Coveberry Limited

Eldertree Lodge

Inspection report

Elder Tree Lane
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Eldertree Lodge is an independent mental health hospital provided by Coveberry (Caretech). Coveberry (Caretech) registered as the provider of services in November 2020 following the acquisition of the location from another provider. It is a 41-bed hospital providing specialist inpatient treatment and longer-term high dependency rehabilitation services for adults aged 18 years and over in locked wards specifically for patients with a learning disability or autism.

We undertook this unannounced, focused inspection because we had concerns about the care and treatment provided at Eldertree Lodge through information and intelligence.

Following the inspection, we served the provider with a letter of intent under Section 31 of the Health and Social Care Act 2008, to warn them of possible urgent enforcement action. We told the provider we were considering whether to use our powers to urgently impose conditions on their registration. The effect of using Section 31 powers is serious and immediate. The provider was told to submit an action plan within 24 hours that described how it was addressing our concerns. Their response did not provide enough assurance they had acted to address immediate concerns.

Due to the serious nature of the concerns we found during this inspection, we used our powers under Section 31 of the Health and Social Care Act 2008 to take immediate enforcement action and imposed additional conditions on the provider's registration. This included a condition to restrict the provider from admitting any new patients to Eldertree Lodge without the prior written agreement of the Care Quality Commission.

We did not look at all key lines of enquiry during this inspection. However, the information we gathered, the significance of the concerns and clear impact on patients provided enough information to make a judgement about the quality of care and to re-rate the provider.

Our rating of this location went down. We rated it as inadequate because:

- The ward environments were not safe and clean. Staff did not always adhere to COVID-19 national guidance, putting staff and patients at risk. Not all staff were trained in the same restrictive techniques to ensure patients remained safe.
- The wards did not always have enough nurses with the right skills, experience and patient knowledge. Staff did not always engage well with patients and put patients at risk by not always following treatment plans due to their lack of knowledge of the patients.
- Risk to patients was not always managed well. Incidents were not investigated thoroughly, and associated learning was not adequately shared amongst staff.
- Not all staff had the skills required to develop and implement good positive behaviour support plans to enable them to work with patients who displayed behaviour that staff found challenging. Staff were slow to deploy de-escalation techniques to prevent patients' further distress.
- Not all patients were treated with dignity and respect. Patients were not always happy with the care and treatment provided.
- Governance processes did not always operate effectively at ward level and performance and risk were not managed well. Managers told us they were working to rectify several concerns since they took over the service, but many identified and unidentified issues remained.
- Leadership was poor and staff did not always feel supported, valued or respected by senior leaders.

However:

Summary of findings

- The ward teams had access to a range of specialists required to meet the needs of patients on the wards, apart from a speech and language therapist. Care plans reflected patient needs and were holistic.
- Carers and families were complimentary about the service and staff communicated well with them.

The Chief Inspector of Hospitals is placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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	Inadequate 	The summary is contained in the overall summary at the beginning of the report. Our rating of this service went down.

Summary of findings

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Summary of this inspection

Background to Eldertree Lodge

Eldertree Lodge is an independent mental health hospital provided by Coveberry (Caretech). Coveberry (Caretech) registered as the provider of services in November 2020 following the acquisition of the location from another provider. It is a 41-bed hospital providing specialist inpatient treatment and longer term high dependency rehabilitation services for adults aged 18 years and over in locked wards specifically for patients with a learning disability or autism. Patients may present with a range of behaviours that are challenging, have a diagnosed mental health condition and drug and alcohol abuse. Patients may be detained under the Mental Health Act 1983 or subject to Deprivation of Liberty Safeguards. The service is commissioned by Clinical Commissioning Groups. There were 30 patients admitted on the days we visited. The service had a Registered Manager.

We carried out this inspection because we had concerns about the care and treatment provided at Eldertree Lodge. We had concerns about the number and type of incidents at the service and we had received whistle blowing concerns. In the four months prior to the inspection, we received six whistle blowing concerns. The themes identified from the concerns raised related to; inappropriate patient handling techniques, poor staff behaviour, unsafe staffing levels, lack of visible leadership, and the quality of some agency nurses. We received three notifications during the same time period related to inappropriate patient handling techniques, and two related to patients being able to self-harm whilst on high level nursing observations.

The hospital has six wards comprising of two admission and treatment units:

Ash – female complex care, six beds

Chestnut – male low functioning, six beds

Two rehabilitation wards:

Willow – female complex care, seven beds

Elm – male high functioning, seven beds

Two pre discharge wards:

Maple – male low functioning, seven beds

Birch – male high functioning, eight beds

Eldertree Lodge provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

We previously inspected this location in January 2020. It was rated as requires improvement overall. It had regulatory breaches in:

Summary of this inspection

Regulation 17: Good governance

The provider did not ensure that the system used to access information was appropriately organised and fully integrated together.

The provider did not ensure that staff were supported with regular supervision and managers did not have reliable systems to monitor this.

Regulation 18: Staffing

The provider did not ensure that staff working with patients presenting with complex autism needs have specialist training and skills to address the complex needs of patients with autism and particularly the communication needs of patients using Picture Exchange Communication System and Makaton.

What people who use the service say

We spoke with four patients and three family members. Patient views were mixed. Two patients said they did not feel safe because they feared another patient. They also said there had been opportunities to self-harm when staff were not observing them correctly, although staff had not corroborated this when they investigated. Two other patients felt safe, but one was worried they would remain in the hospital for a long time.

Family members were very complimentary about the service. They said staff kept them informed about their family members progress and communication was good. One family member was extremely pleased with the significant progress her son had made since his admission to the hospital.

How we carried out this inspection

This was an unannounced, focused, responsive inspection and therefore our inspection activity looked at only part of the safe, effective and well-led key questions. This meant we did not look at all key lines of enquiry. We did not inspect the responsive key question.

Due to the COVID-19 pandemic, we conducted most staff interviews by telephone or videocall. An Inspection Manager and two Inspectors completed a site visit on 23 March 2021. Due to significant concerns and a lack of assurance from the provider following the initial site visit, an Inspection Manager and two Inspectors carried out a second site visit on 25 March 2021. A further Inspector and an Inspection Manager reviewed information remotely.

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information. During this inspection, the inspection team:

- spoke with four patients who were being cared for by the hospital;
- completed a combination of telephone and face to face interviews with 30 staff members;
- looked at the quality of the hospital environment;
- looked at ten patients' care and treatment records;
- completed interviews of three senior managers;
- spoke with three family members;
- attended two handover meetings;

Summary of this inspection

- looked at other documentation and records related to patient care and overall governance of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Not inspected	Inadequate	Inadequate

Inadequate

Wards for people with learning disabilities or autism

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Well-led	Inadequate

Are Wards for people with learning disabilities or autism safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

- We were not assured that wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- Wards appeared bare, with little information displayed for patients, such as; activities, how to complain, and COVID-19 guidance. Where we did see information displayed, staff had not provided it in an accessible format for all patients. For example, in an easy read format.
- Much of the information displayed across patient and staff areas was from the previous provider and had not been replaced with updated information reflecting the new ownership. This included contact details for patients and staff when raising concerns.
- We found the wards to be loud and noisy, which was not therapeutic for people with an autistic spectrum disorder. Ward environments were not tailored to the sensory needs of individual patients.
- The provider had not maintained furnishings and furniture was not in a good condition. Settees and chairs were ripped or coming apart at the seams. Decoration was in a poor state. Paint was chipped throughout the ward areas; curtains were falling down in areas, skirting boards were missing and other fittings, such as mirrors, were damaged exposing sharp corners. We saw bathrooms where puddles had formed in the middle of the floor after patients had a shower, which had the potential to cause someone to slip or fall. We also saw mould growing on some walls. This was not identified in the environmental risk assessment. The provider told us they had plans in place to make improvements to the buildings. However, the COVID-19 pandemic had caused a delay to the improvements being implemented.
- Ward areas were not clean. Furnishings and floorings were stained or marked. The seclusion rooms in Chestnut and Ash wards had soiled items on the bed. Dirty marks were seen on the windows of the Ash ward seclusion room during our first inspection were still there two days later. Bins were overflowing. This could be a potential infection control risk. There was a lack of clinical waste bins for staff to dispose of clinical waste, including COVID-19 personal protective equipment.
- The seclusion rooms in Chestnut and Ash wards had two blind spots which could not be seen from the nursing office. The intercom in the Chestnut ward seclusion room was not working. The blind spots had not been identified on the ward's environmental risk assessment and the provider was unaware the intercom was not working prior to our inspection.
- We found out of date or undated food on Ash, Chestnut and Elm wards. Two items had mould growing from them. On Elm ward, staff did not act when temperature checks in kitchen areas and food fridges were out of range. This meant staff could not be assured that food had been stored correctly and was safe to eat. Many patients had kitchen access and staff could not be assured that patients had not eaten out of date food.

- There were two areas unlocked which contained hazardous materials. The cupboard in the spare lounge on Elm ward contained paints and an unlocked cupboard in the kitchen on Chestnut ward contained ant killer. This had not been identified as a potential risk by the provider.
- Staff did not follow the provider's COVID-19 infection control policy or national guidance. Throughout the inspection we saw staff not wearing face masks appropriately. For example, staff wore masks below their nose or not covering their mouth. On occasions we saw staff in ward areas interacting with patients without face masks. We did not see staff washing their hands regularly and the provider had not made hand sanitiser readily available to staff. While the hospital layout did not always make it easy for staff to maintain social distancing, we also saw occurrences when staff did not adhere to social distancing guidelines when they could. For example, we attended two handovers and saw staff crowded into an office space with no ventilation. The provider had not displayed signage across ward areas to indicate safe occupancy levels within rooms in line with COVID-19 guidance. This meant patients and staff were not properly protected from the risk of transmission of COVID-19.
- The service did not always have enough staff to keep patients safe from avoidable harm. When we inspected on the 23 March, we found there were not enough staff to respond to incidents across the site. We looked at ten shifts ranging from the 13 March to 25 March 2021 whilst on site. We found the wards were short of 23 staff from those ten shifts. However, data received from the provider following our onsite visit did not corroborate this. We reviewed 372 shifts for March 2021. Rotas showed only 18 shifts were short of at least one staff member. This was different to what we found whilst onsite. For example, a member of the care team went home mid-morning on the first inspection day. This was not reflected in the rota the provider sent us following the inspection.
- There were not enough staff to safely provide nursing observations. Staff reported concerns about the lack of sufficiently skilled and experienced staff to safely manage the complexity of patient's needs, nursing observations and the ability to respond to incidents across the site. We saw that the required number of staff to safely keep patients safe was not always available. For example, we saw a patient who required a 3:1, who was reduced to a 2:1 whilst a staff member was on break.
- There were not enough staff who knew the patients. All wards used a high number of agency staff supported by only one or two permanent staff on each shift. Many of the agency staff we spoke with could not describe the needs of the patients they cared for. There were not enough staff who could communicate effectively with patients.
- Staff did not always complete an incident report when a ward was short staffed. This was not in line with guidance provided by local managers.
- Most qualified nurses working at the hospital were agency nurses, although some had been working there for several years. From 1 March to 31 March 2021, agency nurses accounted for 70% of nursing cover across all shifts.
- Staff assessed some risks to patients and themselves. However, staff did not always manage risks safely. Positive behaviour support plans were in place for some patients but not all. There was a shortage of suitably skilled staff to develop and implement positive behaviour support plans.
- One patient had a best interest assessment in place regarding food consumption and the decision was the kitchen should be locked. The patient lacked capacity regarding food consumption and was morbidly obese. The nurse in charge was unaware of his care and treatment plan and believed he had capacity. Lack of knowledge of the best interest decision could put the patient at risk of further deterioration of his physical health.
- We saw that not all staff were trained in the same restrictive techniques to ensure patients remained safe. The provider used one recognised model as their restrictive technique. Staff employed by the provider and some agency staff had received training in this model's techniques. However, we found staff used a combination of restrictive techniques from a number of recognised models. Staff reported occasions when they had to show agency staff how to restrain patients safely during an incident. This could put both patient and staff at risk of injury. We were told of two separate incidents where patients had been at risk of significant harm during a restraint. Managers had taken action. Staff also told us of several occasions when they had been injured whilst restraining a patient. Data showed that only 45% of all agency staff had been trained in the provider's recognised model of restrictive technique. This was on the provider's risk register and managers had actions in place to try and manage it.

Inadequate

Wards for people with learning disabilities or autism

- Two patients feared another patient and did not feel safe on the ward. They gave examples of being attacked and staff had to intervene.
- Staff did not always engage with patients while they delivered high level observations. We observed two incidents where staff were slow to use de-escalation techniques which led to patients being fully restrained. We did not observe staff deploying any distraction for patients to help prevent restraint. Patients and staff were at risk of harm due to a lack of response to an escalating situation.
- We were concerned patients continued to harm themselves despite staff having completed risk assessments and during high level nursing observations. One patient had been able to self-harm five times over an eight-week period. Two patients told us that staff had fallen asleep whilst they were on nursing observations. This meant they had the potential to self-harm or harm others. However, the provider told us they had investigated patient concerns in relation to staff falling asleep during nursing observations and had not substantiated the concerns. However, CCTV footage was not available at the time of the investigation.
- We reviewed ten incidents. The majority of incidents we reviewed lacked detail regarding action taken. It was unclear how learning from events was shared across the staff team. Support staff were not always aware of recent incidents relating to patients they were supporting.
- Some staff could not always easily locate documentation due to technical problems with IT logins. This meant that staff could miss key information and not have information which they needed at hand.

However;

- Staff understood safeguarding and the service worked with other agencies. Staff had training on how to recognise and report abuse and they knew how to apply it.
- We found ligature risks across wards. These had been identified in the ward ligature assessment. Staff mitigated these risks by ensuring they were present within communal areas, and patients had individual risk assessments. The service had up-to-date ligature risk assessments and staff were aware of potential risks.

Are Wards for people with learning disabilities or autism effective?

Requires Improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- Staff undertook assessments when assessing the needs of patients who would benefit. They worked with patients and with families and carers to develop individual care and support plans and updated them as needed. Care plans reflected the assessed needs, were individualised and holistic. However, they were not particularly personalised or written in the patients' voice. Some patients had copies of their care plan while others did not. Staff said all patients could have a copy if they wished. We did not see any in easily accessible formats such as easy read.
- Staff provided a range of care and treatment interventions suitable for the patient group. This included access to psychological therapies, to support for self-care and the development of everyday living skills, and to meaningful occupation. However, staff did not always follow treatment plans because they did not know the patients and their individual needs.
- Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. However, not all staff were aware of patients' physical health needs. For example, the nurse in charge of one ward was not aware of the best interest assessment regarding a patient's physical health needs.
- Managers did not always ensure that staff had the further specialist training to work with complex autism. Staff had not received any ongoing specialist autism training that effectively met the complex needs of patients with autism.

Inadequate

Wards for people with learning disabilities or autism

- The ward teams included or had access to the range of specialists required to meet the needs of patients on the wards, apart from a speech and language therapist. Most staff received supervision. During February 2021, supervision rates for all permanent staff was above 75%, although this was only 16% for bank and agency staff. This meant we were not assured that staff who did not work permanently for the provider received adequate supervision. Managers provided an induction programme for new staff. Agency staff received a local induction specific to the area where they would be working.
- Staff from different disciplines worked together as a team to benefit patients. However, we did not see any evidence of discharge planning within the patient care records. Staff told us this was done at discharge only.

Are Wards for people with learning disabilities or autism caring?

Requires Improvement

Our rating of caring went down. We rated it as requires improvement because:

- We were concerned that patients were not always being treated with dignity. We were concerned that patients were not always being treated with dignity. Patients were not always supported to, or given the tools to, carry out basic living tasks in a way which supported their dignity.
- One patient was sleeping on the sofa in the lounge area. The patient's bedroom was dirty and full of items, some of which were preventing the patient from using the bed. Staff told us they had not attempted to engage the patient in tidying their room and took no action to support their sleeping arrangements.
- Staff did not always understand and respect the individual needs of each patient. Not all staff we spoke with were not aware of patients' needs and did not follow care and treatment plans. Some agency staff we spoke with were unfamiliar with patients' needs. Staff had not always been updated regarding incidents or changes within care and treatment plans. This put patients at risk.
- We did not observe staff interacting with patients whilst on high level nursing observations.
- We spoke with four patients. All patients said some staff were rude to them at times. Three patients were unhappy being at Eldertree Lodge, whilst one was happy but believed he would be there for a long time.
- Patients told us they were able to give feedback on the service and their treatment and staff supported them to do this. However, two patients told us they were not satisfied with the response from managers and did not believe their complaint had been fully resolved. One patient said they did not have support from staff to understand the outcome of their complaint.

However;

- We observed some staff treating patients with respect, providing emotional support, help and support when they needed it. We saw that some staff had built therapeutic relationships with patients' and treated them well and behaved kindly.
- Staff informed and involved families and carers appropriately. We spoke with three family members who were all very complimentary about the service. They said staff kept them informed about their family members progress and communication was good. One family member was extremely pleased with the significant progress her son had made since his admission to the hospital.

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

Inadequate

Wards for people with learning disabilities or autism

Inadequate

Our rating of well-led went down. We rated it as inadequate because:

- Coveberry (Caretech) had taken over as provider of the service on 30 November 2020. Many leaders were new to the service and there had been recent changes in key staff. The Registered Manager and a Service Manager were not available during the inspection period. Two senior leaders had only been in post for one week when we inspected; one of these was an interim Healthcare Consultant. One Service Manager was new in post. Leaders had recognised some of the issues with the service and had developed an action plan. Main concerns included; safer staffing, use of agency staff including consistency and skills, competency of staff in positive behavioural support planning, high levels of stress amongst staff, and a lack of activities or meaningful activity.
- Not all issues had been identified by managers. The provider had not identified a number of the concerns raised during the inspection, despite having recently completed a review of the service.
- Incidents were not always reported and lacked detail regarding action taken. It was unclear how learning from events was shared across the staff team. Support staff were not always aware of recent incidents relating to patients they were supporting.
- Staff views on leadership were mixed, some did not believe that senior leaders listened to them or were supportive. Communication and leadership visibility was poor. Staff said they did not always receive feedback when completing incident forms or complaints, and when they did, they were not always satisfied with the findings. Staff highlighted a lack of leadership on the weekends and cited incidents when they did not feel supported and had had to deal with difficult situations without guidance and assistance. However, some staff were more positive the new provider had plans in place to make improvements to the service.
- Staff said the transition between the old and new provider had not gone smoothly. Information technology systems including incident reporting, rotas, and other computer files had not been made available to staff. Some systems were now in place. The provider had updated and redesigned the incident reporting system and electronic roster. Some staff said they still did not have logins for some IT systems. This meant there was a risk staff could miss important information.
- Staff said they did not always feel respected, supported and valued. Staff had contacted CQC with a number of whistleblowing concerns and had not always reported them directly to the provider.
- Ward based staff told us their main concerns included: patient mix and increased complexity of needs, poor training, not enough staff with adequate skills, and feelings of stress and burn out. Staff were concerned patients were not always safe, and their opinion was that senior leaders were not addressing their concerns.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well.
- Not all identified risks had been dealt with in a timely manner. For example, managers knew that most agency staff had not been trained in the provider's chosen restraint technique. This had been identified in 2019 and had still not been adequately resolved and continued to pose a risk to both staff and patients.
- We had not seen any improvements to the service on the second day of our inspection despite CQC outlining our significant concerns in a letter following the first day of the inspection. For example, the environment was still not adequately clean and more out of date foods were found within kitchen areas. Staff still did not engage with patients whilst on high level nursing observations. Staff continued to wear face masks inappropriately.

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 Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect • The service must ensure that the dignity and respect of patients is maintained at all times. (Regulation 10(1))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure all staff have access to appropriate care information to meet the needs of patients. (Regulation 17)(2)) • The service must ensure that all staff are aware of the provider's policies and procedures and have systems in place to ensure they are being adhered to. (Regulation 17(1)(2)(b))

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that incidents affecting patient care are assessed, monitored, evaluated and learning disseminated across the service to improve the quality and safety of the services provided. (Regulation 17(1)(2)(b))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that all staff involved in patient restraint have undertaken the same training, or refresher training which is suitable for people with a learning disability and autism, including agency staff. (Regulations 12(1)(2)(c); 18(1)(2) • The service should ensure all risks within the environment are thoroughly assessed and managed to ensure a safe and suitable environment for patients and staff. (Regulation 12)(2)(b) • The service must ensure that there are sufficient numbers of suitably qualified, skilled, competent and experienced staff at all times to meet the needs of service users within all wards. (Regulations 12(1)(2)(c);18(1)(2)) • The service must ensure that all staff undertaking observations, including bank and agency staff have the relevant skills, competences and training to do so, and do so in line with the provider's engagement and observation policy and protocol. (Regulations 12(1)(2)(c);18(1)(2))

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must ensure undertake a review of cleaning and infection prevention control practices to ensure the service is clean. (Regulation 15(1)(a)(c))