Healthlinc House

Quality Report

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

Ratings

Overall rating for this location	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

We rated Healthlinc House as Good because:'

- The service had enough nursing and medical staff, who were able to keep patients safe from avoidable harm and abuse. Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. The service was a strong advocate of the STOMP program (stopping over medication of people with learning disability). Staff carried out thorough physical and mental health assessments of all patients on admission. Staff reviewed care plans regularly with the patient and their family or carers, care plans reflected the assessed needs, were personalised, holistic and recovery-orientated. Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice.
- The staff team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure staff had the range of skills needed to provide high quality care. Staff worked well together and understood their roles and responsibilities under the Mental Health Act 1983, and Mental Capacity Act 2005. Staff treated patients with compassion and kindness. Patients had a core care team to ensure that on every shift there was always at least one member of staff that they knew working with them. Staff understood the individual needs of patients and supported patients to understand and manage their care, treatment and condition. Staff and managers had gone the extra mile to ensure that patients could maintain links with their families who lived some distance away. Most carers we spoke with said staff kept them informed of their relatives care and treatment and involved them appropriately.
- Staff planned and managed patient discharge well, as a result, staff rarely delayed discharge for other than a clinical reason. Each patient had their own en suite bedroom, within an apartment, and could keep their personal belongings safe. The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- Managers had created two new key posts to address specific issues. A physical care co-ordinator to work closely with the consultant psychiatrist and visiting general practitioner. An employee engagement lead to buddy new healthcare assistants during the first few months of working at the hospital. The provider had made significant progress towards addressing the concerns raised in our previous inspection report. The provider had produced a quality assurance action plan and had engaged well with CQC to bring about positive changes to their service. There was a culture of mutual respect between managers and staff and patients.

However:

- The decoration and furnishings were dated and tired, and there was some outstanding maintenance work in two apartments that had potential risk for patient safety. Signage around the hospital was poor. We found a disused telephone in the communal corridor with a cord wrapped around it, this had not been removed and staff had not included this on the ligature audit.
- We could not substantiate the providers data showing compliance with supervision was 78%. We could not access enough supervision records to confirm the data. The processes for recording and storage of supervision records were not clear, many staff we spoke with told us supervision was inconsistent, and only two staff knew of the providers new supervision passport. Supervision had been the subject of a requirement notice following our last inspection.
- Staff had not updated two of the seven patient risk assessments we reviewed following a recent incident. Though we saw evidence in the shift handover notes and multidisciplinary team meeting minutes, that the associated risks had been discussed. The providers allocation systems caused delays with new staff getting password access to the electronic patient data system.
- Two carers told us staff had not returned their telephone calls or e mails when requested, nor had they given them minutes of their relatives care planning meetings.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism	Good	

Summary of findings

Contents

Good

Healthlinc House

Services we looked at

Wards for people with learning disabilities or autism.

Summary of this inspection

Background to Healthlinc House

Healthlinc House provides a specialist care and treatment service for women and men with a learning disability and associated complex conditions. The hospital is based in Welton, Lincolnshire. The hospital was obtained by Elysium in October 2017.

This service is registered to provide the following regulated activities: -

• Treatment of disease, disorder or injury, and

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

At the time of inspection there was a registered manager in post, and there was a controlled drugs accountable officer.

Healthlinc House can accommodate a maximum of 25 patients, females and males in apartments. Each apartment can accommodate between one and six patients. Each apartment provides single sex accommodation.

At the time of inspection there were 17 patients receiving care and treatment, 14 of whom were detained under the Mental Health Act 1983. Three patients were subject to Deprivation of Liberty Safeguards (part of the Mental Capacity Act 2005, where patients receive care in a way that does not inappropriately restrict their freedom).

Healthlinc House registered with the Care Quality Commission on 1 October 2010 and has been inspected by the Care Quality Commission on eight occasions. There have been five Mental Health Act Review visits, the last mental Health Act Review visit was in May 2019.

The Care Quality Commission's last comprehensive inspection of the hospital was in May 2017, at which time the hospital was found to be compliant in all domains. However, in response to issues of concern raised between April and June 2018, the hospital was subject to a Care Quality Commission unannounced, focussed inspection in August 2018. We reported on four of the five key questions; safe, effective, caring and well-led. At that time the provider was required to address the following areas of practice:

- The provider must ensure that staff update care plans and risk assessments on a regular basis.
- The provider must ensure that staff receive supervision and appraisals as per the provider's policy.
- The provider must ensure that managers' report and investigate safeguarding incidents appropriately.
- The provider should ensure that they complete all actions identified in their hospital assurance action plan dated July 2018, within the timeframes set.
- The provider should ensure that their new governance measures and audit schedules are adhered to.
- The provider should ensure that they involve staff in the changes to the hospital and communicate with staff more effectively.

At the time of this inspection we found the provider had addressed or made significant progress in addressing all the areas of concern. Details of how these areas had been addressed can be found below.

Our inspection team

Team leader: Debra Greaves – Inspector.

The team that inspected the service comprised one CQC inspector, one specialist advisor nurse, and an expert by experience. An expert by experience is a person, or the carer of a person who has lived experience of the service being inspected.

Summary of this inspection

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

This was a comprehensive, unannounced 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, reviewed the share your experience comments we had received prior to the inspection, and asked a range of other organisations for information about the service.

During the inspection visit, the inspection team:

- visited the communal and accommodation areas of the hospital, looked at the quality of the environment, and observed how staff were caring for patients;
- spoke with seven patients who were using the service;
- spoke with six relatives, who had family members using the service;
- spoke with the registered manager, and members of the senior management team;
- spoke with 18 other staff members including doctors, nurses, occupational therapist, psychologist, healthcare support workers, an education co-ordinator, and physical healthcare worker;
- received feedback about the service from three local authority safeguarding teams or commissioners;
- attended and observed two multi-disciplinary meetings
- observed two therapeutic groups
- reviewed the minutes of team meetings
- reviewed staff supervision and appraisal records
- collected feedback from four patients and staff using comment cards;
- reviewed seven care and treatment records of patients;
- reviewed seven prescription charts of patient;
- carried out a specific check of the clinic rooms and medication management, and
- looked at a range of policies, procedures, records and other documents relating to the running of the service.

What people who use the service say

- Patients we spoke with said the staff were kind and friendly and they felt staff understood their needs. All patients said they had been able to discuss their physical health concerns with staff as well as talk about any problems they had.
- Patients told us they felt safe at the hospital and liked living in the apartments with just one or two other people rather than on a ward. Patients particularly liked the range of activities available at the hospital but would have liked more day trips out.
- Most patients we spoke with said they understood their care plans and knew what their goals for getting better were. Most patients knew what their discharge plans were.
- Family and carers were mostly positive about the care and treatment of their relatives at the hospital and had felt adequately engaged in the care planning process. They said staff always invited to care planning meetings though some said they could not always make the dates and times scheduled due to work or other family commitment.

Summary of this inspection

- However, two carers told us they had not been as involved as she would have liked. Staff had not returned their telephone calls or e mails when requested, nor had they been able to obtain minutes of care planning meetings that had involved their relatives.

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:

- The decoration and furnishings were dated and tired. There was some outstanding maintenance work in two apartments, works included a badly positioned toilet causing the patient to have to sit sideways, and sharp edges on mirrors in the apartment. We found a disused telephone in the communal corridor with a cord wrapped around it that had not been removed, this was not on the ligature audit though staff we spoke with knew it was a risk "hot spot". We advised the managers at the time and they assured us this would be dealt with as a matter of urgency.
- Staff had not recorded the updated risks in two of the seven risk assessment documents we reviewed, following a recent incident. Though we saw evidence they had discussed amended risk management plans in the multidisciplinary team meeting notes and the daily handover notes.

However:

- Staffing levels allowed patients to have regular one-to-one time with their named nurse. Staff shortages rarely resulted in staff cancelling escorted leave or hospital activities. There were enough trained staff to carry out physical interventions including observations, restraint, and escorted leave safely.
- Staff mostly assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The service did not use seclusion. Staff participated in the provider's restrictive interventions reduction programme.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health. They knew about and worked to achieve the aims of the STOMP programme (stopping over medication of people with a learning disability).

Summary of this inspection

- The hospitals had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-orientated.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. This included access to psychological therapy, to support for self-care and the development of everyday living skills, and to meaningful occupation. Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, and opportunities to update and further develop their skills. Compliance with staff annual appraisal, and doctor's revalidation was 100%.
- Managers provided a comprehensive induction programme for new staff, and agency staff who had completed a minimum of twelve shifts at the hospital and who intended to continue working at the hospital.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team had effective working relationships with staff from services that would provide aftercare following the patient's discharge and engaged with them early in the patient's admission to plan discharge.

Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act code of practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- We heard how staff and managers had ensured that patients could maintain links with their families who lived some distance away. Including offering to pay transport costs for one family to visit the hospital, and for another patient to have a three to one escort so they could go to visit their family.
- Four carers we spoke with said staff kept them informed of their relatives care and treatment and involved them appropriately.

However:

- Two carers told us staff had not returned their telephone calls or e mails when requested, nor had they given them minutes of their relatives care planning meetings.

Are services responsive?

Good

We rated Responsive as good because:

- Staff planned and managed patient discharge well. They liaised well with services that provided aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and staff rarely delayed discharge for other than a clinical reason.
- The design, and layout, of the hospital supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

Summary of this inspection

- The service had a food hygiene rating of 4, and patients told us the food was of a good quality. Patients had access to or could make hot drinks and snacks at any time.
- The hospital met the needs of all patients who used the service including those with a protected characteristic. Staff helped patients with communication and supported them to access advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

However:

- Signage around the hospital was poor. Some patients and new staff had told us it was easy to become lost and disorientated in the numerous corridors. Managers told us they would include this as part of their refurbishment plans.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they applied in the work of their team.
- Staff told us they had noticed significant improvement during the last eight months, about how managers interacted with them. They reported that the provider promoted equality and diversity and provided opportunities for career progression. Staff felt able to raise concerns without fear of retribution.
- There was a culture of mutual respect between managers and staff and patients. Most staff reported they felt respected, supported and valued.
- Our findings from the other key questions and our close monitoring of the providers action plans, through the engagement process, demonstrated that governance processes operated effectively, and managers managed performance and risk well.
- Staff engaged actively in local and national quality improvement activities, and innovation.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

- The providers allocation systems caused delays with new staff getting password access to the electronic patient data system.

Summary of this inspection

- The processes for recording and storage of supervision records was not clear. CQC had reported supervision as a requirement notice following the last inspection. Managers explained that supervision process was an item on their quality assurance action plan and they were addressing the issue by introducing new supervision passports and guidance for supervisors.

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.

Seventy-six per cent of staff had training in the Mental Health Act. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy, and staff frequently explained to patients what advocacy was. Staff also explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Staff ensured that patients were able to take Section 17 leave. Section 17 leave is permission for patients to leave hospital when this has been granted. The service displayed notices to tell informal patients that they could leave the hospital freely.

A recent Mental Health Act review visit had found that staff did not always request a second opinion appointed doctor before the end of the first three months of detention, this resulted in the use of using section 62 of the Mental Health Act. In response to the Mental Health Act Review findings the provider had put in plans to address this issue.

Staff stored copies of patients' detention papers and associated records such as Section 17 leave forms correctly and so that they were available to all staff that needed access to them.

Where appropriate care plans referred to identified Section 117 aftercare services for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Staff carried out regular audits to ensure that the Mental Health Act was applied correctly and there was evidence of learning from those audits.

Mental Capacity Act and Deprivation of Liberty Safeguards

Seventy-eight per cent of staff had had training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act, the five statutory principles, and how they applied to their work.

There were eight deprivation of liberty safeguards applications made in the last 12 months to protect people without capacity to make decisions about their own care. Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the organisation regarding the Mental Capacity Act, including deprivation of liberty safeguards.

In three out of seven daily contact notes we saw evidence to show that staff took all practical steps to enable patients to make their own decisions, and they did this on a decision-specific basis regarding significant decisions. Although a recent Mental Health Act review visit found that in all five Mental Health Act records they reviewed staff had not recorded their discussions with patients about informed consent to treatment. The doctor had acknowledged that they needed to complete more work evidencing discussions with patients regarding this.

Detailed findings from this inspection

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. While staff audited the application of the Mental Capacity Act and the organisation carried out their own internal audit of compliance with the Mental Health Act. They had not picked up the non-recording of capacity to consent to treatment.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Wards for people with learning disabilities or autism

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

Are wards for people with learning disabilities or autism safe?

Requires improvement

Safe and clean environment

Staff carried out regular risk assessments of the care environment. Although, ligature and environmental assessments were robust, and staff had mitigated the risks adequately, we found a disused telephone in the communal corridor that was not on the ligature audit, though staff we spoke with knew this to be a risk "hot spot" and managed it accordingly. We pointed this out to managers who assured us that they would deal with the matter immediately.

The hospital complied with guidance on eliminating mixed-sex accommodation. Staff had easy access to alarms and radios, and patients had easy access to nurse call systems.

While the hospital was clean, and cleaning records were up to date, decoration and furnishings were dated and tired. We saw an action plan for the refurbishment of key areas in the hospital, though some actions were undated and still awaiting costing and approval. We also saw some areas that patients had already helped to redecorate.

There was some outstanding maintenance work in two apartments. Works included two toilet seats that needed replacing, a shower door that was missing, a toilet that was badly positioned causing the patient to have to sit sideways, and sharp edges on mirrors in the apartment. The patients told us they had been waiting a long time for the works to be done. We saw a refurbishment plan including most of these works.

Training compliance rate for infection control level 1 was 84%, and level 2 was 80%. Staff adhered to infection control principles, including hand washing.

The hospital did not have a seclusion room and did not use seclusion.

Clinic rooms had accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. Any 'clean' stickers were visible and in date.

Safe staffing

The providers core staff establishment levels were, 14.7 whole time equivalent qualified nurses and 131 whole time equivalent healthcare support workers, plus a full multidisciplinary team. At the time of inspection, the provider had two qualified nurse vacancies and seven healthcare support worker vacancies.

For the period May 2019 to June 2019 there was a total of 2160 day shifts to be covered and 1769 night shifts. Of these shifts known bank staff covered 127 day shifts and agency staff covered 687 day shifts, while 92 night shifts were covered by known bank staff and agency staff covered 924 night shifts. During the same period 19 day shifts and 32 night shifts were not filled. Whenever possible managers used known agency staff and had contracts with three local staff agencies.

For the period June 2018 to June 2019 staff sickness rate was 3.5%, and staff turnover 41%. Managers were able to

account for the high staff turnover. Reasons given included, the change of organisational provider, natural wastage and staff choosing to move to a new unit operated by another service provider.

Managers calculated the number and grade of nurses and healthcare support workers required based on patient numbers, observation levels and needs of the patients, including escorted leave and activity programs. This meant that actual staffing levels fluctuated each day.

The number of nurses and healthcare assistants matched this number on all shifts. The hospital manager could adjust staffing levels daily to take account of case mix.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Bank staff were known to the service, and whenever possible managers used known agency staff. When bank and agency staff were used they received induction and familiarisation with the hospital.

Managers ensured there was at least four qualified staff on all day shifts and two on all night shifts. A qualified nurse was always present in communal areas of the hospital.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Staff shortages rarely resulted in staff cancelling escorted leave or hospital activities. There were enough trained staff to carry out physical interventions including observations, restraint, and escorted leave safely.

There was adequate medical cover day and night and the doctor was employed full time for the hospital, the doctor responded to medical emergencies immediately. Staff reported the doctor was usually available for additional support as required and was very approachable.

In May 2019 the average compliance for mandatory training was 82%. Healthcare support workers had to complete Basic life support training, while qualified nurses completed Immediate life support training.

All new starters received a comprehensive four-week induction that included all initial mandatory training, orientation to the service and organisation, a period of shadowing experienced colleagues in the work place and role specific training as required.

Assessing and managing risk to patients and staff

Staff carried out a risk assessment of every patient on admission. We reviewed seven patient risk assessments. Five out of seven records were comprehensive complete and up to date.

Staff updated patient risk assessments after incidents. However, staff had not updated two records following a recent incident. Although staff had recorded their discussions about the amended risk management plans in the multidisciplinary team meeting minutes and the staff handover report. Staff advised that these would be the sources of information they would use when familiarising themselves with any new patient risk management plans.

Staff used recognised risk assessment tools including the patient baseline risk assessment (PABRA) at point of admission. During the initial 12-week assessment period staff used an Elysium approved Risk matrix and Acute risk matrix to inform ongoing risk assessment and management. The psychologists formulated patients positive behavioural support plans and the Historical Clinical Risk Management 20. In addition, staff used the Escort baseline risk assessment prior to any section 17 leave.

Management of patient risk

Staff were aware of and dealt with any specific risk issues, such as falls, infection, or pressure ulcers. Staff identified and responded to changing risks to, or posed by, patients.

Staff followed good policies and procedures for use of observation including those to minimise risk from potential ligature points and for searching patients or their bedrooms.

Staff applied blanket restrictions on patients' freedom only when justified. At the time of inspection, we were not aware of any blanket restrictions in use.

Staff adhered to best practice in implementing a smoke-free policy. Informal patients could leave at will and knew how to do this. We saw signs around the hospital advising of this.

The service did not use seclusion, or long-term segregation. All staff trained in de-escalation strategies.

Between 01 September 2018 to 28 February 2019 there had been 1046 episodes of restraint, this was slightly lower than the previously recorded number. Staff recorded all hands-on interventions as restraint, including "gentle

hands on encouragement". The number of restraints involved 23 different patients. Sixteen episodes of prone restraint resulted in rapid tranquilisation, and all episodes of prone restraint related to one patient. Staff had care planned for this, based on the patient's physical health needs and following discussion with the multidisciplinary team and the therapeutic management of violence and aggression (TMVA) trainers.

Despite the high number of reported restraints and the complexity of patients challenging behaviours, the hospital participated in the provider's restrictive interventions reduction programme. Staff used restraint only after de-escalation had failed, daily care notes and incident forms used by staff confirmed they used correct techniques.

Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. Prescription charts showed staff followed National Institute for Health and Care Excellence guidance when using rapid tranquilisation.

Safeguarding

Between April 2018 and May 2019 staff raised eighty-four safeguarding concerns. Both Adult and Child safeguarding level 2 training compliance was 87%. All the staff we spoke with showed good understanding of safeguarding, knew how to make a safeguarding alert, and did so when appropriate. Managers and CQC discussed safeguarding matters at regular engagement meetings.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff followed safe procedures for children visiting the hospital.

Staff access to essential information

All patient records were electronic and available in an accessible format. Once staff had received their training and password access all information needed to deliver patient care was available to all relevant staff, including regular agency staff. This included when patients moved between teams.

If staff were very new and had not received their database password, other staff assisted them to access the patient records.

Medicines management

Staff followed good practice in medicines management such as transport, storage, dispensing, administration, medicines reconciliation, recording, and disposal, and did it in line with national guidance.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when doctors may prescribe patients with high dose of antipsychotic medication. The physical care co-ordinator worked closely with the doctor and visiting general practitioner to monitor patient's physical healthcare needs.

Track record on safety

There had been 1045 incidents between 01 April 2019 to 31 May 2019.

Staff rated most incidents as level 1 and 2 incidents classed as minor risk. These incidents included self-harm causing no moderate or major injury, patient on patient verbal altercation, patient on patient or patient on staff, physical altercation with no harm.

Reporting incidents and learning from when things go wrong

All staff knew what incidents to report and how to report them. Staff reported all incidents that they should report, and incident data automatically populated the patient electronic record.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers achieved this through a robust system of internal and external governance meetings. Staff met to discuss that feedback in team meetings, health and safety meetings, shift handovers, and multidisciplinary safeguarding meetings.

Good

Wards for people with learning disabilities or autism

There was evidence that staff had made changes because of feedback. Examples included improved care record audits, redesign of some communal areas, and enhanced staff training around pre-empting patient risk.

Staff received debrief and support after a serious incident. The provider had recently introduced immediate debrief led by psychology. This provided on the spot debrief and pro-active follow up.

Are wards for people with learning disabilities or autism effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed seven care and treatment records. Staff updated care records regularly. Staff completed a comprehensive mental health assessment of the patient at, or soon after, admission. Staff assessed patients' physical health needs in a timely manner after admission. Staff developed care plans that met the needs identified during assessment.

Care plans were personalised, holistic and recovery-oriented. Although a recent mental health act review visit had found little evidence in the actual care plan of the patient's views. Staff showed us how they collected patients views in a separate document that staff incorporated into the main care plan when they wrote this up. Staff updated care plans when necessary.

The providers systems caused delays with new staff getting password access to the electronic patient data system. These staff had to rely on their nursing colleagues to give them access.

Best practice in treatment and care

Care records showed that staff were following National Institute for Health and Care Excellence guidance. Staff used recognised rating scales to assess and record severity, and a range of recognised outcome measures, such as model of human occupation screening tool and self-assessment outcome measures, Health of the Nation Outcome Scales for Learning Disability, and Liverpool University Neuroleptic Side Effects Rating Scale (LUNSER's) for anti-psychotic medication reviews.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and delivered in line with, guidance from the National Institute for Health and Care Excellence. Interventions included medication, staff were committed to implementing the stopping over medication of people with learning disability (STOMP); Psychology - was in the process of developing their service using the psychologically informed environment (PIE) model; and rehabilitation activities, - to develop daily living skills, along with training and work opportunities, intended to help patients acquire wider living skills.

Staff produced patient behavioural support plans to help keep restrictive practices to a minimum, and support patients with their behaviours that challenged.

The model of care used by the provider was unusual in as much as patients were accommodated in self-contained apartments rather than wards, sharing communal spaces such as the dining room, activity lounge and games rooms and therapy rooms. In addition, each patient had a core care team allocated to them based on their individual care needs and level of risk. This meant that there was always at least one member of staff familiar to the patient on every shift regardless of the observation level.

The education co-ordinator encouraged patients to develop their own portfolio to show case the skills they had acquired and for use when moving on. Where appropriate the education co-ordinator also helped patients to achieve goals set in their education statements.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed, and used the National Early Warning Score (NEWS2) assessment tool. The provider had appointed a physical care co-ordinator who worked closely with the doctor and local general practitioner to ensure they identified all patient's physical health needs and addressed them in a timely manner. We also saw plans of how the physical care co-ordinator was revising the patients' health passports to make them easy read, and more comprehensive but easier for the patients to carry with them.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Staff used the Malnutrition Universal Screening Tool (MUST). We saw evidence of specialist nutrition plans and eating and swallowing assessments.

Staff supported patients to live healthier lives such as participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, sexual health matters and dealing with issues relating to substance misuse.

Staff used technology to support patients effectively such as prompt access to blood test results, on line self-help tools, and communication boards to help patients with communication difficulties.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. Audits included medication management, care records, and safeguarding, amongst a calendar of other audits required by the providers quality assurance and governance.

Skilled staff to deliver care

The team included or had access to the full range of specialists required to meet the needs of patients on the hospital. As well as doctors and nurses, there were occupational therapists, educational co-ordinators, clinical psychologists, speech and language therapists, dieticians, healthcare support workers, house keepers and maintenance people.

Staff had the right experience, qualifications skills and knowledge to meet the needs of the patient group.

Managers provided new staff with appropriate induction using the care certificate standards as the benchmark for healthcare assistants. The providers induction program was four weeks long and included orientation to the organisation and the service. All initial mandatory training, restraint training, shadowing existing colleagues and role specific training. The service had appointed an employee engagement lead, this was an experienced support worker to act as a buddy and peer guide in the first few months of working there.

Managers reported that all staff had opportunity to attend meetings that reflected on case management, and to learn from practice. Managers encouraged staff to identify their ongoing training needs, and professional development. Managers also reported they had plans to introduce a new supervision passport for staff in the near future to improve recording of formal and informal supervision. We saw data showing the service had improved its supervision compliance from 1% in July 2018 to 78% in June 2019, though this could not be confirmed at inspection. The providers target for supervision compliance was 90%. Revalidation for doctors was 100%.

We saw evidence showing the providers compliance with annual appraisal, a review of each staff members performance was 100%. Managers ensured that staff had access to regular team meetings. Managers ensured that staff received the necessary specialist training for their roles. Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings, including safeguarding and governance meetings. Staff shared information about patients at effective handover meetings within the team

The service had effective working relationships, including good handovers, both within the hospital, and other relevant teams external to the hospital. Such as local authority departments, care co-ordinators, community mental health teams, and third sector agencies in the areas that patients normally resided or wanted to move to.

Adherence to the MHA and the MHA Code of Practice

Seventy-six per cent of staff had training in the Mental Health Act. Staff trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were. The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy, and staff frequently explained to patients what advocacy was. Staff also explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

Good

Wards for people with learning disabilities or autism

Staff ensured that patients were able to take Section 17 leave. Section 17 leave is permission for detained patients to leave hospital when this has been granted. The service displayed a notice to tell informal patients that they could leave the hospital freely.

A recent Mental Health Act review visit had found that staff did not always request a second opinion appointed doctor before the end of the first three months of detention, this resulted in the use of using section 62 of the Mental Health Act. In response to the Mental Health Act Review findings the provider had put in plans to address this issue.

Staff stored copies of patients' detention papers and associated records such as Section 17 leave forms correctly and so that they were available to all staff that needed access to them.

Where appropriate care plans referred to identified Section 117 aftercare services to be provided for those who had been subject to section 3 or equivalent Part 3 powers authorising admission to hospital for treatment.

Staff carried out regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the MCA

Seventy-eight per cent of staff had had training in the Mental Capacity Act. Staff we spoke with had a good understanding of the Mental Capacity Act, the five statutory principles, and how they applied to their work.

There were eight deprivation of liberty safeguards applications made in the last 12 months to protect people without capacity to make decisions about their own care. Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the organisation regarding the Mental Capacity Act, including deprivation of liberty safeguards.

In three out of seven daily contact notes we saw evidence to show that staff took all practical steps to enable patients to make their own decisions, and they did this on a decision-specific basis with regard to significant decisions.

Although a recent Mental Health Act review visit found that in five out of ten Mental Health Act records they reviewed staff and patient discussions, relating to informed consent to treatment, had not been recorded. The doctor had acknowledged that they needed to complete more work evidencing discussions with patients regarding this. The provider had submitted a Mental Health visit action plan addressing this issue.

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005. When assessment showed a patient had impaired mental capacity to make certain decisions for themselves, staff worked with the patient's support network to ensure best interest decisions were made when relevant.

The service had arrangements to monitor adherence to the Mental Capacity Act. While staff audited the application of the Mental Capacity Act and the organisation carried out their own internal audit of compliance with the Mental Health Act, staff had not picked up the non-recording of capacity to consent to treatment.

Are wards for people with learning disabilities or autism caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff maintained the confidentiality of information about patients.

To help patients settle in, feel comfortable and provide consistency, managers tried to allocate the same staff team to work with individual patients. Managers always tried to ensure that at least one person in each care team was known to the patient.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Good

Wards for people with learning disabilities or autism

Patients we spoke with said staff treated them well and behaved appropriately towards them. Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes to patients without fear of the consequences.

Involvement in care

Staff used the admission process to inform and orientate patients and their families to the hospital and to the service. Staff appreciated that patients needed time to settle in and orientate themselves to the new surroundings before bombarding them with information.

Staff involved patients in care planning and risk assessment as shown by evidence in care plans through the "this is me" document, participation in care planning reviews, and having access to a copy of their care plans.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. Many staff had trained in the use of Makaton a form of sign language, British sign language and often used story boards to help explain complex ideas.

Staff involved patients when appropriate in decisions about the service, such as staff recruitment hospital décor and design, activity programs, social and leisure activities.

Staff enabled patients to give feedback on the service they received through surveys and monthly community meetings. Staff enabled patients to make advance decisions, to refuse treatment, sometimes called a living will, when appropriate. Staff ensured that patients could access advocacy.

We saw how managers had addressed patients' feedback with regards to the provision of a new family friendly visiting area away from the hospital communal areas. Managers had identified an area off the reception foyer for this purpose and included on the hospital refurbishment plan.

We saw evidence of staff having informed and involved families and carers appropriately and provided them with support when needed. Four carers we spoke with said staff kept them informed of their relatives care and treatment and involved them appropriately. However, two carers said staff had not provided them with information when asked, including minutes of care planning meetings, and had not returned their telephone calls or e mails when requested.

Are wards for people with learning disabilities or autism responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

Bed management

Data submitted by the provider for the period 01 June 2018 to 30 June 2019 showed there had been eight new admissions to the hospital and 12 discharges. The provider accepted referrals from anywhere in the country, but always had a bed available, when needed, for patients living in the 'catchment area'.

The service was easy to access. Its referral criteria did not exclude patients who would have benefitted from care. Staff assessed and treated patients who required urgent care promptly and patients who did not require urgent care did not wait too long to start treatment

There was always a bed available when patients returned from leave. Staff did not move patients between apartments during an admission episode unless justified on clinical grounds and was in the interests of the patient. When staff discharged patients, this happened at an appropriate time of day.

Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and staff rarely delayed discharge for other than a clinical reason. At the time of inspection there were two delayed discharges. One was due the lack of a suitable low secure unit and the other because the out of area provider could not accept the service user back at that time. We heard how staff had continued to make regular contact with the case manager for this patient.

Good

Wards for people with learning disabilities or autism

Beds were usually available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and this was sufficiently close for the person to maintain contact with family and friends.

Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had their own bedrooms within separate apartments. Patients could personalise their bedrooms and apartments if they so wished. Patients had somewhere secure to store their possessions. However, there were delays with carrying out maintenance work within the apartments.

Staff and patients had access to a range of rooms and equipment to support treatment and care including clinic room to examine patients, activity and therapy rooms. There were quiet areas in the hospital, and a room where patients could meet visitors. Though following recent feedback from patients' managers had decided to relocate this room to a more convenient area and refurbish it to make it family friendly.

Patients could make a phone call in private. Patients had access to good outside space, including a sports field with picnic tables. Patients told us the food was of a good quality and the hospital had just been awarded a level 4 food hygiene certificate. Patients could make hot drinks and snacks 24/7.

Patients' engagement with the wider community

When appropriate, staff and the education co-ordinator ensured that patients had access to education and work opportunities.

Staff supported patients to maintain contact with their families and carers. We heard how staff and managers had facilitated a three to one discreet escorted home leave for a patient who lived in Liverpool. Another example when managers had agreed to fund the travel and expenses for a family to visit their relative from some distance away.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Including any pre-existing support groups.

Meeting the needs of all people who use the service

The service planned for disabled patients and visitors such as ensuring disabled people's access to premises. Staff had the skills, or access to people with the skills, to communicate in the way that suited the patient. and by meeting patients' specific communication needs. However, signage around the hospital was poor. Managers told us they would include this as part of their refurbishment plans.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain and so on. The information provided was in a form accessible to the patient group for example, easy-read format. Staff made information leaflets available in languages spoken by patients on request. Managers ensured that staff and patients had easy access to interpreters and signers.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Staff ensured that patients had access to appropriate spiritual support, usually from visiting religious leaders or in community places of worship.

Listening to and learning from concerns and complaints

For the period April 2018 to April 2019 there had been nine compliments and twelve complaints for the hospital. Eight of the complaints had been upheld, two had been partially upheld and two had not been upheld. Staff had not referred any of the complaints to the Ombudsman. Most complaints had come from patients, along with two from members of the public, and two from staff.

Patients knew how to complain or raise concerns, and when they had complained or raised concerns, they received feedback. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Staff knew how to handle complaints appropriately. Managers thoroughly investigated complaints and recorded the outcomes as well as any recommendations for changes to the service.

Good

Wards for people with learning disabilities or autism

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Through one of the team or governance meetings and in a regular newsletter. Changes to the service have included the introduction of an anti-bullying program for patients, unannounced night visits by senior managers, and a complaints book was shared at morning handover meetings.

Are wards for people with learning disabilities or autism well-led?

Good

Leadership

Managers had the right skills and abilities to run the service providing high-quality sustainable care. They understood the service they managed, and it followed a recognised model for rehabilitation care. Leaders were visible in the service and approachable for patients and staff.

Leadership development opportunities were available, including opportunities for staff below team manager level. Three staff explained how managers had supported them to develop their roles to and lead on certain projects. Managers explained the leadership program now available through the organisation to underpin leadership and management skills.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied in the work of their team. The senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.

Staff reported that in recent months they had been more aware of opportunities to contribute to discussions about the strategy for their service, especially where the service was changing. Senior staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff we spoke felt respected, supported and valued. Staff felt this was much improvement since our last inspection. Managers had recently introduced several benefits and measures to support staff such as well-being days, and flexible work hours where possible.

Managers reported that the new services first staff engagement survey in early 2019 had been disappointing. Areas of concern had included lack of leadership; unease about the changes to hospital director and deputy appointments; low staff morale; and poor recruitment. However, at the time of inspection managers had and were addressing these issues. We heard how more recent, though unsubstantiated reports, indicated significant improvement in staff engagement; staff morale; and strong leadership. Staff attributed this to the daily presence and visibility of the hospital director, clinical director, psychologists and multidisciplinary team members.

Staff we spoke with felt positive about working for the provider and their team and embraced the changes proposed by their managers. Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and most knew about the role of the Speak Up Guardian.

Managers dealt with poor staff performance when needed. We saw records of how managers had addressed disciplinary matters. Teams worked well together and where there were difficulties managers dealt with them appropriately.

We saw records of staff appraisals that included conversations about career development and how managers could support the plans. Staff we spoke with reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. The service's staff sickness and absence were similar to the provider target. Staff had access to support for their own physical and emotional health needs through an occupational well-being service.

The provider recognised staff success within the service – for example, through the introduction of STAR awards for staff demonstrating the organisations values. Staff felt this was more achievable and meaningful than just outstanding practice staff awards.

Governance

Good

Wards for people with learning disabilities or autism

There were systems and procedures to ensure that the hospital was safe and clean, and that there were enough staff to meet the needs of the patients, and to ensure that patients were assessed and treated well. Governance systems helped managers ensure that access and discharge to the hospital was managed well, that staff reported all incidents, and they investigated and learnt from them.

There was a clear framework of what to discuss at local and directorate team meetings, to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The framework of meetings included hospital clinical governance meeting; regional clinical governance meeting; and a corporate clinical governance meeting. The meetings ensured both upward and downward communication. Key standing items included discussion and evaluation of the hospital's quality assurance plans; complaints and incident investigation outcomes; provider board updates; and the managers performance against key performance indicators and other key targets such as training, supervision and CQC action plans.

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff undertook or participated in local clinical audits. The audits were enough to provide assurance and staff acted on the results when needed. Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patient.

Management of risk, issues and performance

While there appeared to have been significant improvement in supervision compliance, from 1% in July 2018 to 78% in July 2019, we could not substantiate the data because managers could not produce sufficient supervision records for us to review. This meant we could not confirm that the quality and content of supervision was in accordance with the providers policy. Fourteen of the eighteen staff we spoke with were not sure what the formal processes were for recording and storage of their supervision records; only two staff members knew of the providers new supervision passport; and only two staff could provide us with copies of their supervision records. Managers explained that supervision processes were an item on their quality assurance action plan and they were addressing the issue by introducing new supervision passports and guidance for supervisors.

Management oversight of recording was not always robust, as evidenced in supervision, updating risk assessments, and the omission of the telephone box on the ligature audit.

Staff maintained and had access to the risk register at hospital or directorate level. Staff at hospital level could escalate concerns when required. Staff concerns matched those on the risk register.

The service had plans for emergencies such as adverse weather or a flu outbreak, or loss of power. Where cost improvements were taking place, they did not compromise patient care.

Information management

The service used systems to collect data that was not over-burdensome for frontline staff.

Although most staff had access to the equipment and information technology needed to do their work, and the information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Some new and agency staff we spoke with did not have easy access to electronic patient information. We found the providers password allocation system caused delays with new staff getting password access to the electronic patient data system.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Information was in an accessible format, and was timely, accurate and identified areas for improvement. Information governance systems included confidentiality of patient records.

Staff made notifications to external bodies, including the care quality commission, as needed.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used through the intranet, bulletins, and newsletters.

Good

Wards for people with learning disabilities or autism

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Patients and staff could meet with members of the provider's senior leadership team to give feedback. Managers engaged with external stakeholders such as commissioners and Healthwatch, as necessary.

Learning, continuous improvement and innovation

Managers gave staff time and support to consider opportunities for improvements and innovation and this led to changes.

Staff had opportunities to participate in research, development of services, and other projects designed to enhance and improve the quality and effectiveness of the service, such as exploring further use of stopping overmedication of people with learning disability (STOMP).

Innovations were taking place in the service. Such as the introduction of new lead roles for projects such as revision of the patient's health passport, improved and simplified care plans, and adoption of a psychologically informed environment (PIE) model for the hospital.

Although staff used quality improvement methods and knew how to apply them, the hospital did not participate in any national accreditation schemes.

Outstanding practice and areas for improvement

Outstanding practice

The service was a strong advocate for STOMP (stop the over medication of people with learning disability), staff were passionate about pursuing this for the benefit of patients.

The links between the hospital and the local general practice were exemplary. The appointment of a physical care co-ordinator to work with the general practitioner and psychiatrist meant that patients physical health needs were addressed in a timely and expert way.

The recent appointment of an employee engagement lead, and the excellent four-week comprehensive induction and orientation program, meant that new staff felt supported and prepared to meet the challenges of their new roles.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that staff complete all maintenance and refurbishment work required at the hospital in a timely manner.

Action the provider SHOULD take to improve

- The provider should ensure that where indicated staff update all patient risk assessments following an incident.
- The provider should ensure that they have clear and robust systems and processes for the storage and recording of supervision records.
- The provider should ensure that signage around the hospital is appropriate to meet the patient's needs.
- The provider should ensure that all staff have their own access to the electronic care records.
- The provider should ensure that all potential ligature points are recorded on the ligature audit with identified actions required to manage the risk.
- The provider should ensure that staff acknowledge and address, as per policy and patient's wishes, all requests for information made by a patient's family and carers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and Equipment:** The provider had not ensured that staff had carried out all maintenance works in a timely manner. This was a breach of regulation 15(1)(e)