Harcourt House

Quality Report

82 Canadian Avenue
Catford, London SE6 3BP
Tel: 020 8695 5656
Website: www.carepluspartnership.com

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive?	Inadequate
Are services well-led?	Inadequate

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

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

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

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

Summary of findings

Overall summary

We decided to cancel the registration of this service. This means the provider will no longer be able to operate the service at this location.

We rated Harcourt House as inadequate because:

- When a patient was restrained this was not always recorded as an incident. Staff did not always recognise physical interventions as restraint. Patient's physical observations were not taken during or after restraint or rapid tranquilisation.
- There had been 27 serious incidents in the previous year. The service did not have an incident policy. Not all incidents were reported.
- One patient had been locked in their room for several weeks. This had not been recognised as long-term segregation. The patient was not detained under the Mental Health Act. This was a breach of the patient's human rights and amounted to mistreatment.
- One patient's bedroom had a stained floor and an overwhelming smell of urine. The service was not clean and was neglected. Redecoration and maintenance were required. The environment was institutional.
- Patient's risk assessments did not include all potential patient risks. Risk assessments and management plans were not updated after incidents, including serious incidents.
- Safeguarding incidents did not always result in a safeguarding referral. Less than 60% of staff had undertaken safeguarding adults training. The provider could not ensure that it could protect patients from avoidable harm.
- The pads for the defibrillator, to restart a person's heart, had expired in 2009. An oxygen cylinder was unsecured. Had it fallen it could have led to an explosion of gas.
- Patients did not receive psychological treatment appropriate to their needs. Patient's care plans did not include their psychological, spiritual and cultural needs. Patients were not involved in developing their care plans.
- The number of qualified nurses did not ensure that patients received safe, effective and high quality care. Some staff, including senior staff, were not skilled and experienced in the care and treatment of people with a brain injury. There was a low rate for staff attending specialist training.
- Patients were not always treated with dignity and respect. Patient's receiving insulin had to expose their stomach in public to receive their medicine. When staff had contact with patients for physical therapy they wore gloves.
- Patients reported they did not feel listened to by staff. Patients were unable to access an advocate easily. Patients said they were bored and there were very few activities. There was no activity programme in the service.
- There was no effective system for ensuring that best practice and legal requirements were met regarding the Mental Health Act and the Mental Capacity Act.
- There was a lack of clinical audit. Important standards for the care, treatment and safety of patients were not monitored. There had been a systemic failure to assess, monitor and improve the safety, care and treatment of patients.

The provider closed the service two weeks after we conducted the inspection.

Summary of findings

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Inadequate

Harcourt House

Services we looked at

Services for people with acquired brain injury

Summary of this inspection

Background to Harcourt House

At the time of the inspection Harcourt House provided care, treatment and support for people with acquired brain injury. The service offered neuropsychological rehabilitation. There were eight patients at the hospital. Three patients were detained under the Mental Health Act 1983 (MHA) and four patients were detained under the Deprivation of Liberty safeguards (DoLs). One patient was not detained.

Harcourt House was registered to provide assessment or medical treatment for persons

detained under the Mental Health act 1983 and treatment of disease, disorder or injury.

There had been no registered manager for the service for eleven months.

The service received referrals from statutory services from inside and outside of London.

Harcourt House had been inspected five times since 2010. Inspections took place in July 2012, December 2012, January 2014, March 2015 and July 2015. Following the inspection in July 2015, we issued two requirement notices. These related to the management of medicines and the lack of effective systems to assess, monitor and improve the quality and safety of the services provided. During this inspection we found that these continued to be areas of concern.

Our inspection team

The team that inspected the service comprised three CQC inspectors, one CQC inspection manager, one pharmacist inspector and a specialist advisor. This specialist advisor was a consultant psychologist with experience in providing psychological treatments.

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, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the service, looked at the quality of the environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with two carers of patients using the service
- spoke with the service operations manager and interim manager

Summary of this inspection

- spoke with nine other staff members; including the consultant psychiatrist, a nurse, a rehabilitation assistant, the occupational therapist, the psychologist, a hospital manager and the housekeeper
- received feedback about the service from eight commissioners
- attended and observed the clinical governance meeting
- collected feedback from three patients and carers using comment cards
- Looked at six care and treatment records of patients
- carried out a specific check of the medication management at the service
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients did not like the service. Two patients said they did not feel safe. They also told us they were bored and there were few activities. Patients did not know about their care, and did not always feel helped by staff. They said that they had little leave from the hospital due to a shortage of staff. All of the patients wanted to leave the hospital

Before the inspection we had sent comment cards and a comment card box for patients and carers to leave comments. We received three comment cards, all in pre-paid envelopes to the service address. All of the cards described the staff as caring. Two of the cards reported that the service felt safe.

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:

- When a patient was restrained this was not always recorded as an incident. Staff did not always recognise physical interventions as restraint. Less than half of staff (48%) had undertaken restraint training.
- One patient had been locked in their room for several weeks. This had not been recognised as long-term segregation. The patient was not detained under the Mental Health Act. This was a breach of the patient's human rights and amounted to mistreatment.
- Patient's risk assessments did not include all potential patient risks. Risk assessments and management plans were not updated after incidents, including serious incidents.
- The service did not have an incident reporting policy. Not all incidents were reported. Incidents were not analysed for themes or trends. Patient's care or risk management plans were not reviewed following incidents.
- There had been 27 serious incidents in the previous year. Eight of these incidents involved serious medicine errors. A service commissioner had provided input to reduce medicine errors.
- One patient's bedroom had a stained floor and an overwhelming smell of urine. This was an infection control risk.
- Equipment had not been calibrated. This meant there could be inaccurate readings regarding patient's physical health. The pads for the defibrillator, to restart a person's heart, expired in 2009. An oxygen cylinder was unsecured. Had it fallen this could have resulted in an explosion of gas.
- There was one qualified nurse on duty during the day and night. The number of qualified nurses did not ensure that patients received safe, effective and high quality care.
- Thirteen staff (56%) were trained in safeguarding adults. Safeguarding incidents did not always result in a safeguarding referral. One patient's protection plan was discontinued after 24 hours without discussion. The service was unable to protect patients from the risk of avoidable harm.
- When mistakes were made, there was no evidence that patients received an apology.

Summary of this inspection

- Almost every type of mandatory training had been undertaken by less than half of the staff team.
- The building did not have safety adaptations. There were no convex mirrors or alarms. A ligature risk assessment had not been undertaken. The service was not clean or well maintained. There was an absence of infection control procedures.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Nursing staff were not involved in developing patient's care plans. Patients did not have care plans regarding their risk of pressure ulcers or their diabetes. Care plans did not address patient's psychological, cultural or spiritual needs. Patients did not have positive behaviour support plans. Care plans were not recovery orientated.
- Patients did not have a physical examination when they were admitted to the service.
- Patients did not have a functional analysis of their behaviour. The reasons why patients behaved the way they did were not well understood.
- Patients did not receive psychological treatment appropriate to their needs. There were no psychological groups and behaviour charts were not completed. Psychological interventions were unstructured and were not evidence based.
- There was no record that patients received a neuropsychiatric assessment.
- Patient's physical observations were not taken during or after restraint or rapid tranquilisation.
- Some staff, including senior staff, were not skilled and experienced in the care and treatment of people with a brain injury.
- Most staff did not receive regular supervision. Fifty per cent of staff had not received specialist training to meet the needs of patients. Some training had not been undertaken by any staff.
- Patients received fragmented care. There was little, if any, communication between the service and the general practitioner who attended.

Are services caring?

Inadequate

We rated caring as inadequate because:

- Staff had not questioned the practice of a vulnerable adult being locked in their room for several weeks.
- Patient's receiving insulin had to expose their stomach in public to receive their medicine.

Summary of this inspection

- When staff had contact with patients for physical therapy they wore gloves.
- Patients reported they did not feel listened to by staff.
- Patients were not involved with developing their care plans. Patient's views of their care plans were not sought. Patients did not have a copy of their care plans.
- Patient's had only recently been invited to their weekly clinical team meeting (ward round).
- Patients were unable to access an advocate easily.
- There was no system for patients to provide feedback about the service.
- Patients were not involved in the way the service operated. Patient's had little choice regarding the service provided to them.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- One patient in the service had discharge plans. These were not specific or detailed. There was a lack of early discharge planning in the service.
- There was no visitors' room or activities room in the service. Access to the quiet room was difficult for patients with restricted mobility.
- The environment was neglected and in need of redecoration. A curtain was falling off a curtain rail and a window handle had been sawn off. There were no shelves on the walls and very few pictures. The environment was institutional.
- There was no activity programme in the service. Patients said they were bored and there were very few activities.
- Wheelchairs barely fitted through some doorways. There was no toilet which could be accessed by disabled people on the ground floor.
- There was no information available for patients regarding complaints, advocacy, treatment or patient rights.
- There was no system to review how complaints had been investigated. If complainants were unhappy with the response, there was no system for them to ask for the response to be reviewed. There was no effective system for the service to learn from complaints.

Are services well-led?

Inadequate

We rated well led as inadequate because:

Summary of this inspection

- The provider did not have a strategy to learn from incidents and minimise their reoccurrence. There was no date when an incident policy would be available.
- There was a lack of clinical audit. Important standards for the care, treatment and safety of patients were not monitored. There was no system to ensure that best practice and national guidance was consistently followed.
- There was no effective system for ensuring that best practice and legal requirements were met regarding the MHA and the MCA.
- The service had relied on other agencies to identify problems and issues. The service had been unable to resolve these issues without the support and guidance from external agencies.
- The management team had developed a continuous improvement framework. The actions in the framework involved relatively short timescales. These did not allow sufficient time for new practices to become embedded. The action plan did not identify areas of priority.
- The provider operated a clinical governance meeting. However, the information provided to this meeting was basic. There was no clear strategy of how to improve fundamental standards of care. Patient safety was not given a sufficiently high profile in the meetings.
- Baseline information was not collected to measure improvement in the service. Basic governance systems were not in place. There had been a systemic failure to assess, monitor and improve the safety, care and treatment of patients.
- There was no clear leadership message that staff could raise concerns regarding patient care.

Detailed findings from this inspection

Mental Health Act responsibilities

Mental Health Act (MHA) detention paperwork was in good order and stored appropriately. Patients had their rights explained to them on admission. However, patients were not reminded of their rights at certain key times. For instance, when patients MHA detention was renewed, or following a Mental Health Review Tribunal.

One patient's T2 (consent) certificate included a number of physical health medicines. This demonstrated a lack of understanding regarding consent to treatment under the MHA.

Patient's Section 17 leave forms were not always correctly completed. One patient's leave form indicated the patient required escorted or unescorted leave for the same leave. It was unclear if the patient required escorting. When a patient had leave with family members, it was unclear which family members. One patient's leave had not been reviewed for 17 months.

The service did not have systems in place to ensure that the MHA and MHA Code of Practice were consistently followed. Patients did not have regular access to an independent mental health advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most staff had little understanding of the MCA and DoLs. They could not describe the overarching principles or the capacity assessment. Staff, at all levels, could not describe the meaning of 'restraint' in relation to the Mental Capacity Act (MCA).

Capacity assessments were decision specific. However, there was no record of a discussion with the patient. There was no record that the patient had been supported to make a decision. Best interests' assessments were not always requested when they should have been. Capacity assessments were not always signed by a staff member.

An urgent authorisation under the deprivation of liberty safeguards (DoLs) was not accompanied by a record of why the urgent authorisation was required. When patients were subject to DoLs authorisations, some were restricted beyond what was authorised. One patient had been locked in their room for several weeks.

Use of the MCA and DoLs was not subject to audit or monitoring. This meant that use of the MCA and DoLs was not measured against best practice and legal requirements.

Inadequate

Services for people with acquired brain injury

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Are services for people with acquired brain injury safe?

Inadequate

Safe and clean environment

- The service was located in a large converted house. The ground floor had communal areas and one bedroom. The upper floors had bedrooms and a quiet room. There were no clear sight lines for staff, except in some parts of the ground floor. There were no convex mirrors for staff to see into 'blind spots'. Some of the patients in the service had displayed aggressive or violent behaviour. The lack of sight lines in the service posed a risk to the safety of patients and staff.
- There were ligatures in every room in the service. One patient in the service experienced suicidal thoughts. The service had not conducted a ligature risk assessment. This meant staff were unaware of all of the ligatures a patient could potentially use.
- The clinical room in the service was very small. If patients' reached over the stable door to grab staff, staff would have been unable to move out of the way. An oxygen cylinder was freestanding and not secured in any way. Had the oxygen cylinder fallen this could have led to an explosion of gas. There were serious risks to staff members safety. The automated external defibrillator (AED), to restart a person's heart, had disposable pads attached to it. These pads had an expiry date in 2009. This meant that in an emergency the pads may not be effective. There were no checks of the emergency equipment in the service until the day before the inspection. This meant that emergency equipment could have passed its expiry date. Most patients had significant physical health problems secondary to their brain injury. There were no emergency medicines stocked in the service. This meant that should patient's physical health deteriorate rapidly, immediate appropriate treatment could not be given.
- The service was not clean. There was ingrained dirt on skirting boards, rugs and curtains. There were torn floor coverings, which were a trip hazard. There were broken skirting boards and tiles and broken furniture. A radiator cover had been damaged, was dirty and had a sharp edge. The service had a 'deep clean' just prior to the inspection. There was no cleaning schedule for the service. This meant there was no record of which areas had been cleaned when.
- The service did not have an up to date infection control policy. An infection control policy marked 'NHS Professionals' and dated 2010 was located in the staff office. There were no hand hygiene audits or any other systems to detect or minimise the spread of infections. There had been no attempt by the service to follow national guidance (Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, 2015). The service had recently had a food standards inspection. The rating awarded was 'one', indicating major improvement was necessary. The hand basin and flooring in the kitchen were dirty. We observed various types of food left uncovered in the kitchen. The chef informed us that there was no food wrapping to cover the food. One patient's bedroom had a stained floor and an overwhelming smell of urine. Two patients required insulin injections. A small automatic injecting device is

used to administer insulin. Both patients were administered insulin with the same device. This was a serious infection control risk. Three patients in the service were at high risk of developing pressure ulcers. The lack of infection control practices and procedures placed these patients at significant risk of acquiring an infection.

- There was no record that the syphgnomanometer, for measuring patients' blood pressure, had been calibrated. This was also the case for the glucose monitoring machine. A nebuliser, to assist patients to take some asthma medicines, had not been calibrated. There was no tubing or mask available for the nebuliser, and one patient had asthma. Having uncalibrated equipment meant that the equipment may not work properly. This meant patients physical health may not be accurately monitored. In the case of the nebuliser, patients may not receive the correct amount of medicine. In any event, it could not be used as there was no mask or tubing. Medical devices were not maintained in accordance with national guidance (Managing medical devices: guidance for healthcare and social services organisations, Medicine and Healthcare products Regulatory Agency, 2015).
- The service did not have an environmental risk assessment. This meant that risks in the building, such as torn floor coverings and the damaged radiator had not been assessed. The provider undertook an environmental audit two weeks before the inspection. This stated 'deep clean' was needed for almost all rooms in the building.
- There was no alarm system in the service for patients or staff. Staff carried two way radios. This meant patients had no way to summon staff assistance unless they shouted.

Safe staffing

- There were four qualified nurse and 10.5 rehabilitation assistant posts in the service. There were three vacant staff posts at the time of the inspection. One of these posts was for a qualified nurse and two were for rehabilitation assistants. A qualified nurse and a rehabilitation assistant were due to start work at the service immediately after the inspection. They had been transferred from another of the provider's services.
- There had been a 15% turnover of staff in the year before the inspection. In the same time period the staff sickness rate was 1%.
- The service had not used a tool to estimate the number of staff required to provide safe and effective care. Staffing had not been assessed, or changed, to take into account the complexity of some patients' needs.
- There was one qualified nurse and three rehabilitation assistants during the day. At night, there was one qualified nurse and two rehabilitation assistants. This had recently been increased from two staff at night, following concerns from commissioners. The number of qualified nurses did not ensure that patients received safe, effective and high quality care. Additional staff were on shift when patients required continuous observation.
- Bank and agency staff were used in the service. They covered staff vacancies, sickness and absence. They were also required for other activities such as additional observations. In the three months prior to the inspection, all bank and agency shifts had been filled. The service used three recruitment agencies to fill shifts.
- A qualified nurse was not always present in communal areas of the service. The nurse on duty had a range of administrative and clinical duties, including administering medicines.
- Patients did not have a primary or key nurse. Primary or key nursing involves a qualified nurse meeting regularly with a patient to discuss their care and treatment. Primary and key nurses also attend meetings regarding the patient. Patients' care and treatment records did not record regular one-to-one meetings between qualified nurses and patients.
- Three patients reported that leave was often cancelled due to a shortage of staff. The only planned activities occurred when the music therapist and speech and language therapist attended the service.
- During the day there were enough staff to safely restrain a patient, if necessary. During the night there were not enough staff available to restrain a patient.
- The consultant psychiatrist attended the service once per week. They also attended whenever requested by staff. The consultant was on-call for the service all of the

time. When the consultant was on leave, a locum doctor would replace them. However, this arrangement had changed, and there was no medical cover available if the consultant had to take unplanned leave.

- Staff were required to undertake 14 types of mandatory training. Of 23 permanent and regular bank staff, 11 staff (48%) were trained in the management of violence and aggression. This included training in restraint techniques. Two staff (9%) had undertaken care programme approach and AED training. This meant that two staff were trained in the use of the AED, a machine to restart a persons' heart. Twenty five percent of staff were trained in fire safety, and 30% in emergency first aid. Thirty nine percent of staff were trained in infection control. Just over half of the staff (52%) were trained in equality and diversity. The rate of mandatory training undertaken by staff was low. This meant that most staff did not have the core skills relating to their work.

Assessing and managing risk to patients and staff

- The service did not have a seclusion room. There was no seclusion policy. However, we learnt of one patient who had been locked in their room continuously for many weeks. The bedroom had previously been used as an office. There was no temperature regulation or ventilation. A small window limited the amount of natural light. There was no clock, two way call system or alarm. There was no en-suite toilet. The room did not meet the standards of a seclusion room. It should not have been used as a bedroom. The patient did not display violent behaviour. Members of the multi-disciplinary team (MDT), and the managers, were not aware that these conditions constituted long term segregation. The consultant psychiatrist said the room being locked was good for the 'patients' safety'. The patient was not detained under the Mental Health Act 1983 (MHA). Their Deprivation of Liberty safeguards (DoLs) authorisation did not include them being locked in a room. The light in the room had been kept on all of the time. The patient had their liberty restricted without lawful authorisation. This was a serious breach of the patients' human rights, and amounted to mistreatment. At the time of the inspection, the patient was no longer subject to long term segregation. We reported our findings to other agencies.

- There had been 13 incidents of restraint in the previous year. None of these had involved prone restraint. Incident reports demonstrated a downward trend in the number of restraints at the service. There were no incident reports recording restraint for three months. However, incident records did not record the patients' position during a restraint. The restraint techniques, length of time of restraint, or staff involved were not recorded. There was no record that staff had attempted de-escalation prior to the restraint. During and following restraint, patients pulse and blood pressure were not consistently taken. This was not in accordance with national guidance (Violence and Aggression: Short-term management in mental health, health and community settings, National Institute for Health and Care Excellence [NICE], 2015a). One patient's care plan described restraint of the patient being required for certain activities. This would occur three or four times each week. The care plan did not describe this as restraint. There were no incident forms recording these restraints. Two senior clinical staff in the service regarded these incidents as behaviour management, not restraint. Two staff members told us that they 'never had to use restraint'. However, they went on to explain techniques which constituted restraint. Less than half of the staff (48%) had up to date training in the management of violence, including restraint. Any type of restraint involves risks to patients and staff. Risks are significantly increased when staff have not received recent restraint training. The management information regarding the numbers and type of restraints was not reliable. The service did not have a restrictive interventions reduction programme in accordance with national guidance (Positive and proactive care: reducing the needs for restrictive interventions, Department of Health [DH], 2014).

- Patients had a risk assessment when they were admitted to the service. Risk assessments did not address all of the patients' risks. For instance, one patient's care plan described the patient having suicidal ideas. The patient's risk assessment did not record this. When incidents occurred, patients' risk assessments were not always updated. Four patients had been involved in potentially serious incidents in the months prior to the inspection. One of these incidents had involved a patient making threats with a knife. None of the patients' risk assessments had been updated. Patients' risk management plans had not been reviewed and updated.

- A recognised risk assessment tool was not used. The service used their own risk assessment tool. There was no record of who had produced the tool or when it should be reviewed. There was no space to record which staff member had conducted the risk assessment. Not all potential risks were assessed and it was not possible to identify who had undertaken the assessment.
- Seven patients were unable to keep their own money or cigarettes. There was no record of why patients had these restrictions placed upon them. We were told that until recently, patients had been given cigarettes based on their behaviour.
- The provider had a rapid tranquilisation policy. However, this was not immediately available for staff to refer to. The policy did not state that all instances of rapid tranquilisation should be recorded as an incident. Patients' blood pressure, pulse and respirations were not always checked after rapid tranquilisation. On two medicine administration records (MARs) were instructions to try one medicine before the other. These instructions were not followed. On one occasion a patient was administered an injection without being offered tablets first. There was no record of why staff made this decision. The lack of physical health checks after rapid tranquilisation placed patients at risk. There was no record of why patients required rapid tranquilisation.
- Thirteen permanent and bank staff (56%) were trained in safeguarding. There had been at least seven incidents where a safeguarding referral should have been made and was not. One patient had been sent to their relatives home in pyjamas and had been incontinent. Two patients had missed a number of out-patient appointments. A further two patients had been sent to their relatives with incorrect medicines. There had been two serious incidents of patients threatening and assaulting each other. One of these incidents involved a weapon. No safeguarding referrals had been made. One patient was the subject of a safeguarding referral. An immediate protection plan was put in place in agreement with the safeguarding team. This involved an increased level of observation of the patient at night. This occurred for one night and then was stopped. There was no record that stopping the observations had been discussed. The service had a safeguarding log to record all safeguarding referrals. However, incidents where patients had assaulted each other were not recorded in the log. In the previous year the local authority had undertaken a significant safeguarding investigation at the service. This was in relation to frequent and serious medicine errors. Not all staff were aware of situations when a safeguarding referral should be made. This meant the service was not able to protect patients from harm. Safeguarding incidents were not a standing agenda item at the senior management meeting.
- There had been significant medicines incidents in the service, and a commissioning body had provided expert support to the service. Patients had two MARs. One was for the patients' mental health medicines, the other for the patients' physical health medicines. A general practitioner (GP) visited the service weekly and prescribed physical health medicines. One patient had been prescribed an injectable medicine. It was not clear how frequently this medicine should be administered. A type of insulin for one patient had been stopped. However, this had not been struck through on the MAR. On at least four occasions in the previous month, patients had missed their doses of medicines. The code recording the reason why did not correspond with the service medicine policy. One patient was prescribed paracetamol and co-dydramol. Both of these medicines contain paracetamol. The patient was at risk of accidental paracetamol overdose. The same patient was also prescribed two anti-inflammatory medicines. The patient was at risk of accidental overdose and an increased risk of a stomach bleed. Stomach bleeds can be fatal. There was no record that these risks had been identified or acted upon. One patient had been dispensed an antibiotic for over two weeks. The antibiotic was not required for this long. When a nurse was dispensing medicine they were constantly interrupted. This increased the risk of medicine errors. A new controlled drugs register was implemented a month before the inspection. When we looked at the old controlled drugs register, we saw evidence of poor management of controlled drugs. One medicine had an incorrect stock balance in the controlled drugs book. Medicines management in the service did not reduce the risk of avoidable harm to patients.
- One patient had a risk assessment for falls four months prior to the inspection. This recorded the patient was at high risk of falls. There was a plan to reassess the

patient's risk of falls every month. No further risk assessment had been undertaken. The month before the inspection another patient had fallen three times. The patient's risk assessment had not been updated for three months. Three patients were at risk of pressure ulcers due to restricted mobility. Each patient had been assessed using the Waterlow score. This is a recognised pressure ulcer risk assessment tool. Each patient was assessed as being at high risk of pressure ulcers. Patients had special mattresses for this. Two of these patients had monthly Waterlow score assessments. However, there had been no re-assessment for three months. One patient was noted to have a skin infection, and their Waterlow score had not been updated. There was a high risk that patients could develop painful pressure ulcers.

- The service had a child visiting policy. This policy stated that a risk assessment should take place prior to a visit. However, the policy did not identify where any visit should take place. The service did not have a family room and all other communal areas were used by all patients. An incident form prior to the inspection recorded an unexpected visit by a patient's relative. They had their children with them. The visit was unexpected, and had not been discussed, risk assessed or agreed. The visit went ahead. This potentially placed the children at risk of harm.
- We reviewed six staff records. One staff member had not had their identification or right to work in the United Kingdom checked. They had no references from previous employers. Two other staff members had significant gaps in their employment history. There was no record that these gaps had been explored. These staff members had one employment reference. One of the references did not have a company stamp and was not on headed paper. Two other staff members had a Disclosure and Barring Service (criminal records) check. However, this was not available. There was no record of the contents or if the service had reviewed them. Both staff members had one employment reference. These references confirmed their dates of employment but did not comment on their suitability for their role. The service had failed to undertake the necessary pre-employment checks for staff.

Track record on safety

- There were 27 serious incidents in the service in the previous year.
- Eight serious incidents related to medicine errors. Patients had not received their medicines as the service had run out of stock. This included an antibiotic and an antipsychotic medicine. Patients had not received their medicine for up to 10 days. On three occasions, patients were given the wrong dose of medicine. Nine serious incidents involved violence by patients. Five incidents involved patients subject to detention leaving without authorisation.
- There had been a decrease in the number of medicine errors. However, this was due to one of the services' commissioners providing additional input. There had been minimal learning from incidents of violence.

Reporting incidents and learning from when things go wrong

- The service did not have an incident reporting policy or procedure. A policy was being drafted at the time of the inspection. Staff were unaware of what should be recorded as an incident, due to the lack of a policy. The operations manager and acting manager told us that they told staff to 'report everything'.
- Reporting of incidents had increased in the months prior to the inspection. The number of incidents reported had increased from nine per month to fifteen. The acting manager considered there continued to be under-reporting of incidents at weekends. When incidents were reported they were not analysed for themes or trends. Patients acting violently or being sexually inappropriate accounted for 55% of all reported incidents. One patient had fallen three times in one month. There were no changes made to patients care or risk management plans as a result of these incident patterns.
- When mistakes had been made which could have affected patients' care, we were told that the patient received an apology. Following mistakes involving patients medicines, we could not find any record of an apology being made to the patients. We were also told that letters had been sent to patients' relatives following the mistakes involving medicines. There were no copies of these letters available to us.

Inadequate

Services for people with acquired brain injury

- Staff did not receive feedback following incidents. Incidents were not discussed at staff meetings. There was no other information available for staff to understand how future incidents could be avoided. Incidents were not a standing agenda item at the senior management team meeting.
- Staff had debriefing following incidents. The contents of the debriefing were not recorded. Ways to prevent or manage incidents better were not recorded.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- We reviewed six patient's care and treatment records. Patients were assessed by two staff before they were admitted to the service. This assessment was undertaken by a nurse and the consultant psychiatrist or a therapist. Patients also had an assessment when they were admitted to the service. This assessment identified patient's physical and mental health problems. However, patients did not have a functional analysis of their behaviour. This is a way of understanding why a patient behaves the way they do. The absence of a functional analysis meant that patients could not be appropriately supported to manage difficult situations. When patients display behaviour which challenges a functional analysis should be undertaken (DH, 2014).
- Patients did not have a physical examination when they were admitted to the service. Patients did not receive annual health checks. Patient's with diabetes had their blood sugar checked daily. All patient's had their blood pressure, pulse and oxygen saturation levels taken weekly. Oxygen saturation refers to how much oxygen is present in persons' blood cells. However, when patient's required their weight to be checked regularly, this did not take place.
- Patient's care plans were written by the occupational therapist and the psychologist. Nursing staff were not involved in producing care plans. Patients had a care plan for each of their needs. Some care plans for different patients contained very similar wording. One patient's care plan included the name of another patient. Care plans focussed on patient's care needs such as washing, dressing and using the toilet. Patients at risk of pressure ulcers did not have a care plan regarding this risk. This meant that basic care to reduce the risk of pressure ulcers was not planned. Patients who had diabetes did not have a care plan for this. This meant that patients care needs were not planned. It also meant that these patients did not have an educational programme regarding their diabetes. Providing patients with education regarding their diabetes is best practice (Type 1 diabetes in adults: diagnosis and management, NICE, 2015b). Care plans for patients 'as required' (PRN) medicines did not always include all of their 'as required' medicines. It was not clear under what circumstances patients may require all of their medicines. Care plans for supporting patients when their behaviour was challenging recorded the signs of when this may happen. The ways to support patients during this time were basic and limited. There was minimal focus on talking with patients at these times. Patients did not have a positive behaviour support plan. This was not in accordance with best practice (DH, 2014). Patient's did not have a care plan addressing their psychological, spiritual or cultural needs. Almost all patients finances were managed by staff, but most patients did not have a care plan for this. Patient's care plans did not identify how patient's skills could be increased and were not recovery focussed. Care plans did not indicate how patients could be supported to maximum independence. Patient's care plans were reviewed in the weekly clinical team meeting. However, three patient's care plans were not up to date and did not reflect their current care needs. Almost all patient's care plans had not been signed by a staff member. Patient care plans involved instructions for staff, and were not written for, or with, patients.
- Most patient information was stored in their care and treatment records. However, patients behaviour recording charts, physical observation records and requests for the GP were stored in different places. When a patient was seen by the GP, there were not always notes in the patient's care and treatment record.

Best practice in treatment and care

- When patients became agitated, aggressive or violent, they were sometimes administered medicines. These medicines were prescribed in accordance with best practice (NICE, 2015a). Patients were also prescribed other medicines on an individual basis. These medicines were to manage a variety of patient's symptoms. Two patients had type one diabetes. Their medicines were prescribed in accordance with national guidance (NICE, 2015b). However, these patients had not been assessed for self-administration of their insulin medicine. This was not in accordance with the guidance. One patient was prescribed two medicines containing paracetamol and two anti-inflammatory medicines. This was not best practice and there was a risk of accidental overdose.
- Patients did not receive psychological treatment appropriate to their needs. There was no framework for providing individual patients with psychological therapy. The service did not operate any psychological or psycho-educational groups. All of the patients had behaviour charts. Why, and how these behaviour charts were to be used was unclear. Patients behaviour charts were rarely completed. Three patients wanted to continue to use alcohol. No psychological assessment or treatment took place with patients regarding this. Psychological interventions took place 'as and when' patients were agreeable. These interventions were unstructured and not evidence-based.
- The GP for the service attended weekly. Patients were referred to the physiotherapist, dietitian and dentist when required. However, there was no record of patients receiving a specific neuropsychiatric assessment.
- The chef reported that they were unable to cook dishes on the menu due to a lack of suitable ingredients. There was a risk that patients with diabetes would not be provided with the appropriate food. Patients at high risk of pressure ulcers did not have their fluid intake and output monitored. Dehydration increases the risk of pressure ulcers. One patient often refused food and drinks supplements. They did not have a fluid balance chart.
- The occupational therapist used the Barthel Index to assess patients activities of daily living. This was also used to record patients' outcomes. We were told that the service benchmarked patient outcomes against the UK Rehabilitation Outcomes Collaborative (UKROC). However, of 10 clinical tools required for benchmarking, the service only completed one; the Barthel Index.
- The only clinical audit undertaken in the service was the medicines audit.

Skilled staff to deliver care

- The staff team in the service included a consultant psychiatrist, qualified nurses and rehabilitation assistants. There was also a full time occupational therapist and psychologist, and a therapy assistant. A speech and language therapist attended the service every two weeks. A music therapist also worked in the service one day per week. We were informed that a physiotherapist could be requested to attend when required. There was no social worker in the service or input into the service from a pharmacist.
- Some nursing staff had worked in brain injury and neuro-rehabilitation services before. However, the psychologist did not have experience of working in such services. The consultant psychiatrist did not have any postgraduate qualifications in neuropsychiatry or rehabilitation. They had not worked in a brain injury or neuro-rehabilitation service prior to working in the service.
- Permanent staff and bank staff had an induction when they started working in the service. Agency nurses received a medicines competency induction. When agency staff worked a night shift for the first time they did not receive an induction. The information they received regarding the service was provided in a handover from the day staff.
- The supervision and appraisal records of all permanent staff were reviewed, except for the consultant. Of the fourteen staff, five staff had not received supervision for over one year. Within the last year, three staff had one supervision session. A further three staff had two supervision sessions. The most supervision sessions a staff member had was four in the previous year. This was for one member of staff. The occupational therapist and psychologist had received one supervision session in the previous year. The consultant psychiatrist told us

they attended peer supervision. However, the other doctors in their peer group did not work in brain injury services. Most staff were new to the service, and were not due to have an appraisal.

- Specialist training was available to staff. Ten permanent and bank staff (43%) had undertaken moving and handling training. Three patients required staff assistance with their mobility. No members of staff had undertaken training regarding the safe use of insulin. Two patients were prescribed insulin. The six permanent qualified nurses had undertaken medicine management training. None of the qualified bank nurses had undertaken such training. Training on diabetes, epilepsy, understanding brain injury and dysphagia (choking) had been undertaken by less than 42% of staff. This meant most staff did not have the knowledge or skills to meet patients' needs. No analysis of the training needs of staff had been undertaken.

Multi-disciplinary and inter-agency team work

- Patients care was discussed each week at a clinical team meeting. Notes of the meetings were often brief and there was little evidence of clear treatment plans. Nursing staff had little involvement in the planning of care. The clinical team meetings were not recovery-focussed.
- The working relationship with the GP providing input into the service was unsatisfactory. There was little, if any, communication between staff in the service and the GP who attended. The consultant psychiatrist, and the staff, did not seek information from the GP. Patients care and treatment was provided by the service and the GP separately. This included two different MARs for each patient. Patients received fragmented care. When staff needed the GP to see a patient they recorded this in a book. They also recorded the reason why. This was not recorded in the patient's care and treatment records. When the GP had seen the patient, they drew a line through the request. Details of the GP's examination were not always written in the patient's care and treatment record. Recent entries in the GP book had not been crossed through. We were not provided with a satisfactory explanation, and the service had not followed this up.
- The service's relationship with other agencies and commissioners had been strained. The management team had not identified and informed them of the problems in the service. The local safeguarding team were not confident that all safeguarding incidents resulted in a safeguarding referral. Commissioners of the service had difficulty relying on reassurances by the service management.

Adherence to the MHA and the MHA Code of Practice

- Six staff members (26%) had undertaking training in the MHA. MHA training was not mandatory training for staff.
- We reviewed the records of three patients. Patient consent (T2) and authorisation (T3) certificates were attached to patients' MARs. One patients' T2 certificate included paracetamol, lactulose and a nicotine inhaler. These are medicines for physical health reasons, and should not have been included on a T2 certificate. This demonstrated a lack of understanding of consent in relation to the MHA.
- Patients did not receive information regarding their rights when they should have. Two patients had their detention under Section 3 of the MHA renewed. Following the renewal of their detention, there was no record that patients had been informed of their rights. One patient did not have their rights explained to them following the outcome of a Mental Health Review Tribunal. Patients were not provided with information concerning their rights in accordance with the MHA Code of Practice (2015).
- One patients' Section 17 leave form recorded leave as 'escorted/unescorted – general'. It was unclear if the patient should be escorted or unescorted when on leave from the hospital. Another patients' Section 17 leave form had expired, but had not been crossed through. This meant staff may understand the patient continued to have such leave. Section 17 leave forms described patients' leave being 'escorted' or 'accompanied'. The leave forms did not describe which family members may accompany a patient on leave. There was no record that family members understood their responsibilities when accompanying patients on leave. This was not in accordance with the MHA Code of Practice (2015). One patient's Section 17 leave form was dated seventeen months previously. The patient's leave form had not been updated since that time.

Inadequate

Services for people with acquired brain injury

- The service did not have a designated MHA administrator with additional knowledge or training in the MHA. This meant that that the service did not have clear guidance on the requirements of the MHA.
- Patients' detention under the MHA was recorded correctly, up to date and was stored appropriately. An MHA compliance audit had been undertaken almost one year earlier. There was no ongoing MHA audit. There was no record of how the MHA audit had changed practice in the service.
- Patients did not have regular access to an independent mental health advocate (IMHA). The service did not have arrangements to ensure that an IMHA was available when required. We were told the service requested commissioning bodies to provide IMHAs for individual patients.

Good practice in applying the MCA

- Four staff (17%) had received training in the MCA. MCA training was mandatory for staff. The service had an MCA and DoLs policy.
- An urgent DoLs authorisation had been made shortly before the inspection. There was no record in the patient's care and treatment record of why the urgent application had been made. There was no record that the patient's capacity had been assessed.
- Most staff had little understanding of the MCA and DoLs. They could not describe the overarching principles or the capacity assessment.
- Capacity assessments were usually undertaken by the consultant psychiatrist. Capacity assessments were decision specific. However, the assessments did not document how the patient had been involved in the discussion. There was no record that patient's views were sought or that they were supported to make decisions. On at least two occasions, the decision being considered should have prompted a best interests assessment. This did not happen. Capacity assessments were not always signed by a staff member. A recent capacity assessment had been the subject of criticism from a Mental Health Review Tribunal (MHRT). The patient requested legal representation by a different company than other patients used. A member of the MDT had conducted a capacity assessment. They assessed the patient did not have the capacity to make such a decision. The medical member of the MHRT also conducted a capacity assessment of the patient. They concluded that the patient had the capacity to choose their own legal representative.
- Staff, including the consultant psychiatrist, were unable to describe what was meant by the term 'restraint' in relation to the MCA and DoLs. There was an informal patient in the service. There was a risk that the patient could be 'restrained' and that this would not be recognised by staff.
- One patient was subject to continuous observation by staff and this was not included in their DoLs authorisation. Another patient had been locked in their bedroom for a number of weeks. This had not been part of their DoLs authorisation.
- Use of the MCA and DoLs was not subject to audit or monitoring. This meant that use of the MCA and DoLs was not measured against best practice and legal requirements.

Are services for people with acquired brain injury caring?

Inadequate

Kindness, dignity, respect and support

- Patients were not always treated with dignity and respect. Two patients required an insulin injection. They had to expose their stomachs outside of the clinic room to receive their injections. This was in the main corridor. Some staff were involved with assisting patients with exercise. This involved staff touching the patient. The staff undertaking these activities wore gloves.
- Patients reported that they did not feel staff listened to them. Two patients spoke highly of individual staff members, but were not positive overall. Two patients also provided examples of when staff did not provide support.
- A vulnerable patient had been locked in their room for a number of weeks. The light in the room had been left on all of the time. Staff had not considered the patients' dignity and had not questioned the practice.

Inadequate

Services for people with acquired brain injury

The involvement of people in the care they receive

- Patients were not involved in developing their care plans or risk assessments. Patients' views of their care plan were not sought. Patients did not have a copy of their care plan. Patients had only recently been invited to attend their weekly clinical review meeting (ward round).
- Patients were unable to access an advocate easily. An advocate did not visit the service and information regarding advocates was not displayed.
- Families and carers were involved in patients' care and treatment. This was well documented in patients' care plans. One of the carers we spoke with was positive regarding the service. The other carer was unimpressed with the service. They did not feel involved in the patient's care. The service did not hold carers' meetings.
- The service had held one community meeting for patients. The minutes of this meeting were not available. The service had not undertaken a patient survey to understand patients' views. There was no system for patients to provide feedback about the service.
- Patients were not involved in the way the service operated. Patients had little choice regarding the service provided to them.

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

Inadequate

Access and discharge

- The service had 93% bed occupancy in the six months prior to the inspection.
- Patients could be admitted to the service at short notice. When this occurred, the patient was admitted without all of the necessary background information being available. Following meetings with commissioners, the service had voluntarily agreed not to admit any new patients. This was to allow time to resolve the difficulties the service had experienced.
- Patients average length of stay was two years. However, we found only one patient in the service had any discharge plans. These plans were not specific and detailed and did not have a clear timescale. The lack of early discharge planning increased the risk that patients discharge would be delayed when they were ready to leave the service.

The facilities promote recovery, comfort, dignity and confidentiality

- There was no visitors room in the service. All of the communal areas were used by other patients. This meant it was not possible for visitors to see patients in private. There was no activities room. Activities were undertaken in the main lounge in the presence of other patients. A small quiet room was located on the top floor. The only other communal area for patients to sit was the lounge, which had a television.
- The environment was neglected and in need of redecoration. Fixtures and fittings required repair. A curtain was falling off a curtain rail and a window handle had been sawn off. There were no shelves on the walls and very few pictures. A large perspex window allowed staff in the office to look into the lounge. The environment was institutional.
- Patients did not have access to a private telephone. Patients had to negotiate with staff to use the office telephone. Patients were not able to have mobile phones.
- There was a large garden at the rear of the service. Patients were able to access the garden during the day. At night the garden doors were locked.
- Patients reported that the quality of food was poor. One patient's relative had informed the manager that they had arranged for a restaurant to deliver food to the patient.
- Patient's bedrooms were bare, apart from furniture. One patient's clothes were in bags in a cupboard. Patients had not personalised their bedrooms. One patient had the key to their bedroom.
- There was no activity programme in the service. We observed that some activities took place in the lounge. However, patients said they were bored and there were

very few activities. Most activities involved patients going on leave. When this happened patients went to the shops and cinema. This depended on the availability of staff.

Meeting the needs of all people who use the service

- There had been minimal adjustments to the service to accommodate wheelchairs. Wheelchairs barely fitted through some doorways. There was no toilet accessible to disabled people on the ground floor. However, a stair lift had been installed. Access to the quiet room on the top floor involved climbing steep, narrow stairs. This was difficult for patients with mobility problems. One patient admitted to the service had significant mobility problems and required a wheelchair. Their bedroom was located on the ground floor in what had been an office. This room was unsuitable to be used as a bedroom.
- There was no information available for patients regarding complaints, advocacy, treatment or patient rights.
- Patients reported that they had little choice regarding food, except for breakfast. One patient told us they had no choice at mealtimes.
- One patient wanted to practice their faith outside of the hospital. They had not been able to do so. The patient reported that staff had not asked them about their religion. There was no record that patient's religious or spiritual needs had been assessed. There was also no record of religious or faith leaders visiting the service.

Listening to and learning from concerns and complaints

- In the previous three months five complaints had been made regarding the service. All of the complaints were from patients' relatives. We reviewed the response to these complaints. There was no record of how the service had responded to two of these complaints. The response to a different complaint did not address all areas of the complaint. Another complaint recorded that a meeting had been held with the complainant, and a letter had been sent. There were no notes of the meeting or copy of the letter available.
- The interim manager provided the response to complaints. There was no system to review how complaints had been investigated. If complainants were unhappy with the response, there was no system for them to ask for the response to be reviewed.
- There was no effective system for the service to learn from complaints. Two of the complaints related to the same problem on different occasions. Complaints were not reviewed on a regular basis by the senior management team.

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

Inadequate

Vision and values

- The provider of the service had a published vision and values. Staff were aware of the service's vision to provide excellent rehabilitation.

Good governance

- There were low levels of staff undertaking mandatory training. Staff did not receive regular supervision. There were low levels of staff attendance at specialist training. This meant staff were not equipped to meet the range of patients' needs. There was a lack of knowledge amongst the staff team, including senior staff, regarding the care and treatment of patients with a brain injury.
- The provider did not have a strategy to learn from incidents and minimise their reoccurrence. There was no date when an incident policy would be available.
- There were not a sufficient number of qualified staff on duty to provide safe, effective and high quality care to patients. There were no plans to reassess staffing levels or to use a validated dependency tool to guide staffing levels.
- There was a lack of clinical audit. Important standards for the care, treatment and safety of patients were not monitored. There was no system to ensure that best practice and national guidance was consistently followed.

Inadequate

Services for people with acquired brain injury

- There was no effective system for ensuring that best practice and legal requirements were met regarding the MHA and the MCA.
- There was no system for patients and carers to provide feedback to the service.
- The service had relied on other agencies to identify problems and issues. The service had been unable to resolve these issues without the support and guidance from external agencies.
- The management team had developed a continuous improvement framework. This was a lengthy action plan to address shortcomings in the service. Some elements of the action plan had led to improvements. However, all parts of the action plan involved relatively short timescales. The number of changes to be made within the timescales did not allow sufficient time for new practices to become embedded. The action plan did not identify areas of priority. Some actions were documented as completed. However, the improvements in practice had not been consistent. Most of the actions were not sufficiently detailed for progress to be accurately assessed.
- The provider operated a clinical governance meeting. However, the information provided to this meeting was basic. There was no clear strategy of how to improve fundamental standards of care. Patient safety was not given a sufficiently high profile in the meetings.
- The governance arrangements for the service were at an embryonic stage. Baseline information was not collected to measure improvement in the service. Basic governance systems were not in place. There were no key performance indicators for the service. There had been a systemic failure to assess, monitor and improve the safety, care and treatment of patients.

Leadership, morale and staff engagement

- Sickness rates in the service were low. There were no cases of staff alleging bullying and harassment.
- There was no clear leadership message that staff could raise concerns regarding patient care. The previous and current interim managers had adopted a top-down style of leadership with the aim of improving standards. However, not all staff were confident that they could raise concerns regarding standards of care.
- Staff reported improvements since the new interim manager had started at the service. However, staff morale was affected by the external scrutiny on the service and it's long term future.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of patients was not appropriate, did not meet their needs, and did not reflect their preferences. Care and treatment was not designed to ensure patients' needs were met. Patients were not supported to understand treatment choices or make decisions about their care to the maximum extent possible. Patients did not have care plans for all of their needs. Patients were not supported to understand their care and treatment choices. Patients did not participate in making decisions about their care or treatment. This was a breach of regulation 9 (1)(b)(c)(3)(a)(b)(c)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients were not treated with dignity and respect. The privacy of patients was not maintained. Patients were not given privacy and dignity when receiving some treatment. This was a breach of regulation 10 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for patients. The provider did not assess and mitigate the risk to patients' health and safety. Staff providing care did not have the competence, skills and experience to do so safely. Equipment provided for providing care and treatment was not safe for such use. The provider did not ensure the proper and safe management of medicines. The provider did not assess, prevent, detect and control the spread of infections. Timely care planning did not take place with others sharing responsibility for the care and treatment of patients. Patient risk assessments and management plans were not updated. Staff did not provide effective, evidence-based care. Equipment was not calibrated. A patient was prescribed medicines that could have caused an accidental overdose. There were no infection control procedures. Care between the service and the general practitioner was fragmented. This was a breach of regulation 12 (1)(2)(a)(b)(c)(e)(g)(h)(I)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Patients were not protected from abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of patients., or to investigate an allegation or evidence of such abuse.

This section is primarily information for the provider

Enforcement actions

Not all safeguarding incidents were referred to the local safeguarding team. A patient was controlled in their bedroom when this was not necessary. The patient's circumstances were degrading and ignored their needs for care and treatment.

This was a breach of regulation 13(1)(2)(3)(4)(b)(c)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises were not clean or suitable for the purpose for which they were being used. The premises were not properly maintained. There was ingrained dirt on skirting boards, rugs and curtains. There was no visitors room or activity room. The clinic room was very small. There were torn floor coverings, and broken skirting boards and tiles. A radiator was damaged. This was a breach of 15(1)(a)(b)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not establish and operate systems effectively to assess, monitor and improve the quality and safety of the services provided. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others. The provider did not seek and act on feedback from patients.

This section is primarily information for the provider

Enforcement actions

There were low levels of staff training. There was no effective system to learn from incidents and complaints. There was no incident policy. There was a lack of clinical audit. There was no system for patient feedback.

This was a breach of regulation 17(1)(2)(a)(b)(e)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider did not deploy sufficient numbers of qualified and experienced nurses. Staff in the service did not receive appropriate supervision and training.

One qualified nurse worked on each shift in the service. Staff did not have access to regular supervision. Staff did not receive appropriate training to carry out their duties.

This was a breach of regulation 18(1)(a)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Recruitment procedures were not established and operated effectively to ensure staff were of good character and had the skills and experience necessary for the work to be performed by them. All of the required pre-employment information was not available.

Staff did not have gaps in employment explored, appropriate references, their right to work in the Uk reviewed, or confirmed checked on Disclosure and Barring certificates.

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 19(2)(a)(b)(3)(a)(b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The service did not keep a written record that patients were informed of a notifiable incident, provided an explanation and apology, or were given the results of further enquiries. There were no records avaivailble to confirm patients had been informed of notifiable incidents, received an apology or were given the results of further enquiries. This was a breach of regulation 20 (3)(e)(4)(a)(b)(c)(d)(e)