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

Quality Report

The Olive Carter Unit. 135 Cateswell Lane, Hall Green, Birmingham West Midlands. B28 8LU
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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

Overall summary

This inspection was not rated because it was in response to concerns raised about the care provided to patients. The inspection took place during the Covid 19 pandemic and was a unnounced. We focussed on the on the key questions of caring and well led.

The Olive Carter unit specialises in neurobehavioral rehabilitation for men and women over the age of 18 years with a primary diagnosis of acquired brain injury.

We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

- We found that patients were not always treated with kindness and compassion. There had been an incident of physical abuse towards one patient by a member of staff. The provider reported the incident to the police the local safeguarding team and CQC as soon as they became aware of this. In addition, three members of staff have been suspended and the perpetrator has been dismissed. Patients told us that some staff did not communicate with patients and ignored their request for information
- Patients privacy and dignity was not protected all the time. Some bedroom windows did not have privacy films allowing people to be seen in their rooms.
- There was evidence that a night staff slept during the night whilst they should have been awake to monitor and support patients. A member of staff had reported to the unit lead and registered manager that night staff had made up a bed to sleep in. The Registered Manager addressed this at the earliest opportunity and the nurse was suspended and dismissed.
- Patients were not supported to undertake the therapeutic activities designed to aid their rehabilitation by the rehabilitation assistants.
- Some bedrooms and shared bathroom did not have nurse call systems for them to summon help when they needed help.

Summary of findings

- There was poor leadership at unit level. No action had been taken in relation to night staff sleeping, commissioners found communications with the unit difficult and the unit leaders had little oversight or robust governance arrangements to monitor activities at the unit.
- There was poor morale amongst staff who did not feel valued or supported

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		

Summary of findings

Contents

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 located 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 and Mental Capacity Act.

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 17 and 18 September 2019. We told the provider it must make improvements to:

- ensure regular reviews of medicines are carried out and outcomes are recorded.
- 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.
- 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.
- ensure staff do not use unauthorised seclusion for patients in any area of the ward Unauthorised seclusion happens when a patient is forcibly confined to a room or space without staff having the legal right to confine them.
- provide Mental Health Act training as part of the mandatory training for all staff.
- ensure that the lift is replaced.
- ensure that all fire doors operate effectively.

The inspection was undertaken to follow up on specific issues so we did not review what progress the provider had made with the above required improvements. We will follow this up in due course.

Our inspection team

The team that inspected the service comprised one CQC Inspector and an Inspection Manager.

This inspection took place during the Covid 19 pandemic lockdown restrictions and this meant that we did not request a use Specialist Advisors or Experts by Experience.

Why we carried out this inspection

This was an unannounced, focussed inspection. We inspected this service in response to an allegation of patient abuse and concerns about patient safety on the Olive Carter Unit.

Summary of this inspection

How we carried out this inspection

During this inspection, we looked at the questions of caring and well led. We did not change the rating for the service because this was a focused inspection.

Before the inspection visit, we reviewed information that we held about the location, asked a range of staff, about their experience of working in the unit and spoke to people who commissioned places for patients. We sought feedback from previous patients and their carers through telephone interviews.

During the visit, the inspection team:

- Visited the unit, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the Clinical Lead in person who was on call at the time of the inspection
- spoke with 3 other staff members
- Looked at three care and treatment records of patients:

What people who use the service say

We spoke to three patients during the inspection. We heard that staff were not always helpful and friendly, some ignored patients refusing to acknowledge them. They told us that when staff undertook one to one observation, they spent much of their time on their mobile phone rather that interacting with patients.

We heard from one relative that care was good. However, it had to be carried out when staff wanted to do it. One example was If a patient was in bed and staff offered them help with getting up and dressed and the patient refused then it was unlikely that staff would willingly provide the care later when the patient asked to get up. and if patients did not do things when staff wanted to do it, it was unlikely to be offered again or carried out when the patient wanted to do that activity. Relatives said they observed that there were very few leisure activities available for patients in the unit.

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 caring?

- Staff had not treated patients with compassion and kindness. There had been an incident of physical abuse towards a patient by a member of staff. The manager had reported the incident to the police the local safeguarding team and CQC as soon as they became aware of what had happened. Three members of staff had been suspended and the perpetrator was dismissed. Some staff did not communicate with patients and ignored their request for information.
- Some night staff slept during the night whilst they should have been awake to monitor and support patients
- Despite the psycologist and occupational therapist developing therapeutic programmes the rehabilitation assistants did not understand the individual needs of patients and did not support patients to manage their care, treatment or condition. Rehabilitation assistants did not support patients to participate in therapeutic activities that had been designed to facilitate their rehabilitation.
- Patients privacy and dignity was not protected all the time. Patients bedroom windows did not have privacy films allowing people outside in public spaces to observe them in their rooms.
- Some bedrooms and shared bathroom did not have nurse call systems for them to summon help when they needed help.

Are services well-led?

- The service was not well led at ward level. Incidents that had happened had not been acted on by the unit clinical lead and had not shared concerns with the registered manager. Appropriate action had been taken.
- Staff did not know or understand the provider's vision and values and how they applied to the work of their team.
- Low morale amongst some staff had been recognised and the service was working actively with staff to respond to their concerns and make changes that would benefit them.
- Staff did not feel respected, supported and valued.
- It was clear that the leadership team had little oversight of what was happening at ward level. The governance processes did not operate effectively and did not identity poor practice. So no action had been taken to make improvements.

Services for people with acquired brain injury

Caring

Well-led

Are services for people with acquired brain injury caring?

Kindness, privacy, dignity, respect, compassion and support

Staff were not discreet, respectful, and responsive when caring for patients. The interactions we observed between staff and patients was of a poor standard. Staff did not give patients help, emotional support and advice when they needed it. We observed staff carrying out one to one observation with very little interactions between them and patients, although there was clear guidance in patient files on how to make one to one observation therapeutic. We found patients in bedrooms lying on their beds with no activity taking place within the hospital for them to participate in. We saw and heard from patients, carers and other professionals that therapeutic activities were not carried out by the rehabilitation staff. A patient told us that staff were not very sociable and they did not see the night staff because they isolated themselves from the patients in the television lounge.

Patients said staff did not treat them well and were unkind. During the inspection we were shown a video, recorded by a patient, of an incident of physical abuse upon another patient by a member of staff. The patient also had other videos of staff ignoring him when he spoke to them and refusing to share their names. We saw recordings of staff on one to one observation using their mobile phones and not engaging with the person they were observing. We heard that staff were seen looking through a clear window from the hospital's garden into a patients room whilst they were undressed. We were told and saw a recording of staff laughing when a patient told them they had injured their foot.

Staff did not understand or respect the individual needs of each patient. Some bedrooms did not have privacy screens meaning they can be seen by anyone walking by on the road and when people were in the garden. Not all bedrooms and a shared bathroom had a nurse call alarms which meant that patients might not receive care in a timely manner.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff we spoke to felt that all staff were professional and cared about the patients. They thought care was good with excellent communications between everyone.

Involvement in care

Not all staff involved patients and gave them access to their care planning and risk assessment process. We spoke with three patients, two of whom told us they had a care plan and a list of the medication they were taking. We saw copies of care plans and medication list on the walls of their bedrooms. Staff recorded in patients files if they had been offered a copy of their care plan and whether the patient had been able to sign on receipt of the plan.

Patients could not give feedback on the service and their treatment and staff did not support them to do this. We heard that patients did not attend the multi-disciplinary meetings. One patient told us that he had had not been able to attend recent multi-disciplinary meetings but had attended once. We had heard at the previous inspection from staff that patients were not invited to the meetings but attended review meetings with their inpatient and community teams.

Staff did not always make sure patients understood their care and treatment however some found ways to communicate with patients who had communication difficulties. We saw examples of information provided to patients from the clinical psychologist about their care and treatment in a format that aided their communication style. The three patients that we spoke to found it difficult to explain to the inspectors what their care and treatment plan was and what their rehabilitation aim was.

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

Leadership

Some leaders did not have the skills, knowledge and experience to perform their roles. The clinical manager for

the unit had recently been suspended and there was no identified lead to take day to day responsibility for the Olive Carter Unit. Staff we spoke to said the registered manager was accessible by phone, email and visited the service however, she lived a long way from the unit and was not on site every day.

Vision and strategy

When we inspected the unit out of four staff on duty only one was a regular member of the Olive Carter care team. The others were all temporary staff who had previously worked different shifts on the unit, this meant we were able to talk to staff who understood the vision and strategy for providing services to patients on the unit.

Culture

Staff we spoke to said they did not feel respected, supported and valued. They reported that team leaders or managers did not enquire about them or asked how they were feeling even after challenging situations. We heard from Managers that debriefings took place after incidents and staff received supervision. Whilst staff did not see managers on the unit, they said they could contact them when they needed to speak to them. We heard from professionals that they found communication with the unit was very difficult, often resulting in information not been shared or passed on to the right person. This impacted on patients by creating delays in treatment or discharge from the hospital.

Management of risk, issues and performance

The unit had the information it needed to provide safe and effective care. Patients had care plans and risk assessments however, staff did not have time to carefully read and understand each person's care plan. On our inspection we found four staff on duty with three one to one observations ongoing. That meant staff did not have the time to sit and read the patient file and care plans that would enable them to properly support and engage with patients. New and temporary staff said they relied on the handover and any advice permanent staff could give them for looking after patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients are protected from the risk of abuse and ill treatment by staff
- The provider must ensure that patients have support to participate in therapeutic activities that have been written to support their recovery
- The provider must ensure that patients privacy and dignity are protected
- The provider must ensure that all patients have access to a nurse call alarm when in their bedrooms and communal bathrooms so they can call for help when they need to.
- The provider must ensure that there is sufficient staffing within the Olive Carter unit and with robust leadership

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Staff did not implement the therapeutic activities designed to support patients rehabilitation. This was a breach of regulation 9 (1)

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 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: The provider was not protecting the privacy and dignity of patients whilst in their bedrooms. (Regulation 10 (1)

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 How the regulation was not being met: Patients did not have access to nurse call alarms in bedrooms and shared bathrooms Regulation 12 (1)

Regulated activity	Regulation

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Patients had been assaulted by staff, night staff were sleeping through the night and staff refused to tell patients their names. Regulation 13 (1)

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 How the regulation was not being met: The Olive Carter Unit did not have sufficient staff with the right knowledge, skills or leadership to care for patients safely. Regulation 18 (1) (2)