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

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?	Good
Are services responsive?	Requires improvement
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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

We rated The Olive Carter Unit as requires improvement overall because:

- Fire doors at the service did not have door closures as they were highlighted as a risk to patients and removed by the service. They had not been replaced in a timely manner; this left patients at risk in the event of a fire. We saw that two of the communal toilets within the ward were visibly soiled.
- Although staff had training on percutaneous endoscopic gastrostomy (PEG) feeding there were no protocols in place to support staff when completing the task.
- We saw during our inspection, a patient taken to their room and staff prevented them from leaving by holding on to the door handle. This was contrary to the training provided by the service. There was no specific care plan to support this type of seclusion.
- Mental Health Act training did not form part of the service mandatory training. Staff were provided with ongoing training from consultant psychiatrists on specific staff training days. Staff signed a record of attendance to provide the service with completion rates.
- Risk assessments were not always updated.
- The lift needed to be replaced and was not in use at the time of the inspection. The manager informed us that the service had developed a plan to replace the lift.
- Staff did not always record fridge temperatures accurately.

However;

- The ward was well equipped, well-furnished and fit for purpose. The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- The ward had a good track record on safety. The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Summary of findings

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

Summary of findings

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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 Hunters Moor Residential Services Limited and is in a residential area of Birmingham. The unit specialises in neurobehavioral rehabilitation for men and women over the age of 18 years with a primary diagnosis of acquired brain injury. This includes those whose rights are restricted under the Mental Health Act 1983.

The unit provides services for up to ten patients and as a specialist challenging behaviour unit, patients come from a wide geographical area. Commissioners where patients ordinarily reside commission the service.

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 comprehensive inspection was on the 27 and 28 September 2016 where the provider was in breach of the following regulations; regulation 9-person centred care and regulation 12 Safe care and treatment, Health and Social Care Act 2008 (regulated activities) Regulations 2014. We told the provider what they must do to improve the service which included the following;

- Ensure all patients' own medication is labelled and has the correct amended expiry dates on insulin vials.
- All patient own medication administered to the patient must be recorded on the medicine administration chart.
- All staff must be trained in monitoring fridge temperatures and know what actions to take when temperatures are not at a safe limit. Also ensure the fridge was not overstocked preventing the fan from circulating cool air.
- Care plans must have involvement from patients and reflect their preferences. Also, it must show whether patients had been offered a copy of their plan.
- The provider should ensure all staff including bank staff complete mandatory training. This included deprivation of liberty safeguards and Mental Capacity Act training.
- All staff should receive training for personality disorder as identified in the services training needs analysis.
- All outcomes for the second opinion doctor should be communicated to the patient and documented.
- Information on the role of the Care Quality Commissions role in reviewing complaints should be displayed.
- The training kitchen should be entirely for the use of patients and not used as a staff kitchen.

The follow up inspection on the 3 November 2017 found the provider had addressed the issues which lead to the breaches. Since the last inspection, the service has had a new registered manager who has been in post from July 2018.

Our inspection team

The team that inspected the service comprised four CQC inspectors, team leader a medicines inspector, one Mental Health Act reviewer, a nurse specialist advisor and one expert by experience. An expert by experience has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Summary of this inspection

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?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited 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 registered manager and managers for the unit
- spoke with 15 other staff members; including doctors, nurses, rehabilitation assistants and occupational therapist
- attended and observed one multi-disciplinary meeting
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management on the unit

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to two patients who were generally complimentary about staff. They expressed a dislike of the food served at the Oliver Carter Unit. One person told us that they did not feel safe because of the behaviour of other patients on the unit.

We were provided with contact details for two carers, however, were unable to make contact with them.

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:

- We saw that a patient had been secluded in their bedroom despite the service not having a seclusion policy or supported the seclusion of patients in their bedrooms.
- Fire doors at the service did not have door closures therefore leaving patients at risk in the event of a fire. The service had not replaced the doors in a timely manner after removing the door closures when they were highlighted as a ligature risk.
- Staff did not update all risk assessments in clinical files or as part of patient's section 17 leave.
- Although staff had training on percutaneous endoscopic gastrostomy (PEG) feeding there were no protocols in place to support staff when completing the task.
- Two communal toilets used by patients within the ward were visibly soiled.
- All patients had three sets of patient files they had large amounts of documents that made it difficult to find information. Not all patient files were kept in the same building two files were kept in the adjacent Janet Barnes unit.

However;

- All wards were well equipped and well-furnished.
- The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Although the service had detained patients under the Mental Health Act, they did not have Mental Health Act training as part of their mandatory training.

However;

Summary of this inspection

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented.
- Staff provided a range of care and treatment interventions suitable for patients with a diagnosed brain injury and consistent with national guidance on best practice. This included access to support for self-care and the development of everyday living skills. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Access to some parts of the building were restricted for those who required disabled access as the lift had been out of service for some time. Managers said arrangements had been made to replace the old lift with a new one. However, we were not provided with a timeframe of when the work would be completed.

However:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed.

Summary of this inspection

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.
- Facilities were available for patients to make hot and cold drinks and snacks at any time.
- The ward met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Our findings from the other key questions demonstrated that governance processes did not always operate effectively. Not all meetings were consistent or structured. Clinical governance meetings did not always take place consistently.
- There was limited evidence that staff engaged actively in local and national quality improvement activities.

However:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Although not all staff could recall the visions and values of the organisation, it was displayed in their everyday work with the patients. Such as promoting well-being and healthier lives.
- Staff felt respected, supported and valued. We saw that the provider promoted equality and diversity in its day-to-day work and staff told us they provided opportunities for career progression. They felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Health Act responsibilities

The service did not have the Mental Health Act as part of their mandatory training. Staff told us that ongoing Mental Health Act training was delivered by the consultant to all staff on specific staff training days. Staff signed attendance sheets for proof of attendance, which up to July 2019 showed eleven staff had attended the training.

The service had up to date accessible, relevant policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff and patients told us staff always facilitated section17 leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw in records of detained patients completed SOAD assessments. However, there was no evidence of reviews of treatment being completed by the responsible clinician under section 61 of the Mental Health Act 1983.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with, training in the Mental Capacity Act. The service reported staff completion rates of 85 percent.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff told us they were able to obtain support and advice concerning Mental Capacity Act from the nurse manager.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff said and we saw psychologists completed capacity assessments documented in patients' care plans. Best interests' assessments were also completed.

Staff made applications for a Deprivation of Liberty Safeguards authorisations only when necessary and monitored the progress of these applications. The service had a co-ordinator to oversee the applications made to the local authority and the progress. They also monitored and informed managers when authorisations were due to expire.

CQC have made a public commitment to reviewing provider adherence to Mental Capacity Act and Deprivation of Liberty Safeguards.

Requires improvement

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Inadequate

Safe and clean environment

The ward was well equipped and well furnished.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all the care environment and removed or reduced any risks they identified. The service completed health and safety assessments and fire risk assessments that were up to date. The most recent health and safety assessment completed 7 August 2019 was completed in conjunction with an external agency. It identified fire doors were not able to close by themselves. This was because the service had removed the door closers as it posed a ligature risk as identified in the ligature audit of June 2019. The service removed them with a view to replacing them as per audit request within one week. On the day of inspection, we found fire doors in the corridors of the unit were open and door closers had not been replaced. We spoke to the unit manager, who explained they had tried to replace the door closers with spring locks but found they were not appropriate. The operations manager and estates manager explained they had to complete a detailed fire door survey. This would support them to identify the correct fire doors for the service. They were hoping to do this within the next two weeks, with a view to installing the new doors in October or November 2019. This meant during this time the service and those using it would be at risk if a fire were to occur. The fire doors were unable to close to contain the fire and would allow it to spread to other parts of the unit more quickly. We asked the managers what they were doing in the meantime to mitigate the risks. Managers explained that during this time they completed observations throughout the day. They ensured that at night staff were divided and based both upstairs and downstairs at all times to complete observations.

Staff could observe patients in all parts of the unit. The service had mirrors throughout the unit at blind spots. The service had anti ligature furnishings and where there were ligature risks, they mitigated with observations.

The unit complied with guidance and there was no mixed sex accommodation. The unit had sperate sleeping areas for both male and female patients and all rooms were ensuite. On the day of the inspection the service users were all male.

Staff had easy access to alarms and patients had easy access to nurse call systems. We asked the managers for evidence concerning the monitoring of alarms. We were provided with information stating when batteries should be inspected with a signing in and out sheet and evidence of when batteries had been changed. We heard the alarms being used during the day of the inspection and staff responded appropriately.

Staff tested fire alarms weekly and performed six monthly fire drills which they recorded.

Maintenance, cleanliness and infection control

Areas within the unit were not always clean. We saw that two of the communal toilets were visibly soiled. Patients we spoke with told us that they found the unit was not always clean. However, the furnishings were well maintained and fit for purpose.

Cleaning records were completed and up to date, cleaning staff attended the unit daily and were present during the inspection.

Staff followed infection control policy, which included handwashing. The service had certificates to confirm the water supply was checked regularly by an outside agency for legionella. The last certificate was dated 13 September 2019.

Safe staffing

The service had enough nursing staff of relevant grades to keep patients safe. Managers explained staffing ratios were based on NICE guidelines for inpatient units. The service had a total of twenty-two qualified and unqualified substantive staff. They recruited permanent bank staff who were recruited on zero-hour contracts.

Managers explained there was one vacancy for qualified night staff, the vacancy had been advertised and interviews were due to begin the following week. There were no vacancies for rehabilitation assistants. The service used regular bank and agency staff to cover observations on the unit. They also rostered staff from their neighbouring unit who had experience of working with the service user group to work night shifts.

Managers could adjust staffing levels according to the needs of the patients. On the day of our inspection the unit was staffed by six rehabilitation assistants, the unit lead and one agency qualified nurse who was covering sick leave. The unit manager told us they could adjust staffing figures as required and would often do this to cover patient observations. There were two patients on two to one observation.

Between February 2019 and April 2019, the service reported the use of 30 bank staff and 30 agency staff of these 18 shifts were not filled.

The service reported one substantive leaver in the period between 4 April 2018 and 4 April 2019 and two percent of staff on long term sick leave.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The registered manager stated they were engaged in a program to reduce agency use to zero. They had worked with employment agencies to recruit to permanent positions and bank staff.

Managers explained bank staff were the same as the permanent staff the only difference was the contracts. The service only used regular agency and bank staff who were familiar with the unit and the service users.

The service reported a 50 per cent reduction in the use of agency staff between the periods of February 2019 and June 2019.

A qualified member of staff was always present on the unit. The service had one qualified staff member on the unit and the unit lead.

Staffing levels allowed patients to have regular one to one session. Staff said throughout the day they had contact with patients. Each time a care plan was reviewed patients could request to have a one to one.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. There were no reports from staff of cancellations of escorted leave or activities on the unit. One patient we spoke to said they had escorted leave from the unit weekly which always happened. However, another patient said there was not enough staff to take them to their activities in the community. They explained that staff had informed them there were not enough staff to complete the activity.

The service had enough staff on each shift to carry out any physical interventions safely. Staff reported there were always enough staff to carry out physical interventions when required.

Medical staff

The service had daytime and night-time medical cover and a doctor available to go to the unit quickly in an emergency. The service had a consultant who attended the unit once a week to conduct patient reviews. Staff said the doctor was flexible and could attended the unit if required day or night. There was medical cover for the consultant to cover annual leave and sickness.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Staff received mandatory training through a

combination of e learning and face to face training by external trainers, clinical and non-clinical trainers. Managers explained mandatory training took place in the first two weeks of every month.

Managers monitored mandatory training and alerted staff when it required updating. The service had a coordinator who maintained an electronic training spreadsheet and completed monthly audits for managers to view. They used a red amber green system to indicate when staff were either up to date with training, nearing refresher dates or when training had expired and needed to be updated. Managers stated when completion rates fell below the required level additional training would be implemented for staff to attend. Staff had the option to attend on their day off for which they were paid or in work hours. Where staff opted to attend training in work hours managers ensured there was enough staff to cover.

At the time of the inspection the service reported an overall average completion rate for mandatory training of 85 percent. The highest completion rate was for the physical intervention and restraint reduction course at 100 percent. The service stated mandatory training figures were correct and up to date at the time of the inspection. Mental Health Act training was not included in the service mandatory training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks for patients and completed risk assessments on admission. We looked at six sets of patient records, which had detailed clinical risk assessments that were personalised. Staff used recognised risk assessment tools.

On admission patients were assessed using the Northwick park dependency score used in rehabilitation units. In the patient records we saw staff had completed Antecedence Behaviour Consequence (ABC) documentation. Staff fully completed the Antecedence Behaviour Consequence (ABC) documentation and they corresponded with the care plan and clinical risk assessments. Staff told us risk assessments were reviewed monthly or when required. However, three of the six risk assessments were not updated. Two had been updated in March 2019 and the other had the previous providers risk assessment in place. It did not appear to have been updated since the patient was admitted to the Olive Carter unit. The two patients detained under the Mental Health Act had no risk assessments linked to their leave completed by the responsible clinician. There was no pre or post risk assessment completed by staff documented in records.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff observed patients and followed procedures to minimise risks where they could not easily observe patients. We saw staff completing observation for patients. Staff told us they completed 15 minutes to 60-minute observations for patients. At the time of the inspection staff were completing two to one observation for two patients. Staff discussed observation levels in the multi-disciplinary team meetings and adjusted or decreased the levels of observation as required. Staff told us risks were also discussed at the daily hand over meetings and observation levels were reviewed.

One patient told us they did not feel safe on the unit. They explained they had been the victim of an assault on the unit by another patient and felt that staff had not managed it well.

Staff followed the service's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us they received training on searching patients and their bedrooms. If they had been alerted to a specific risk, they would complete health and safety room searches twice daily and complete documentation following the search.

At the time of our inspection the service did not operate a smoke free environment. Patients smoked in the garden. Staff told us they provided patients with smoking cessation for those who wanted to stop smoking.

During the inspection the service had one informal patient, however there was no sign at the front door informing informal patients of their rights to leave the unit. Access to and from the unit required an access code therefore service users were required to ask staff when they wanted to leave the unit. The access code was not given to patients. Staff said patients who wanted to leave the unit must be escorted by staff, this included informal patients. We looked at the care plan of one informal patient, there was no documentation of the impact of the locked door in the care plan. The service provided recorded evidence of when staff documented that they had given the patient their rights written or orally under the Mental Health Act 1983.

Staff at the unit participated in the provider's restrictive interventions reduction programme**.** The training matrix showed 100 percent completion rate. On the day of our inspection, we observed staff supporting a patient who had become agitated. Staff enabled the patient to go into their bedroom to prevent further agitation. However, staff then shut the door and prevented the patient from leaving their bedroom by holding the door handle for a few seconds, secluding the patient in the room. This was contrary to the service training provided for staff. In January 2019 similar concerns had been raised through safeguarding by the registered manager and a whistle blowing complaint to the Care Quality Commission was also received in April 2019. We were assured by the service that the registered manager had addressed the concerns by holding an investigation and subsequently held training refresher courses and meetings with staff. We also raised the recent issue we had observed with the manager who promptly addressed the concerns raised. We were provided with the services reducing restrictive practice policy which gave information relating to seclusion. The service did not have a seclusion policy or a seclusion room.

Staff told us they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff told us they always used verbal de-escalation first, however at times it became necessary to use physical restraint. One patient told us staff had recently restrained them after they had displayed aggression towards other service users. They felt staff managed the incident reasonably and gently.

The service did not have a seclusion room.

The service reported 63 incidents of restraint none of which were prone restraint.

Safeguarding

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The service made six safeguarding referrals between 31 August 2018 and 31 August 2019, of which all concerned adults.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. Staff gave us examples of safeguarding referrals they had made.

Staff kept up to date with their safeguarding training. The service reported a completion rate of 88 percent which was up to date at the time of the inspection.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke to said they would report any safeguarding concerns to the to the manager.

Staff access to essential information

The service used paper records. Patients had up to three ring binder folders as files. They were separated into Mental Health Act or Deprivation of Liberty Safeguard notes, therapy notes and clinical notes. The clinical notes remained on the Olive Carter unit while the other two were kept at the adjacent unit based within the same grounds. Staff told us information contained within the other two files were duplicated and put into the clinical notes so that all staff had the information required to support the patients.

Patient files were quite large and at times proved difficult to navigate. This was an issue we raised in the report following the inspection in September 2016, which was rectified in the report of November 2017. We spoke to the unit lead about this and were shown a document that provided information briefly concerning the patient. This included date of admission, diagnosis and risk. However, the details of risk were not detailed in that it did not explain how individual risks were managed. Managers showed us a white board with patient information that was shown to agency staff to update them on patients on the unit. They also showed agency staff the personal behaviour support plan and read me folder that also supplied up to date information concerning patients. .

In the minutes of the clinical governance meeting on the 30 September 2019, we saw discussions concerning patient files and the outcome from a recent external audit. The service stated clinical and therapy files would be revised and combined to improve the navigation for staff.

Managers audited patient records monthly, we looked at audits for July and August 2019, but we saw no analysis or outcomes from this. Other audits we viewed sent to us following the onsite inspection showed some outcomes to be addressed.

Records were stored securely.

Medicines management

Staff followed systems and processes when safely prescribing, recording and storing medicines. All medicines for the service were prescribed by the general practitioner. The prescribing of mental health medicines was through recommendations from the service's psychiatrist. The service used medicines administration records (MAR) to record the receipt and administration of medicines.

Staff did not have information directly available to them when administering medicines through percutaneous endoscopic gastrostomy (PEG) tube. We found where patients needed to have medicines administered directly into their stomach through a tube, medicine specific information was not immediately available to ensure safe administration. We found information from the speech and language therapists which informed staff about the process of administering medication through the tube. The information included how much water to use with medication when administering food through the tube. However, the information was not present with the medicine administration records (MAR) charts therefore not all staff would be informed on how to prepare and administer these medicines.

Staff followed the service covert administration protocol. However, the service had all but one of the necessary measures in place to ensure the safe administration of these medicines. There was no evidence that specialist advice had been sought to ensure medicines administered covertly remained effective. Staff managed controlled drugs effectively.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. However, there was no evidence that medicines prescribed to patients who had been detained under the Mental Health Act had been reviewed in line with the Mental Health Act 1983. Staff told us the general practitioner reviewed the physical health medicines and the service's psychiatrist reviewed the mental health medicines. We found no evidence of when these took place and whether communication between the GP and the psychiatrists formed an holistic approach to the review of all medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. All medicines were stored securely.

Staff measured and recorded fridge temperatures twice daily. Staff showed us how the temperatures of the fridge were measured and recorded. They recorded the ambient temperature 2.5 °C as the minimum which was in fact 1.7 °C and the maximum as the minimum temperature. The minimum temperature recorded may not be the actual minimum temperature. At the time of the inspection the contents of the fridge were not temperature sensitive.

Staff followed current national practice to check patients had the correct medicines.

When interim medicines were received into the service, we observed them being checked against the MAR charts but not against the original prescription/order form to check what had been dispensed was what had been prescribed.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. We saw information to support staff when administering medicines prescribed when required were mainly in place. The information we reviewed lacked person-centred details needed to be more person centred and in greater detail so that these medicines could be administered safely and effectively.

Track record on safety

The service reported no serious incidents in the last twelve months, April 2018 to April 2019

Reporting incidents and learning from when things go wrong

Information shared by the service reported a total of 26 incidents from July 2018 to October 2019. The incidents were a combination of assaults on staff by patients, slips

and trips. Incidents were discussed at the governance meetings, the minutes highlighted incidents such as absconding, pressures sore, and physical altercations between patients.

Staff knew what incidents to report and how to report them using the services incident reporting system. Staff reported incidents such as falls and injuries to staff or patients.

Managers debriefed and supported staff after any serious incident. Staff explained they received debriefs after incidents and supported patients with debriefs. Staff told us managers shared learning from incidents through training, emails and handover meetings. There was also a communication book where information on lessons learnt would be documented. Previously we have seen reports from managers concerning training they implemented as a result of an incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff could give examples of when they had apologised to patients and relatives and provided explanations.

Staff met to discuss the feedback and look at improvements to patient care this was evident in the minutes of the staff meeting.

There was evidence that changes had been made as a result of feedback. This included improvements to the environment in relation to the colour schemes at the unit and reflective lighting. The service reviewed specialist equipment for restraint to ensure there was less likelihood of a patient being injured in restraint. Increased training of conflict management for all staff to ensure additional assistance was available when required. Use of a music pod to assist in reduction of distress and potential aggressive incidents for one patient on Olive Carter unit.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Staff completed a comprehensive assessment of each patient either on admission or soon after. The service also completed assessments prior to the patient's admission to the unit. This was in preparation for their stay and to address support needs that needed to be put in place. The assessments included mental health, mental capacity and physical health assessments. We looked at six sets of care records. All patient records were based on the recovery model and a recognised framework for personal recovery.

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the unit. Staff told us patients physical health was monitored weekly unless otherwise advised by the medical team. We saw staff updated patient records with regards to physical care. This included, falls risk assessments, weight charts, national early warning signs (NEWS) and Waterlow scores which addresses risk of pressure sores.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. The service developed several care plans for patients based on individual needs. This included diet and healthy eating, observations, mobility, therapeutic activities, community leave and discharge planning. Some of the care plans we viewed were more for directional use for staff in supporting patients. However, we saw that staff did not review and update all care plans regularly.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for patients. Records we reviewed demonstrated the kind of care and treatment offered. This included interventions that delivered care in line with best practice and national guidance, such as conceptual framework for personal recovery in mental health, sensory modality assessment and rehabilitation tool SMART. Patients had group interventions and activities such as breakfast club, speech groups, walking and bike groups. Staff told us that there was no consistency with activities for the patients. Managers had addressed this and appointed an activities co-ordinator to work alongside the therapy team. Therapists also completed travel assessments to support patients to access and travel in the community safely.

Staff identified patient's physical health needs and recorded them in their care plans.

Requires improvement

Services for people with acquired brain injury

Staff made sure patients had access to physical health care, including specialists as required. We saw that staff referred patients to other disciplines to support them with their physical health such as the fracture clinic and general practitioner.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff used malnutrition universal screening tool (MUST) and food charts to support patients.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Staff told us they were encouraged to engage with therapists to learn about preparation of healthy meals for patients. Staff worked with patients to jointly agree a health action plan to address any health concerns they had and improve or develop healthier lifestyles. This included offering smoking cessation.

Staff used technology to support patients. Some therapy staff used electronic tablets in the sessions to support patient cognitive assessments.

Staff took part in clinical audits; we saw evidence of completed clinical notes audits and medication audits. Where issues were raised managers used results from audits to make improvements.

Skilled staff to deliver care

The service had a full range of specialists to meet the needs of the patients on the unit. This included qualified nurses, rehabilitation assistants, doctors, occupational therapists, psychologist, physiotherapist and speech and language therapists. The service also had access to a general practitioner.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The service ensured staff were supported to access training such as safeguarding, medication management, the care certificate and basic life support. The organisation had a head of nursing who undertook learning needs for staff and delivered training.

Managers gave each new member of staff a full induction to the service before they started work. The service provided all bank staff with an induction, training and shadowing of permanent staff. All agency staff received an induction and shadowed other staff. They were required to provide evidence of ongoing training through the agency. Managers completed an agency first shift check list to ensure all areas of induction had been addressed.

Managers supported staff through regular appraisals of their work. The service acknowledged previous issues with recording and completion of supervision, which at that time was sporadic. At the recent inspection on the 17 September 2019 information provided by the service gave clinical supervision completion rates of 75 percent as of the 1 June 2019. This was under their target of 80 percent. Staff told us they received regular supervision. Managers followed the service's guidelines of four supervisions per year. Allied health professional told us the provider paid for external supervision for any profession if required specific to their role.

Staff received reflective practice sessions with the therapist team. Staff either identified individual cases to be discussed or the therapy team selected a topic.

Managers ensured staff received a yearly appraisal. As of 1 June 2019, the service reported an overall appraisal rate of 75 percent. The service had recently hired new staff who were still in their six-month probationary period and therefore had not received an appraisal. The new staff would be reviewed and receive their appraisal in the following six months.

Staff attended regular team meetings. The manager rotated the times of the meetings so that they happened in the evening where night staff could also attend. Managers explained those who could not attend would obtain information from the "read me folder", memo files. Staff also had access to a monthly newsletter that provided updates about the service.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they had weekly continuous professional development and time was allocated for trained staff to complete their revalidation. Rehabilitation assistants had opportunities to develop skills by working with the therapy team. This supported staff to gain experience needed to apply for therapy roles when they became vacant. The service also provided training on percutaneous endoscopic gastrostomy (PEG) feeding to ensure staff were equipped to support a recent admission that required this treatment.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended one multi-disciplinary meeting. The team reviewed actions from the last meeting, they discussed the current circumstances of patient's home life and current inpatient support from the team. This included safeguarding, financial concerns, therapy input, observations, 117 meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff relayed and shared information with safeguarding teams, social workers, advocates and other disciplines as required.

The service had a nurses' forum held twice monthly and managers meeting every Monday where actions were emailed to all staff.

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

The service provided information of staff who had attended Mental Health Act training. Eleven staff had attended training in July 2019. The service did not have the Mental Health Act as part of their mandatory training. Staff told us that ongoing Mental Health Act training was delivered by the consultant to all staff on specific staff training days. Staff signed attendance sheets for proof of attendance.

The service previous Mental Health Act administrator had left; therefore, the registered manager covered the post. The service was in the process of advertising the vacant post.

The service had up to date accessible, relevant policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Noticeboards on the unit displayed advocacy services which included Mental Health Act and Mental Capacity Act advocacy. However, it appeared to be more for staff information than for the patients. The advocates visited the unit for care review meetings and when required. Patients who did not have family involvement were automatically referred to an advocate. However, we did not see evidence of informal patients and patients subject to Deprivation of Liberty Safeguards referred to advocacy.

Staff explained to each detained patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. However, it did not meet Code of Practice guidance as staff did not document the context of which they were reminding patients of their rights, for example, lay managers hearing or care programme approach meeting.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff and patients told us staff always facilitated section17 leave. However, one of the leave forms did not indicate if the patient or others including family member had a copy of the leave form. The leave form did not contain a contingency plan for the patient, staff or family to follow in case the patient needed to return to the unit early.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We saw in records of detained patients completed SOAD assessments. However, there was no evidence of reviews of treatment being completed by the responsible clinician under section 61of the Mental Health Act 1983.

Staff stored copies of patients' detention papers and associated records and staff could access them when needed. All detained patients had a Mental Health Act file where paper records of detained patients were kept. We checked the clinical records of patients and found duplicates of Mental Health Act documentation. Staff said this was due to the Mental Health Act files being kept in the Mental Health Act administrator's office in the adjacent unit.

The service did not have a sign at the front door informing informal patients of their rights to leave the unit and to ask staff when they want to leave the unit. We looked at the care plan of an informal patient which did not highlight the impact of the locked door on the informal patient.

The service had audits of scrutiny of Mental Health Act paperwork, completed when the Mental Health Act administrator was in post. The unit manager completed

the most recent audit on the 26 July 2019 for two patients, no issues were identified. The service issued policies to staff and practice guidance on what staff should do to safeguard the patient during their detention.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

At the time of our visit the service had four patients under deprivation of liberty safeguards. There had been five Deprivation of Liberty applications in the last six months September 2018 to April 2019.

Staff received and kept up to date with, training in the Mental Capacity Act. The service reported staff completion rates of 85 percent.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Staff told us they were able to obtain support and advice concerning Mental Capacity Act from the nurse manager.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. Staff said and we saw psychologists completed capacity assessments documented in patients' care plans. Best interests' assessments were also completed.

Staff made applications for a Deprivation of Liberty Safeguards only when necessary and monitored the progress of these applications. The service had a co-ordinator to oversee the applications made to the local authority and the progress. They also monitored and informed managers when authorisations were due to expire.

Are services for people with acquired brain injury caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We observed good interactions between staff and patients.

Patients we spoke with stated they got on with most of the staff and that they were polite. They treated them well and behaved appropriately towards them. Staff understood and respected the individual needs of each patient.

Staff directed patients to other services and supported them to access those services if they needed help. We saw in patient records evidence that staff connected patients with and provided access to external agencies. In the progress notes we saw staff had made arrangements for a patient to meet with an agency to obtain support with substance misuse.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients, without fear of consequences.

Involvement in care

Staff introduced patients to the unit and the service as part of the admission process. Staff told us patients were introduced to staff and other patients on the unit. They were shown to their room and provided with information about their stay at the unit.

Staff involved patients and gave them access to their care plan and risk assessments. We saw care plans were personalised, holistic and recovery-orientated and that patients had been involved in the completion of their plan. We spoke with two patients one told us they had a care plan and staff involved them in the planning of their care and had also involved their families and carers. The other patient stated they did not know what a care plan was. Staff documented in the patients records if they had been offered a copy of their care plan and whether the patient had signed it.

We were given inconsistent reports of patient's attendance at multi-disciplinary meetings. Some staff said patients were not invited to these meetings but would attend six to eight weekly review meetings with their inpatient and community teams. Others stated that depending on the issues to be discussed patients exercised their right to attend if they felt their needs were not being met, indicating that they were not routinely invited. We looked at seven minutes of multi-disciplinary team meetings and found that patients were not present at any of the meetings. Both patients we spoke to stated they had not

been invited to the multi-disciplinary meetings. One said they felt they had not been invited as they were outspoken, they spoke to their consultant informally when they attended the unit.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. The service had easy read information available for patients concerning the Mental Health Act and Mental Capacity act. However, we did not see any evidence of easy read care plans. One patient told us they did not know the names of their medication but knew the colours of each tablet and knew they took them because of their brain injury.

Staff used pictorial communication with one of the patients. There was also enlarged type face on leaflets for one of the patients to be able to see and read.

Staff involved patients in decisions about the service, when appropriate. Patients could give feedback on the service and their treatment and staff supported them to do this. Staff said they could also give feedback through the advocates. Patients had monthly meetings where feedback was provided. We saw the minutes of staff meetings were feedback from patients were discussed.

Staff told us patients who did not have family involvement were automatically referred to an advocate. Advocacy services also visited the unit for care review meetings as and when required. However, we did not see evidence of informal patients and patients subject to Deprivation of Liberty Safeguards referred to advocacy.

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

(for example, to feedback?)

Requires improvement

Access and discharge

The service reported bed occupancy as 60 percent from 1 September 2018 to 1 April 2019. The service had a national geographic catchment area therefore accepted patients from across the country.

Patients at the service had an average length of stay of between six to eighteen months. The longest stay up to 1 April 2019 was just over twenty-nine months. We spoke to the registered manager about this and they informed us that identified placements for the patient had not progressed as they could not meet the patient's needs. Managers and staff explained that delays in discharges from the service were due to reasons such as identifying a suitable placement for patients with acquired brain injury and behaviours that challenge. Relocation for patients back to their normal area of residence outside the Birmingham area was difficult to achieve. There were sometimes funding issues and difficulties in obtaining assessments for patients. We heard a discussion at the multi-disciplinary meeting around issues that may arise for a patient concerning finding suitable accommodation. Staff told us patients had review meetings every six to eight weeks this incorporated discharge planning with all professionals involved with the patients care.

Staff told us they planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff told us patients had six to eight weekly reviews with all professionals involved with their care, which incorporated discharge planning.

Patients could move from Olive Carter unit to the adjacent unit at Janet Barnes if their needs changed or as part of their rehabilitation process. The Janet Barnes unit was registered separately. 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, dignity and confidentiality

Each patient had their own bedroom, which they could personalise. Patients told us they were able to paint their room a colour of their choice if they so wished. They were able to personalise their rooms to make them feel comfortable in their surroundings.

Patients had a secure place to store personal possessions. Staff told us that patients had keys for their bedrooms rooms and were able to lock them as and when required. This was risk assessed on an individual basis. Staff had master keys to override any locked bedroom doors.

Staff used a full range of rooms and equipment to support treatment and care. The unit was small and had an area for

patients to be seen. They also had a kitchen that patients could use as a therapy kitchen. Staff and patients had access to therapy rooms and the gym at the adjacent Janet Barnes unit.

The service had quiet areas There were day lounges as well as individual bedrooms, where patients could meet with families and carers. Patients could also meet visitors in the garden. Staff followed the service visitor's policy. Pre-arranged child visits were facilitated if there were no risks posed. Protected areas were allocated for the visit.

Patients could make phone calls in private. Some patients had mobile phones and could make calls as when and where they required.

The service had an outside space that patients could access easily. Patients had access to a well-kept garden.

Not all patients liked the quality of food and in March 2019 staff had discussed complaints raised by patients. Staff told us actions had been taken, for example, patients received individualised portions. Staff told us patients had responded positively to the improvements in food quality. Patients could make their own hot drinks and snacks.

Patients' engagement with the wider community

Staff made sure patients had access to opportunities for education and work, and supported patients. Staff supported patients to access opportunities within the community. One example staff told us was supporting a patient to access voluntary work.

Staff helped patients to stay in contact with families and carers. Staff encouraged home leave or meeting relatives and carers in the community or at the unit.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service had specific bedrooms allocated for those who required disabled access. However, when we attended the unit in 2016 and 2017 the lift was not working. During this inspection the lift was out of service and needed to be replaced. We spoke to the manager about this they informed us that a new lift had been purchased and would require the old one to be removed before fitting the new one. There were no timescales presented to us. This meant not all people using the service would be able to access the first floor television room without the lift.

Patients could access information on treatment, local service, their rights and how to complain. The service had information leaflets in the airlock leading to the building. However, this meant it was only accessible when patients were leaving or entering the building. There was a notice board located within the patient area that had information about Mental Capacity and Mental Health Act advocacy services, safeguarding and how to make a complaint. The information was secured behind a plastic cover which meant further details were not accessible unless patients asked staff for more information. Patient rights information were in an accessible format for both the Mental Capacity and Mental Health Act.

Managers told us they ensured patients obtained support from interpreters or signers when needed.

Listening to and learning from concerns and complaints

Patients knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Staff told us patients raised concerns and complaints with members of the multi-disciplinary team, staff relayed information to managers to investigate. Patients received feedback from managers after the investigation into their complaint. Outcomes of complaints were fed back to patients on an individual basis and with family and carers. One patient told us they had recently made a complaint to the service but felt it had not been resolved to their satisfaction. We saw complaints fed into staff meetings and outcomes. The service reported three complaints in the past twelve months two of which were upheld. The service received a low number of complaints reflecting that patients were satisfied with their care.

Staff received feedback from managers after investigations.

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

Requires improvement

Leadership

Requires improvement

Services for people with acquired brain injury

The manager had been in post one year prior to the inspection and the management team had introduced changes which were not fully embedded within the staff team and philosophy of the service.

Managers had the right skills, knowledge and experience to perform their roles. They demonstrated a good understanding of the patients and the service provision.

The manager and leadership team regularly attended the unit and staff could approach them at any time for advice, guidance and support if they needed it. Staff told us the leadership team were very good. They knew who the senior managers were and said they regularly visited the unit.

Vision and strategy

The organisations core values were integrity, trust, kindness, dignity, compassion and respect.

The unit manager told us the vision was to be the best provider, strive and improve. We saw the organisation's visions posted on the office door which was to "Promote the well-being of patients, improve their health and fulfil their aspirations". Although staff we spoke to did not relay the visions of the organisation, they displayed them in their actions towards the patients and their colleagues.

Staff had opportunities to contribute to discussions about the service in staff meetings. We saw in the minutes of the meetings where staff provided ideas on how to improve the service. This included staff recognition awards and the unit environment.

Culture

Staff told us they felt respected and that the team of staff were happy, they had good and bad days. However, they felt they had a good skill mix and worked well together.

Staff felt able to raise concerns without fear of retribution. Staff were aware of the whistle blowing policy and stated they could raise concerns without fear of victimisation. One member of staff told us they had raised whistle blowing concerns and it was well managed with a good outcome. The service had an up to date dignity at work policy dated November 2018 and a policy on the freedom to speak up was implemented in August 2019. Staff did indicate that they were aware of the policy.

Staff appraisals included discussions on career progression and learning and development and how the service could support staff to achieve their goals.

The service recruited from a worldwide black and minority ethnic group. Patients admitted also came from a diverse cultural background. We saw evidence of support provided by the service to staff who required work permits. Ensuring they had time and space to renew permits.

The service changed the recruitment process to include advertisements in job centres, job fairs built relationships with employment engagement officers and work coaches and invited them to walk around the unit. The service then had the opportunity to discuss the unit environment, benefits and challenges. The change in the recruitment process supported the service to attract a cross section of people for vacant roles. The service offered a variety of shifts to staff so that not all were full time, thereby including those who had other commitments such as childcare or supporting family.

The service had an overall sickness rate of two percent. They conducted supportive return to work interviews following periods of absence. They gave an example of supporting a disabled member of staff back to work using relevant 'reasonable adjustments' and potentially access to work plans.

In the minutes of the staff meeting, there were discussions around previous staff recognition awards being repeated as it had stopped. Managers stated they would look in to how this could be achieved.

Governance

Leaders did not always ensure there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities but did not always have opportunities to meet, discuss and learn from the performance of the service.

Overall governance within this service had structures, processes and systems of accountability for the performance of the service but was inconsistent. Although there was evidence the service completed various audits, investigated complaints and incidents the forum for discussions were not always available.

Staff meetings happened regularly, however the minutes of the meetings we viewed did not have an agenda/ framework for staff to follow. The minutes showed general

discussions about the unit, some complaints and outcomes. We did not see information concerning incidents but saw concerns from staff about patients increasing behaviour.

Although the clinical governance meetings did not have an agenda it had information concerning quality safety and monitoring, incidents complaints safeguarding and audits which was duplicated at subsequent governance meetings. Up to the date of the inspection the service had completed two clinical governance meetings one in January 2019 the other was in September 2019. The registered manager told us it had been difficult to have regular meetings due to availability of the senior staff and review meetings that happened at the same time. This led to meetings being cancelled. The registered manager was hopeful that a solution had been found where all senior staff could attend, and the next clinical governance meeting was due to happen on the 9 December 2019. In the meantime, weekly operations meetings had begun and had been in place for two months, however we did not see minutes for those meetings. The service had a project planning meeting where operational, clinical, training and development plans and actions for completion of audits were reviewed. It was not clear how often this meeting happened.

Management of risk, issues and performance

Leaders did not always manage performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff were not always able to contribute to decision-making on service changes as there were irregular governance and business meetings.

Information management

Staff said they were provided with information to complete their roles. They had access to computers and phones as required. However, the patient files were kept in three ring binder folders and were extremely large and difficult to navigate. Some of the information was kept in another building. Information was duplicated for the files that remained with the patient. The service was aware of the issues and were in the process of streamlining the files.

Information governance systems were confidential for both staff and patients. Staff files were kept in a locked cabinet and on the services electronic systems. Patient files were kept secure in locked rooms and cabinets.

Managers had access to information to support them with their management role. This included staffing and patient care. Information was provided by the coordinator who maintained, training figures and supervision rates and staff performance. The human resources department kept managers up to date with staff revalidation, disclosure barring service checks and renewals. Multi-disciplinary and staff meetings supported information concerning patients.

The service made notifications to external bodies such as the local authority for safeguarding concerns and the care quality commission.

Engagement

Staff were encouraged to give feedback through surveys and to have a say and give opinions on the way the service was run. Staff said they were asked for ideas on how to improve the service. Managers provided us with the outcome of a staff survey, however there was no date of when it had happened.

The service had information on their website and intranet for staff, patients and carers to access. There was a local newsletter for staff that provided information on their specific unit such as events, staff appointments and staff leavers.

Managers explained as all patients had an acquired brain injury and remained difficult to engage. It was noted that an alternative approach was required for patient feedback on an individual basis. Managers said a revised plan to have an evaluation of the care experience with pictorial responses would in some way aid patient feedback and had plans to put this in place.

Learning, continuous improvement and innovation

We saw limited evidence that staff were committed to continually improving services and had a good understanding of quality improvement methods.

Managers explained the Olive Carter Unit strived to identify equipment that would improve patient and staff safety during restraint. The service purchased a large bean bag and is used on the unit to support restraint. This was in response to lessons learnt from an incident with restraint of a patient. The service continues to look at the environment of the unit and colour schemes to support reducing stimulation for patients. However, there was a lack innovation and participation in research within the unit.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure regular reviews of medicines are carried out and outcomes are recorded.
- The provider must ensure staff do not use de-facto seclusion for patients in any area of the ward.
- The provider must provide Mental Health Act training as part of the mandatory training for all staff.
- The service must ensure that all risk assessments are regularly updated. A copy of the risk assessment should be provided for family members and carers to support section 17 leave.
- The service must ensure that the lift is replaced.
- The provider must ensure that all fire doors operate effectively.
- The provider must ensure the true maximum and minimum temperatures of the refrigerator are measured and recorded daily to ensure medicines remain effective in treating the conditions they were prescribed for.

Action the provider SHOULD take to improve

- The provider should ensure information to support the use of required medicines are person centred and detailed enough so staff know how these medicines should be managed
- The provider should ensure written protocols are in place to inform all staff on how to prepare and administer medicines through a percutaneous endoscopic gastrostomy (PEG) tube.
- The provider should ensure that all meetings relevant to the running of the service happen consistently and have a clear agenda.
- The service should have information near the exit door to inform informal patients of their right to leave the unit.
- The service should ensure that patients are invited and supported to attend multi-disciplinary meetings where their care and treatments are discussed.
- The service should ensure that governance processes and new management protocols are embedded into the developing 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 provider must ensure regular reviews of medicines are carried out and outcomes are recorded. • The service must ensure that all risk assessments are regularly updated. A copy of the risk assessment should be provided for family members and carers to support section 17 leave. • The provider must ensure the true maximum and minimum temperatures of the refrigerator are measured and recorded daily to ensure medicines remain effective in treating the conditions they were prescribed for.

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 The provider must ensure staff do not use de-facto seclusion for patients in any area of the ward.

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 HSCA (RA) Regulations 2014 Staffing The provider must provide Mental Health Act training as part of the mandatory training for all staff.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The service must ensure that the lift is replaced. The provider must ensure that all fire doors operate effectively.