Elm Park

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

Summary of findings

We rated Elm Park as 'good' because:

- The wards were safe, clean and had designated rooms for therapies and activities. Staff had undertaken environmental risk assessments to identify potential ligature anchor points that might endanger people at risk of suicide. They had plans in place to manage them safely. There was a fully equipped clinic room with accessible resuscitation equipment. Staff regularly checked equipment.
- Beds were available to admit and treat patients when needed and the provider reported no delayed discharges.
- There was a weekly timetable of community and on-site occupational activities. The hospital had a 'pets as therapy' dog and patients could look after chickens. Patients were able to personalise their rooms and quiet areas were available on the ward where patients could meet visitors. Patients had private access to a telephone.
- The wards had an adequate number of staff to provide safe care. Where there were vacancies, they used suitably skilled bank and agency staff to cover any gaps.
- All staff carried personal alarms and we saw alarms in patient bedrooms for summoning assistance when needed. The provider had an induction programme for new staff and rehabilitation workers were offered training via the care certificate. Staff received annual appraisals.
- Staff were skilled in managing risks to patients and received training in managing challenging behaviour. Staff completed regular observations of patients and recorded these. They managed and administered medication correctly. Staff reported incidents and managers monitored these reports to identify and implement any lessons learnt. Managers ensured that the trust board was aware of this information.
- Patients detained under the Mental Health Act 1983 (MHA) were aware of their rights and paperwork was in order and stored appropriately. Staff used the Mental Capacity Act 2005 to assess capacity for individual decisions. Staff received training and support was available from a MHA administrator when needed.
- Staff from different disciplines worked well together to provide care. Staff undertook a multidisciplinary assessment following admission and used this to develop a care plan.
- There were appropriately trained staff to deliver care. Staff received annual appraisals.
- Staff included neuropsychology, psychology, occupational therapy, psychiatry, speech and language therapy, physiotherapy, social worker, nursing and rehabilitation workers. This included meeting the patient's physical healthcare needs. A practice nurse was available and a GP visited the site weekly. Podiatry and dental care were available and referrals for specialist input were made when needed.
- Staff used nationally recognised outcome measures to gauge how patients were doing. Senior staff attended daily handover meetings, which reviewed actions and outcomes for patients and the hospital. Regular team meetings were held, to include senior management team meetings, referral, admission and discharge meetings, ward team meetings, community meetings and staff and patient link up meetings. Actions and outcomes from meetings were recorded.

Summary of findings

Contents

Good

Location name here

Services we looked at
Services for people with acquired brain injury.

Summary of this inspection

Background to Elm Park

Partnerships in Care Limited provide locked specialist neuro-rehabilitation inpatient services for men at Elm Park in Colchester, Essex.

Elm Park is registered with the Care Quality Commission for the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983 (MHA)
- treatment of disease, disorder or injury.

Elm Park is an independent hospital providing services to treat and discharge patients with complex neurological needs that follow a traumatic or acquired brain injury.

Elm Park provides individual treatment programmes for men with complex behaviour issues, including those with a forensic history. These programmes are available to both voluntary patients and those detained under the Mental Health Act (MHA).

The hospital can accommodate 17 patients. There is one ward. Fourteen residents received care and treatment at the time of our inspection. Eight patients were detained under the MHA, one patient was voluntary and five patients were subject to deprivation of liberty safeguards (DoLS).

Elm Park Hospital has a registered manager and a controlled drugs accountable officer.

The Care Quality Commission last inspected Elm Park in August 2013. We found no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 during that inspection.

Our inspection team

Team leader: Karen Holland, inspector, mental health hospitals, Care Quality Commission

The team that inspected the service comprised four CQC inspectors, one Mental Health Act reviewer, one specialist advisor and two assistant inspectors.

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 and sought feedback from carers.

During the inspection visit, the inspection team:

- visited the ward, looked at the quality of the ward environment and observed how staff cared for patients
- held discussions with six current patients and one patient who had been discharged

Summary of this inspection

- spoke with five carers via telephone
- spoke with the registered manager, the newly appointed hospital director, the director of clinical services and the ward manager
- received feedback about the service from 16 other staff members including a consultant psychiatrist, nurses, support workers, an occupational therapist, a physiotherapist, psychologists, a speech a language therapist, a social worker, administration staff and housekeeping staff
- attended and observed an early morning review meeting attended by clinical lead staff
- collected feedback from two patients and one carer using comment cards
- looked at nine patient care and treatment records
- reviewed 13 medication prescription charts
- carried out a specific check of medication management on the ward
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Two patients told us that Elm Park was the best hospital they had been in. Patients told us that the staff were very good. One patient said the staff always did their best for patients and another said staff always had time to support him.

One patient said that staff had supported him to improve his memory.

- Patients said that they had regular community leave and that there were always staff available to escort them. Throughout the course of the day, we saw patients going out into the local community. The majority of patients were happy with their treatment programmes and activities. One patient told us he was bored but admitted his interests were not easily catered for.
- One patient reported being hit by another patient. He said that staff had dealt with the situation and he felt safe at Elm Park.
- One patient told us they really appreciated their room, which was like their own apartment.

We spoke with five carers who told us:

- Staff involved them in the care of their relative. All had received information on care and treatment and three carers regularly attended care programme approach meetings where treatment and care was discussed and planned. One carer told us they did not receive as much information as they would like; for example they did not have a copy of the care plan and did not know what discharge planning was in place. Four carers told us they had copies of relatives' care plans and were able to share their views.
- One carer commented that their relative was well supported by the hospital and a senior manager confirmed that they were working to support the patient on home leave and gaining feedback via telephone and email.
- Carers told us that care was good. One carer described care as "excellent" and another as "second to none". One carer was happy that her relative was attending college and another spoke about plans for a transfer to one of the rehabilitation cottages.
- Some carers had long distances to travel; however told us they could always make contact by telephone. One carer told us staff escorted the patient to have family contact in the community.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- mandatory safeguarding training levels were below the provider's compliance target
- we found an unlocked cabinet in the therapy cabin with an opened and leaking chemical container, which posed a risk under the Control of Substances Hazardous to Health 2002 regulations (COSHH)
- a consultant psychiatrist attended the hospital two days per week but there were no other medical staff on site
- we were told a doctor from a nearby hospital could be contacted if needed, but staff could not show us any written protocol for this arrangement
- one patient did not have a risk assessment despite being on the ward for over a month
- not all patients had care plans to manage identified risks; this posed a danger that staff might not have the information needed to provide care and treatment
- patients could not access the garden for fresh air or to smoke after 19.30, and this restriction was not based on individual risk assessments.

However:

- clinical areas were clean and equipment was well maintained
- ligature risks were identified and documented
- the provider installed mirrors and increased patient observation levels to reduce risks from ward areas in which staff could not easily see patients
- bank and agency staff were familiar with patients' needs as well as the service's needs
- the provider used effective processes to manage security
- most patients' risk assessments were up to date and regularly reviewed
- staff used physical interventions (restraints) in accordance with relevant guidelines
- staff were trained in safeguarding processes and knew how to make referrals
- staff stored and administered medication appropriately, including storing controlled drugs securely and keeping appropriate records
- the provider managed and recorded incidents in accordance with its internal policy

Summary of this inspection

- staff had regular individual time with patients and recorded this time in patients' care records
- senior staff arranged debriefs quickly after incidents to support staff and patients
- patients told us they felt safe in the hospital environment.

Are services effective?

Good

We rated Elm Park as 'good' because:

- most patients received comprehensive and timely assessments of their needs after admission
- staff completed and monitored patient physical health checks
- a GP and practice nurse were available on site to meet patients' physical health needs; a dentist and podiatrist could be accessed as needed
- patient care plans were comprehensive and holistic
- staff reviewed care plans regularly
- a range of staff had appropriate knowledge, skills and experience to deliver patient care and treatment
- the provider completed service-relevant outcome assessments to assist clinicians with setting goals
- healthcare support workers could take the national care certificate, a qualification aimed at providing the skills and knowledge needed to offer safe and compassionate care
- the provider held regular staff meetings and patient community meetings. Minutes effectively captured feedback, actions to take and timeframes for completion.

However:

- nursing staff supervision did not take place regularly as per the provider's target of 95%, therefore limiting staff ability to identify and discuss performance issues and development opportunities.
- staff did not routinely complete capacity to consent assessments for patients detained under the Mental Health Act 1983 when they first administered medication or considered detention renewal.

Are services caring?

Good

We rated Elm Park as 'good' because:

- the provider displayed 'dignity in care' posters across the hospital
- staff and patients interacted well and staff were respectful and friendly when speaking with patients

Summary of this inspection

- staff responded quickly to patients' requests for assistance and were passionate and enthusiastic about providing care to patients with complex needs
- nurses allocated each patient a 'patient buddy' on admission to help with orientation
- staff advocated for patients, for example staff who were concerned about the time taken to resolve a patient's physical health matter made an informal complaint to the treating hospital
- carers received information from the service relating to their loved ones' care and treatment
- two carers told us they regularly attended Care Programme Approach (CPA) meetings where patient progress and plans were discussed.
- regular community meetings enabled patients to discuss concerns and be involved in ward decisions
- management discussed the results of annual patient satisfaction surveys at clinical governance meetings; regional clinical governance leads reviewed resulting action plans.

However:

- not all patient care plans included patients' comments
- when patient care plans stated patients were unable to comment, it was not always clear what steps staff had taken to ensure these patients' involvement, for example use of advocacy support.

Are services responsive?

Good

We rated Elm Park as 'good' because:

- the hospital had links with two rehabilitation houses to which patients could transfer and continue their treatment in community settings
- the provider had a range of rooms for delivering care and treatment
- a varied activities programme was available for patients within the hospital and in the community
- the provider encouraged patients to continue education and some attended college
- the hospital had a 'pets as therapy' dog in the hospital every day as well as a large on-site chicken coop where patients could look after chickens
- quiet areas were available on the ward
- rooms were available in which patients could meet visitors
- patients had access to a telephone and could make calls in private

Summary of this inspection

- a patient whose first language was not English had a staff member available who spoke his first language; the provider used external qualified interpreters for medical reviews and meetings
- ongoing refurbishment plans updated and improved the hospital environment
- aids and adaptations supported patients with mobility difficulties and patients at risk of falls
- the hospital involved patients in menu planning and offered a choice of food to meet ethnic and religious dietary requirements
- the provider used a system to track and record complaints and staff knew how to support patients and carers who wanted to make complaints.

Are services well-led?

Good

We rated Elm Park as 'good' because :

- staff told us managers were approachable and senior managers regularly visited their areas
- the provider managed quality and safety using various tools, for example a 'ward to board' dashboard to monitor performance, quality and safety against agreed targets
- the provider had systems for monitoring compliance with mandatory staff training
- staff received annual appraisals that identified training needs and performance
- the provider employed staff with appropriate skills for care and treatment and used regular bank or agency staff when needed to promote continuity of care
- staff could spend time on direct patient care activities, for example offering individual time for patients to discuss their progress, goals and concerns
- the provider had systems for reporting and recording incidents and staff received feedback from lessons learnt
- the provider held quarterly meetings with the local safeguarding lead and police to review reported incidents.
- the provider had systems to monitor compliance with the Mental Health Act 1983 and Mental Capacity Act 2005
- staff completed annual satisfaction surveys to give feedback on the service and the provider had action plans for any improvements needed
- staff told us morale and job satisfaction was good and they could raise concerns without fear of victimisation.

However:

Summary of this inspection

- nursing staff supervision did not take place regularly as per the provider's target, therefore limiting staff ability to identify and discuss performance issues and development opportunities.
- Staff compliance with mandatory training was below the provider's target.
- The provider did not have a clear process for medical cover when the consultant was unavailable.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- At the time of the inspection there were eight patients detained under the Mental Health Act 1983 (MHA) receiving care and treatment.
- Staff received training in the MHA and the new Code of Practice. Staff knew how to contact their Mental Health Act leads for advice. The provider had an effective system for checking MHA documentation. Staff uploaded detention papers onto the electronic records system and these appeared to be in order.
- Patients were aware of their rights under section 132 MHA and staff regularly discussed rights with patients. Independent mental health advocates (IMHA) were available to attend clinical meetings and information for patients about this service was visible on the ward.
- The responsible clinician authorised leave and this was appropriately documented. Nursing staff completed risk assessments prior to patients using leave. Each patient had a leave contingency plan.
- Patients receiving medication had consent to treatment or appropriate second opinion approved doctor (SOAD) assessments completed. Treatment forms were available for staff to check when administering medication.
- The provider conducted regular MHA audits to ensure that the MHA was appropriately applied.

However:

- We found, following periods of leave, nursing staff detailed some outcomes in individual patient's daily notes but this was not consistent. Patients' involvement in care planning was variable.
- Senior staff told us the team were working on reducing the number of blanket restrictions. However, some restrictions were applicable to all patients regardless of their risk assessments. For example, patients had restricted access to the garden for fresh air and/or to smoke.
- The responsible clinician attended the hospital two days per week. There were no other medical staff on site. We did not see a clear protocol as to how cover was to be provided.
- We could find no records to show that staff assessed capacity and consent to medication at first administration. Staff did not routinely assess capacity and consent when renewal of detention was being considered.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There were five patients subject to Deprivation of Liberty Safeguards (DoLS) receiving care and treatment.
- Staff had received training in the Mental Capacity Act 2005 (MCA). Staff had good understanding of the five statutory principals of the MCA and demonstrated how this was implemented in their role. The provider had a policy on the Mental Capacity Act to which staff could refer if needed. The MHA administrator was available for support.
- The provider had made four DoLS applications in the past six months.
- Patients had access to independent mental capacity advocate (IMCA) services when needed.
- We saw evidence of decision specific capacity assessments.
- The hospital had one informal patient. Appropriate MCA assessments, to establish capacity to consent to care and treatment, were completed.

However:

- We were unable to find records of best interest meetings or discussions that included family members or advocates.
- The provider did not routinely assess patients' capacity when making safeguarding referrals.
- In May 2015, staff made referrals to the supervisory body for renewals for two patients whose DoLS authorisations

expired in June. Despite staff having regular contact with the local authority, the assessments had not taken place and there were no current authorisations. Consequently, the deprivation of liberty for those patients was taking place without any formal authority. We were unable to find any records or care plans to support staff to manage the situation. It was not clear whether patients were aware of their rights.

Good

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Requires improvement

Safe and clean environment:

- Some areas of the hospital meant staff did not have clear lines of sight to observe patients, for example in corridors. The provider identified and reduced the risk of blind spots by installing mirrors, where possible.
- There were identified ligature points inside and outside the hospital. A ligature point is an object to which a patient can attach an implement for the purpose of self-strangulation. For example, a hose reel, hanging baskets outside the therapy log cabin and taps and rails in the toilet that could pose a risk to patients with self-harming behaviours. The provider had a comprehensive, up to date and weighted ligature risk audit in place, which included height measurement. The provider mitigated these risks by observation levels when needed. The provider had no patients identified as at risk of tying ligatures at the time of the inspection.
- There were 17 patient bedrooms with en-suite toilets and washbasins. Some bedrooms also had showers. All bedrooms had viewing panels to aid staff observations.
- There was a fully equipped clinic room with accessible resuscitation equipment. Staff regularly checked equipment and records were in date.
- We saw that appropriate assessments had been undertaken to identify, manage and review potential risks to ensure and maintain safety of the premises
- There were sensors in bedrooms for patients at risk of falls. This provided an alert to staff if a patient at risk of falls was walking in their room.
- The provider did not have seclusion facilities on site and we found no evidence of patients being secluded.
- All areas of the ward were clean and had adequate and well-maintained furnishings. The provider had up to date cleaning records and we saw these.
- Staff were observed to wash their hands prior to handling food and fluids. There was also hand sanitiser at the chicken coop to be used by patients and staff.
- Environmental risk assessments were comprehensive and up to date.
- We found an unlocked cabinet in therapy cabin with an opened and leaking chemical container. This posed a risk under the control of substances hazardous to health 2002 regulations (COSHH). Staff told us they would take action to address.
- All staff carried personal alarms and we saw alarms in patient bedrooms for summoning assistance when needed. There were extra alarms available for visitors' use.

Safe staffing:

- The provider had an establishment of eight whole time equivalent (WTE) registered nurses. At the time of the inspection, there was a full establishment. This meant there were adequate qualified staff to deliver safe care and treatment.
- The ward manager could adjust staffing levels when required to meet the needs of patients, following discussion with senior management.
- The provider had an establishment of 23 WTE health care assistants. At the time of the inspection, there were three vacancies. Regular bank staff were utilised to fill shift vacancies.

Good

Services for people with acquired brain injury

- The provider had used bank or agency staff to cover 105 shifts in the past three months and reported that they were unable to fill 90 shifts. Unfilled vacancies related to unplanned absences, for example sickness. Staffing levels were appropriate to deliver safe care and treatment and no staff or patients reported concerns with current staffing levels.
- Data provided indicated a staff sickness rate of 2.29% over the past twelve months. This was below the national average. Staff vacancies were 14% and represented nine permanent staff leavers. The majority of staff leavers were due to professional development and new staff had recently been recruited to senior clinical posts.
- Bank staff were familiar with patients and the service. The provider did not routinely use agency staff; but recently this had been necessary due to high patient observation levels. However, every effort was made to use the same agency staff where possible. This ensured care delivery by staff familiar to patients.
- We found that qualified nurses were available in communal areas of the ward during our inspection. This meant that appropriately trained staff were visible and available when needed.
- Between May and July 2015, 91% of all planned patient 'one to one' time with a primary nurse was facilitated. This gave patients the opportunity to discuss their care and treatment with their named nurse.
- Staff delivered 76% of planned activities to patients. The majority of undelivered activities were recorded as 'patient declined'. The provider had identified that staff were not recording some activity and, therefore, these figures might not accurately reflect patient involvement with their activity programmes. The provider cancelled less than 2% of planned activities.
- Eighty six percent of all staff were up to date with training in the management of violence and aggression against a target of 95%. Staff requiring training or refresher were identified on the mandatory training matrix and the provider told us training would be secured. The provider had plans to ensure 100% attendance. Senior staff told us that the trainer, if required, provided individual staff training related to specific patient need.
- The consultant psychiatrist attended the hospital two days per week. There were no other medical staff on site. We did not see a protocol as to how cover was to be provided, as outlined in the Mental Health Act Code of Practice. The protocols should ensure that cover arrangements were in place when the responsible clinician was not available. Senior managers told us that medical cover arrangements were documented in a ward file for staff to refer to; however, we did not see this. Data provided showed the duty cover arrangements for access to a responsible clinician related to a neighbouring hospital, but its use was unclear in the provider's policy. The Provider could not be sure that staff had clear guidance for access to a responsible clinician, when their own was unavailable. However, the policy advised staff to contact emergency services if required.
- All staff were required to complete mandatory training as identified by the provider. The provider monitored compliance via their governance processes. The average compliance was 88% against a target of 95%. The lowest attendance recorded was for basic life support at 66%, security at 74% and safeguarding adults at 70%. Therefore, we could not be sure that the provider adequately trained all staff for their role. However, the provider told us a new method for completing and recording training had recently been introduced and some training data may not yet have been captured.

Assessing and managing risk to patients and staff:

- There were no seclusion facilities on site. Seclusion is the supervised confinement of a patient in isolation away from others and is used as a last resort for the management of severely disturbed behaviour likely to cause harm to others. There were no reported incidents of patients requiring seclusion or long-term segregation in the last six months.
- There were 24 incidents of physical restraint in the last six months. No incidents of physical restraint resulted in patients placed in the prone (face down) position. The provider did not always have medical staff on site. Therefore, we could not be sure that medical staff reviewed patients, subject to restraint, in a timely manner and in accordance with the 26.67 MHA Code of Practice or 1.4.55 and 1.4.4 violence and aggression: short-term management in mental health, health and community settings, NICE NG10.
- The responsible clinician attended the hospital two days per week. There were no other medical staff on site. We did not see a protocol as to how cover was to be provided, as outlined in the Code of Practice chapter 36.3, which states that hospital managers should have

local protocols in place for allocating responsible clinicians to patients. The protocols should ensure that cover arrangements were in place when the responsible clinician was not available. Senior managers told us that medical cover arrangements were in a ward file for staff to refer to; however, we did not see this.

- We reviewed the care records of nine patients. One patient, who had been on the ward for over a month, did not have a risk assessment. Risk assessments were present on the other files we looked at and nursing staff regularly updated these. However, corresponding plans to manage identified risks were not always in place.
- We found blanket restrictions related to access to outside space after 19:30hrs. Patients could not access the garden for fresh air or to smoke after this time. This restriction was not related to individual risk assessments. Staff were unclear how they would manage this if informal patients wished to access outside space after this time. The provider could not be sure that rights of informal patients to leave at will were protected, in accordance with the MHA Code of Practice, or that blanket restrictions were proportionate and reasonable.
- The provider had policies and procedures for the use of patient observation. Staff kept good records of their observations and we saw these. Observation levels were discussed daily in the senior management morning meeting.
- Patients were subject to room searches and searches on return from leave; when appropriate and following risk assessment. The provider had procedures in place to review and record this.
- Senior staff told us that a business contingency plan included an evacuation plan developed with police and fire services. Each patient had a personal emergency evacuation plan (PEEPS). This provided staff with clear plans for maintaining patient safety in the event of an emergency.
- Physical restraint was used as a last resort and staff practiced verbal de-escalation and distraction techniques with good effect. Ninety percent of staff had received training in conflict resolution and breakaway techniques and this training was refreshed annually. This promoted care delivery in accordance with guidance provided in 'Positive and Proactive Care, Department of Health' (2014).
- Senior staff had procedures for keeping staff safe. These included the use of key management systems, alarms, training and development, support, access to 'care first' external staff support systems and occupational health support.
- Senior staff told us that they escalate concerns to the executive team/directors. Risk assessments for the hospital were monitored via governance meetings and the regional senior management team. Information was available through the 'ward to board' dashboard and viewed at monthly service manager meetings. The provider had a dashboard that could break down incident reports and analyse themes. This allowed for incidents occurring locally to be reviewed at a corporate level and any actions required identified.
- There were no records of the use of rapid tranquilisation for patients.
- Safeguarding training was mandatory for all staff; however only 70% of staff were up to date with training, against a target of 95%. The provider could not, therefore, be sure that all staff were aware of safeguarding procedures. However, new training methods, recently introduced, might account for the shortfall in these numbers, as some training data might not have been captured. Staff we spoke to were able to give examples of safeguarding processes.
- We reviewed 13 medication charts. The hospital used a comprehensive prescription and medication administration chart. This facilitated the safe prescribing and administration of medicines. Doctors and pharmacists regularly reviewed prescriptions, and records of administration were fully completed. Controlled drugs were stored securely and recorded in the register.
- A local community pharmacy provided pharmacy services and attended the wards regularly.
- This ensured medicine was available when needed. Pharmacy audits were regularly undertaken. Where needs were identified, we saw evidence of actions being completed.
- The provider had a policy in place for managing child visits to the hospital and had designated rooms to ensure privacy and safety.

Track record on safety:

- There were no reported serious incidents in the last 12 months.

Good

Services for people with acquired brain injury

Reporting incidents and learning from when things go wrong:

- Staff knew how to recognise and report incidents. We saw evidence of appropriate incident reporting and follow up.
- Staff were able to demonstrate good understanding of their responsibilities for explaining to patients when things go wrong. The provider had a policy detailing staff responsibilities under the principals of Duty of Candour.
- Staff received feedback from investigations of incidents, both internal and external to the service, via email and through staff meetings. We observed a senior staff meeting and processes for discussing incidents, which included actions to be taken.
- Staff learnt from incidents when things go wrong; for example, improvements had been made to daily observation and handover sheets following a serious incident in another location. This demonstrated that the organisation shares lessons learnt across sites.
- Staff told us senior staff arranged debriefs quickly after any incident, to support both staff and patients. Senior managers would attend when needed. Staff told us they felt supported by senior managers when incidents occurred.

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care:

- We reviewed the care records of nine patients.
- Patients received a comprehensive and timely assessment of their needs after admission.
- Care records showed that there was ongoing monitoring of physical health and all patients received physical health checks within 48 hours of admission and then annually. A registered general nurse visited the site on a weekly basis to provide physical healthcare support.
- Care plans were comprehensive and holistic, and contained a full range of needs and problems. Risks were highlighted and individual risk assessments were linked into care plans. Some plans we looked at did not evidence patient involvement and some care plans and risk assessments had not been reviewed by the due date. Care plans evidenced national institute for health and care excellence (NICE) guidelines. Patients held their own copies.
- Confidential patient information was stored securely within electronic records.

Best practice in treatment and care:

- We reviewed 13 medication cards and found medication prescribing to be in accordance with NICE guidelines and within British National Formulary (BNF) limits for safe prescribing.
- Between May and July 2015 provider's data showed that, 94% of patients were able to access psychological therapies.
- Staff carried out routine physical observations. The practice nurse was usually the initial point of contact for advice about minor physical health care needs. The local GP visited the hospital weekly. Staff made referrals for specialist input when needed. We saw records of healthcare screening appointments, including dental and podiatry care. Care plans were in place to support patients with ongoing healthcare needs.
- Patients were encouraged to participate in healthy lifestyles, to include accessing the gym.
- The provider used a number of patient outcome measures, including the St Andrews Swansea neurobehavioural outcome scale (SASNOS). This tool was used to assess neurobehavioural disability and provided a baseline to track progress in rehabilitation. This helped clinicians with setting goals. Staff rated patients using the SASNOS in the initial stages of admission and then every three to six months.
- Staff used nationally recognised rating scales to assess and record patient severity and outcomes, which included health of the nation outcome scales (HoNOS).
- Staff participated in clinical audits. The provider had a timetable that included plans for future audits and we saw minutes of meetings where these were discussed. Audits undertaken included patient observations, self-harm, mattresses, care programme approach (CPA), Mental Capacity Act 2005 (MCA) and carers' survey.

Skilled staff to deliver care:

- The provider had an experienced full transdisciplinary team (TDT). A transdisciplinary team was one in which members come together from the beginning to jointly

communicate, exchange ideas and work together to come up with solutions. This TDT provided a holistic approach in the delivery of individualised patient treatment programmes, to include neuropsychology, psychology, occupational therapy, psychiatry, speech and language therapy, physiotherapy, social worker, nursing and rehabilitation workers. This provided patients with access to a variety of skills and experience for care and treatment.

- New staff had an induction programme lasting 12 weeks, which was signed off by their manager. Senior staff told us they had adequate induction for their role and that quarterly meetings were held for professional roles and support, which included staff across three sites. This provided staff with opportunities to discuss professional issues.
- Two registered nurses were current mentors. This provided practical experience and support for student nurses undergoing training.
- Agency staff should be subject to DBS checks carried out by their employer. However, a senior manager identified they had not checked with the agency, prior to booking staff, to ensure that those staff had received clearance, or had the necessary skills to work in their environment. A senior manager had identified this issue prior to the inspection and had plans to address this.
- Rehabilitation workers could undertake training via the care certificate. This qualification provides health and social care support workers with the knowledge and skills needed to deliver safe, compassionate care. Currently two staff had achieved level one, two were being peer assessed and two had achieved level three.
- Seventy four percent of non-medical staff had received an appraisal in the last 12 months. However this figure did not include newly appointed staff that were not yet due to be appraised.
- Team meetings were held regularly. We saw evidence of minutes appropriately recorded. This ensured that team objectives were regularly discussed and outcomes reviewed.
- The provider identified that supervision for nursing staff had not been taking place regularly and data confirmed this. We could not, therefore, be sure that performance issues or development opportunities were identified or discussed with staff. Plans were in place to address this going forward and we had sight of these. Some staff from other disciplines accessed their supervision externally.
- Senior staff told us specialist training was available. For example, staff had received training in neurobehavioural skills and acquired brain injury and further training was planned for 2016. Staff told us they were supported to undertake training and gain extra qualifications. Other staff were involved in delivering training to their peers, for example, nurses delivered mental health and personality disorder training which the clinical director oversaw. This ensured staff were suitably qualified for their role and encouraged to participate in professional development.

Multi-disciplinary and inter-agency team work:

- The provider held a daily handover meeting attended by senior staff, which included discussions about patient care, staffing and hospital management. This meeting used an electronic dashboard that populated directly from the nursing care note entries. This ensured that information was accurate and that any actions required could be implemented in a timely manner. Clinical leads ensured that information from the meeting was relayed to ward staff.
- Regular team meetings were held, to include senior management team meetings, referral, admission and discharge meetings, ward team meetings, community meetings and staff and patient link up meetings. We saw appropriately recorded minutes with identified actions.
- Multi-agency adult safeguards meetings were held monthly with a neighbouring hospital to ensure that patients were appropriately safeguarded with management plans in place.
- Staff worked with external agencies, such as commissioners, community mental health teams, ministry of justice, police and local authority. This included liaison with multi-agency public protection arrangements (MAPPA). This ensured a proactive approach to the co-ordinated care of patients.

Adherence to the MHA and the MHA Code of Practice:

- At the time of the inspection there were eight patients detained under the Mental Health Act 1983 (MHA) receiving care and treatment.
- Ninety five percent of staff had received training in the MHA and Code of Practice. This included bank staff. This showed that staff received training appropriate for their role.

Good

Services for people with acquired brain injury

- Staff uploaded detention papers onto the electronic records system. The section papers were complete and appeared to be in order. Reports from approved mental health professionals (AMHPs) were available.
- Staff ensured patients' rights under section 132 of the MHA were discussed with them every month. The discussion included information on the role of independent mental health advocates (IMHA). Information about the role of the IMHA was included in the patients' portfolios and on display on the ward. IMHAs attended clinical reviews and other meetings on request.
- The clinical team considered leave at the patients' monthly review meeting. The responsible clinician authorised leave on a standard electronic form. Escort arrangements were clearly recorded. Copies of Ministry of Justice (MoJ) authorisations were on files of restricted patients and any conditions were replicated on the electronic leave forms.
- Leave was taken at the discretion of the nurse in charge. Separate forms were completed to record leave taken. The leave records showed a risk assessment had been undertaken prior to patients going out. This was not recorded on the leave form; however, there were brief descriptions of the patients' mood or behaviour in some of the clinical notes.
- Each patient had a leave contingency plan.
- Patients receiving medication had consent to treatment or appropriate second opinion approved doctor (SOAD) assessments completed. Treatment forms were available for checking when administering medication. This meant that staff could be sure that medication administration was in accordance with the MHA for detained patients.
- Staff knew how to contact their Mental Health Act leads for advice.
- There was an effective system for checking MHA documentation.
- Staff completed monthly MHA audits to ensure the MHA was appropriately applied. Clinical governance meetings had identified improvements in the reading of Section 132 rights because of issues identified from audits.
- We found some detailed outcomes in individual patient's daily notes but this was not consistent. Staff recorded the outcome of the leave as 'patient returned'. We found some detailed outcomes in individual patient's daily notes but this was not consistent.
- Patients' involvement in care planning was variable. There was no evidence that staff completed plans in collaboration with patients but some contained the patient's comments. Some care plans included notes stating the patient was unable to comment but it was not always clear what steps staff had taken to involve them.
- Senior staff told us the team were working on reducing the number of blanket restrictions. However, some restrictions were applicable to all patients regardless of their risk assessments. For example, restricted access to the garden for fresh air and/or to smoke.
- The responsible clinician attended the hospital two days per week. There were no other medical staff on site. We did not see a protocol as to how cover was to be provided, as outlined in the Code of Practice chapter 36.3, which states that hospital managers should have local protocols in place for allocating responsible clinicians to patients. The protocols should ensure that cover arrangements were in place when the responsible clinician was not available. Senior managers told us that medical cover arrangements were in a ward file for staff to refer to; however, we did not see this.
- One patient had been detained for less than three months and was receiving medication under the 'three-month rule'. We could find no records to show their capacity and consent to medication had been assessed at first administration. Staff did not routinely complete capacity and consent assessments when renewal of detention was being considered. Therefore, we could not be sure that patients' capacity to consent to their treatment programme had been considered during the initial treatment period or at renewal of detention.

Good practice in applying the MCA

- There were five patients subject to Deprivation of Liberty Safeguards (DoLS) receiving care and treatment.
- Ninety five percent of staff had received training in the Mental Capacity Act 2005 (MCA). This indicated that staff were suitably trained for their role and had the appropriate knowledge to protect patients' rights.
- Staff had good understanding of the five statutory principals of the MCA and demonstrated how this was implemented in their role.
- The provider had made four DoLS applications in the past six months.

Good

Services for people with acquired brain injury

- The provider had a policy on the Mental Capacity Act to which staff could refer if needed. The MHA administrator was available for support.
- Patients had access to independent mental capacity advocate (IMCA) services when needed.
- We saw evidence of decision specific capacity assessments, for example, a patient requiring dental treatment had an assessment of capacity to give consent to care and treatment. There were plans to assess a patient's capacity to manage his own finances following concerns raised from staff.
- The hospital had one informal patient. Appropriate MCA assessments, to establish capacity to consent to care and treatment were completed. Clinical leads discussed this in the morning meeting and there were plans to repeat the assessment. The provider was taking appropriate action to safeguard the rights of this patient.
- Two patients had treatment plans that stated they were in their best interests. One patient had been assessed to lack capacity but there was no record of a capacity assessment for the other patient. We were unable to find records of best interest meetings or discussions that included family members or advocates.
- We reviewed three patient protection plans and noted the provider had not assessed capacity relating to patients' understanding of safeguarding referrals. Senior staff told us that this was not routinely undertaken. We could not be sure that patients had understood the safeguarding process.
- In May 2015, staff made referrals to the supervisory body for renewals for two patients whose DoLS authorisations expired in June. Despite staff having regular contact with the local authority, the assessments had not taken place and there were no current authorisations. Consequently, the deprivation of liberty for those patients was taking place without any formal authority. We were unable to find any records or care plans to support staff to manage the situation. It was not clear whether patients were aware of their rights

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support:

- Two patients told us Elm Park was the best hospital they had been admitted to. Patients told us the staff were very good. One patient said the staff always did their best for the patients and another said staff always had time for him.
- We observed good interactions between patients and staff and saw staff were friendly and respectful when speaking with patients. Staff responded quickly to requests for assistance.
- From the hospital's 'patient satisfaction survey' 2015 (15 responses), 60% said they felt listened to by staff, 60% had confidence in the clinical team and 73% said they were treated with dignity and respect by staff. In all cases, 33% of patients gave no response.
- We found that staff were passionate and enthusiastic about providing care to patients with complex needs. They explained to us how they delivered care to individual patients. This demonstrated that they had a good understanding of the specific care and treatment needs of their patients. 'The provider had 'dignity in care' posters displayed across the hospital and staff could refer to these.
- We found staff advocating for patients; for example, staff concerned about the length of time taken to resolve a physical health matter for a patient had made an informal complaint to the treating hospital.

The involvement of people in the care they receive:

- From the hospital's 'patient satisfaction survey' 2015 (15 responses) two patients (13%) said they were given enough information about the pre-admission assessment with one patient (6%) stating that not enough information was available and four patients (26%) were unable to answer. Nine patients (60%) felt supported on admission to the hospital. Five patients (40%) were unable to respond.
- Nursing staff allocated patients a 'buddy' on arrival at the hospital. This system matched newly admitted patients with an existing patient to help orientate them to the hospital. This meant that patients received peer support during the early days of admission.
- Patients' involvement in care planning was variable. Not all plans contained patients' comments and whilst some included notes stating the patient was unable to comment, it was not always clear what steps the provider had taken to involve them, for example, by use of advocacy support. Patients had copies of their plans.

Good

Services for people with acquired brain injury

- Nursing staff reviewed most of the care plans we saw between one and three monthly. However, there was one time limited assessment plan, related to an external activity, which nursing staff had not reviewed. This meant there was no direction for ongoing support.
- Carers told us they had received information from the service relating to the care and treatment of their family member.
- Senior staff told us that they involve family and friends in the assessment process and continue this during the patients' review meetings. Two carers told us they regularly attend review meetings. The provider had developed a families' booklet and have held family and carers days where they could meet the team.
- One carer commented that their relative was well supported by the hospital and a senior manager confirmed that they were working to support the patient on home leave and gaining feedback via telephone and email.
- Regular community meetings were held where patients could discuss concerns and be involved in ward decisions. The provider held regular patient and staff link-up meetings. This meeting was a direct link to management and used to discuss issues that were not resolved in community meetings.
- Annual patient satisfaction surveys were completed and we saw evidence of this.

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

(for example, to feedback?)

Good

Access and discharge:

- The hospital had 17 beds. At the time of the inspection there were 14 patients receiving care and treatment.
- The hospital had average bed occupancy over the past six months of 82%. This is within the national recommended standard. This meant that beds were available to admit and treat patients when needed.
- Care pathways and admissions could be from a variety of establishments. Patients were admitted from various parts of the United Kingdom if specialist services were not available in their local area to meet needs. Following referral, the provider aimed to offer an assessment within 72 hours. The provider told us that admissions could be delayed due to complex funding arrangements.
- The provider planned discharge from admission, using outcome measures to assess progress towards agreed goals. Staff discussed outcome measures, in consultation with the patients and their families.
- The hospital had links with two rehabilitation houses where patients could transfer to continue their recovery in a community setting,
- The provider reported no delayed discharges over the past 12 months.
- Senior staff told us there were difficulties planning discharge for some patients, for example, one patient had no community care coordinator identified and there had been difficulties finding a community team to accept responsibility for attending care reviews and planning discharge.
- The provider did not provide details of average length of stay for patients.

The facilities promote recovery, comfort, dignity and confidentiality

- The provider had a range of rooms for delivering care and treatment. These include a fully equipped clinic room with facilities for examining patients.
- In addition to a ward activities room, there was a therapy cabin in the grounds where patients could carry out other activities, for example table tennis. The ward activities timetable showed sessions for physiotherapy, cognitive skills, menu planning, orientation and planning, project group, community meeting, multi-sensory activities lounge, group walks and ironing. Computers were available in the activities room.
- The 2015 patient satisfaction survey indicated that 46% of the patients answered 'all of the time' to the question "is there enough for you to do during the day Monday to Friday" with 6% saying 'no'. For activities at the weekends, 40% said there were activities 'all of the time', compared with 20% who disagreed. One patient said he enjoyed activities, particularly table tennis, exercises and weights.
- The hospital had a 'pets as therapy' dog available in the hospital every day and there was a large chicken coop on site where patients could look after chickens.

Good

Services for people with acquired brain injury

- Patients were able to personalise their rooms and we saw this. One patient told us he had a big picture on his wall to help him remember things.
- A patient, whose first language was not English, had a member of staff available to him who spoke his first language. An external interpreter attended important meetings and comments were translated into English.
- Quiet areas were available on the wards and we saw rooms where patients could meet visitors in private.
- Patients had access to a telephone and could make calls in private.
- There was a water cooler in the dining room and equipment was available for patients to make hot drinks at any time. Patients could request snacks of any type at any time during the day.
- There were ongoing refurbishment plans at the hospital.

Meeting the needs of all people who use the service

- There were aids and adaptions for patients with mobility difficulties or at risk of falls, for example sensors in bedrooms that would alert staff if a patient fell. There was a disabled bathroom with a hoist bath chair.
- Patients had portfolios that included information about the service, advocacy details, the role of care quality commission and other relevant information.
- The hospital offers a choice of food to meet dietary requirements of religious and ethnic groups, for example kosher. Following requests, patients who enjoyed Indian tea could request this as a daily alternative. The chef and catering team held monthly meetings to allow patients to have an input into the daily menu.
- The provider considered spiritual needs during the pre-admission process. Patients who had leave could visit local churches and other places of worship and two patients were currently accessing services of their preferred faith in the community. There were no multi-faith room facilities on site.

Listening to and learning from concerns and complaints

- There were 28 complaints made to the provider in the past 12 months. Of these, 20 were upheld. No complaints had been forwarded to the parliamentary health service ombudsman.
- The provider had a system for recording and tracking complaints. An electronic spreadsheet recorded complaints, actions and outcomes and complaints was an agenda item in the morning handover meeting.
- Complaints were linked to safeguarding processes, where appropriate.
- The provider had a complaints officer to assist patients and staff with the complaints process. Staff referred formal complaints to the complaints officer for investigation. However, we saw one complaint, that had not been resolved, re-examined on an informal basis for a second time. We were not clear at what point an unresolved informal complaint would be treated on a formal basis.
- There were no recent formal complaints. Patients could raise concerns with staff and managers for discussion in weekly community meetings and orientation group.
- Staff knew how to support patients and carers to make complaints.

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

Good

Vision and values

- The 2014 staff survey showed that 76% of staff were aware of the organisations visions and values. The 2015 survey was taking place when we inspected. Staff we asked identified the values of the organisation and how this was implemented in practice.
- Staff told us senior managers were approachable and they regularly visited their area. We saw evidence of this during the inspection and observed that patients were familiar with the senior managers when they attended the wards.

Good governance

- The provider managed quality and safety using various tools, for example a 'ward to board' dashboard utilised across the service to monitor performance, quality and safety against agreed targets
- Eighty nine percent of staff were compliant with mandatory training, against a target of 95%.

Good

Services for people with acquired brain injury

- Seventy four percent of staff have received an annual appraisal. However, this figure did not include newly appointed staff for whom an appraisal was not yet due.
- The provider employed a range of staff with appropriate skills for care and treatment. There were registered nursing staff qualified in mental health and learning disabilities. Records showed that there were sufficient staff of suitable grades and experience to deliver care and treatment and bank staff were familiar with the patients and the service. The provider had used agency staff since September 2015 to provide care for patients requiring observations that are more intensive. Where possible, the provider used the same agency staff to promote continuity.
- Information provided showed that staff were able spend the majority of their shift on direct patient care activities. Patients confirmed that staff were always available to them.
- The provider held a daily morning meeting to discuss recent incidents and patient outcomes and we attended one of these meetings. Ward managers and clinical leads disseminated agreed plans to the wards. We noted that the reporting was comprehensive and relevant.
- Systems were in place for reporting and recording incidents. All incidents within the organisation were cascaded via email and discussed at governance and ward meetings.
- Managers had access to dashboards that tracked incidents and other relevant data for their ward and hospital. The provider had a 'ward to board' tool they used to monitor quality across hospital sites. We observed that this tool was comprehensive and timely.
- The provider held quarterly meetings with the local safeguarding lead and police to review reported incidents. Outcomes and actions were recorded.
- Systems were in place to monitor compliance with the Mental Health Act 1983 and Mental Capacity Act 2005.

Leadership, morale and staff engagement

- staff completed annual satisfaction surveys. For instance the 2014 survey indicated:
- eighty four percent of staff were satisfied with the quality of services provided
- sixty five percent reported job satisfaction and motivation
- sixty six percent were satisfied with the leadership and management
- seventy four percent were satisfied with patient focus
- eighty percent were satisfied with teamwork
- seventy nine percent were satisfied that learning and development needs were met and
- fifty six percent were satisfied with opportunities for personal performance and opportunity.
- sickness and absence rates reported an average of 2.29% over the past 12 months. This was lower than the average sickness absence rate for the NHS in England, which was 3.94%.
- There were no incidents of bullying and harassment reported.
- A whistleblowing policy was available to all staff and they knew how to follow it.
- Staff told us they would feel supported to raise concerns without fear of victimisation and managers were understanding, supportive and approachable.
- Staff told us they enjoyed working at Elm Park and that morale was good. They said the service was well staffed. We were told there was a very low turnover of staff and many had worked at the hospital for a number of years. Staff reported good multi-disciplinary and ward team working. A newly qualified member of staff told us they had received good support by managers and peers when joining the service.
- Staff were able to approach their managers with any concerns or feedback and felt supported by them.
- There was an out of hours on call rota for senior nurses and managers for staff to contact and discuss issues.

Commitment to quality improvement and innovation

- The provider participated in the NHS Safety Thermometer. The NHS Safety Thermometer gives nurses a template to check basic levels of care, identify where things were going wrong and take action. Frontline healthcare workers used this tool to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, venous thromboembolisms and falls.
- The Director of Clinical Services for this service was the winner of the UK acquired brain injury forum (UKABIF) in March 2015. He was selected for successfully reducing the need for restrictive intervention in managing recovery, through his development of observational rating scales and outcome measures. He has also been

Good

Services for people with acquired brain injury

instrumental in developing clinical interventions to reduce social handicap associated with neurobehavioural disability and is credited with the publication of over 60 research papers or books.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that supervision for nursing staff is provided regularly to support staff with their role.
- The provider must ensure there is a robust protocol for medical cover out of hours and when the responsible clinician is unavailable.
- The provider must ensure that treatment plans made 'in best interest' have a record of capacity assessments, and include involvement from family and advocates.
- The provider must ensure that patients are not subject to blanket restrictions in accordance with the Mental Health Act Code of Practice.
- The provider must ensure that informal patients are free to leave the hospital at will and are aware of processes in place to promote their liberty, in line with the Mental Health Act Code of Practice. Staff must have clear guidelines to support patients.
- The provider must ensure that, where there are delays in accessing best interest assessments for patients requiring renewal of their deprivation of liberty safeguard authorisations, there are clear care plans in place to support staff. The provider should evidence that, under such circumstances, patients are aware of their rights and are appropriately supported.

Action the provider SHOULD take to improve

- The provider should ensure that patient risk assessments are up to date.
- The provider should ensure for patients detained under the Mental Health Act 1983) staff should assess capacity to consent to treatment at first administration of medication. This should be documented and reviewed when renewal of detention is being considered.
- The provider should ensure that when considering protection plans, capacity assessments are undertaken detailing whether patients have understood the safeguarding process.
- The provider should ensure that care plans evidence patient involvement or detail how patients were supported with the process.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing The Provider had not ensured that nursing staff were receiving regular supervision. **This was a breach of regulation 18(2)(a)** The Provider had not ensured that a protocol was in place to provide medical cover out of hours. **This was a breach of regulation 18(1).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not ensured that capacity assessments were completed for treatment plans prior to making decisions for patients in 'best interest'. **This was a breach of regulation 11(3).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider operated restrictive practice with regard to patients' freedom to access outside space in the evening. This included informal patients for whom no lawful detention was in place. Staff were unclear of their responsibilities to uphold patients' rights. The provider had not ensured that, where there are delays in accessing best interest assessments for

This section is primarily information for the provider

Requirement notices

patients requiring renewal of their deprivation of liberty safeguard authorisations, there are clear care plans in place to support staff. The provider must evidence that, under such circumstances, patients are aware of their rights and are appropriately supported.

This was a breach of 13(5)(7)(b)