess, monitor and improve the quality and safety of the services provided. The provider was failing to meet regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not always treated with respect and dignity. Some communication with people was not respectful. The service did not ensure the privacy of service users. there was not a female only lounge. The provider was failing to meet regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Systems and processes had not been established and operate effectively to prevent abuse to service users. The service did not a have policy in place to detail the rationale and protections for people through use of 'time outs'.

The provider was failing to meet regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was note provided in a safe way for service users. The management of medications was not proper or safe. Some patients were not receiving their medicines as prescribed and some patients are at risk of receiving an incorrect dose of medicine as changes to patients' doses were not accurately recorded on the medication record by the prescriber. The provider was failing to meet regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.