Harcourt 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

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.

Overall summary

• This was a focussed inspection. We have not rated the service as we do not rate a service until we have conducted a full, comprehensive inspection.

• At our last inspection we found that the care and treatment was not provided in a safe way for service users. The management of medicines was not safe and proper. In this inspection we reviewed the progress the service had made in safe administration of medicines. The service had made a number of changes and was now complying with the areas identified following our last inspection. However, we found that a number of new concerns with regards to the management of medications.

• At the last inspection we identified that the provider had not acted in accordance with legal requirements in the Mental Capacity Act (2005) (MCA) and the MCA Code of Practice. At this inspection we found there had been a number of improvements and the service was now meeting this standard. However, there remained a number of areas for improvement in embedding staff understanding of the MCA.

• At our last inspection we asked the provider to take action because there was no evidence that people were involved in their care planning process. The provider was now meeting this standard. New care plans had been introduced, which demonstrated involvement from

Summary of findings

patients in their development. However, some patients did not yet feel fully involved and discussions at the clinical team meeting did not demonstrate involvement of patients.

• At our last inspection the service had not told us that their registered manager had left. Since this inspection the service had provided regular updates to CQC. However, a new manager had not yet been appointed.

• The service had made a number of improvements since our last inspection. Staff were very positive about the impact the new Operations manager had made. However, the service did not yet have an effective system or process to assess, monitor and improve the quality and safety of the services provided. There was no system to review incidents, including those of restraint. Team meetings were not happening regularly.

• The hospital had moved to a new care plan structure at the time of our inspection. Care plans which had been completed were comprehensive and reflected the individual needs of patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Services for people with acquired brain injury		This report describes our judgement of the quality of care provided within this core service by Harcourt House. Where relevant we provide detail of each location or area of service visited. Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Harcourt House and these are brought together to inform our overall judgement of Care + Ltd.

Summary of findings

Contents

Location name here

Services we looked at
Services for people with acquired brain injury

Summary of this inspection

Our inspection team

Our inspection team was led by:

Team Leader: George Catford, Care Quality Commission.

The team that inspected the hospital consisted of six people: two inspection managers, two inspectors, a pharmacist and an expert by experience.

Why we carried out this inspection

We inspected this hospital to review the progress the provider had made in addressing concerns raised at a previous inspection.

How we carried out this inspection

To get to the heart of 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?

This inspection was an unannounced focussed inspection. We undertook the inspection to review the progress the provider has made in addressing concerns raised at a previous inspection.

When the service was inspected in March 2015 we found the provider was not meeting a number of the standards, as follows:

• Care and treatment was not provided in a safe way for service users. The management of medicines was not safe and proper. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 9 (1) (2) f g of the Health and Social Care Act (Regulated Activities) Regulations 2014. We served a warning notice to be met by 22 May 2015

• The provider had not informed the CQC when the registered manager was no longer carrying on the regulated activities at this location. This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 6 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014. A compliance action was issued asking the provider to take action to meet this standard.

• Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare because there was no evidence that people were involved in their care planning process. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 9 (1) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issue a compliance action asking the provider to take action to meet this standard.

• Where people did not have the capacity to consent to care or treatment, the provider had not acted in accordance with legal requirements in the Mental Capacity Act (2005) and the Mental Capacity Act Code of Practice. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponded to regulation 11 (1) (2) (3) of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issue a compliance action asking the provider to take action to meet this standard.

During the inspection visit, the inspection team:

• Interviewed the operations manager and the consultant.

Summary of this inspection

• Spoke with or interviewed seven other members of staff: a cook, two nurses, an occupational therapist, two rehabilitations assistants, and a social worker.

• Spoke with five patients who were using the service.

• Observed interactions between staff and patients using the service.

• Attended a clinical team meeting.

We also:

• Reviewed the personal files of four patients.

• Reviewed the prescription and medical administration charts for 10 patients.

• Looked at policies, procedures and other documents relating to the running of the services

At the time of the inspection the provider was implementing a new system for care plans. In the week following the inspection the provider sent us examples of the new care plans for ten patients, which we reviewed as part of the inspection.

Information about Harcourt House

Harcourt House is a mental health hospital providing inpatient care, treatment and support to a maximum of ten people with acquired brain injuries. The service offers neuropsychological rehabilitation services. The hospital is able to accommodate people liable to be detained under the Mental Health Act 1983.

What people who use the service say

We spoke with six patients at the hospital. The feedback they provided was variable. Four people told us that they did not feel involved in decisions about their care. Three people told us they did not always feel safe. However, people three people told us that they liked the staff at the unit and that they were nice.

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?

• At our last inspection we found that the care and treatment was not provided in a safe way for service users. The management of medicines was not safe and proper. In this inspection we reviewed the progress the service had made in managing medications. The service had made a number of changes and was now complying with the areas identified following our last inspection. However, we found that a number of new concerns with regards to the management of medications.

• Risk assessments were undertaken, but it was not clear when these were updated.

• How staff followed up and reviewed incidents of physical restraint was not clear in the records

Are services effective?

• At the last inspection we identified that the provider had not acted in accordance with legal requirements in the Mental Capacity Act (2005) (MCA) and the MCA Code of Practice. At this inspection we found there had been a number of improvements and the service was now meeting this standard. However, there remained a number of areas for improvement in embedding staff understanding of the MCA.

• The hospital had moved to a system of care planning at the time of the inspection. Care plans which had been completed were comprehensive and reflected the individual needs of patients. The care plans have adopted a psychosocial framework to care planning incorporating the assessment of patient's psychological, physical and social care needs.

Are services caring?

• At our last inspection we asked the provider to take action because there was no evidence that people were involved in their care planning process. The provider was now meeting this standard.

• New care plans had been introduced, which demonstrated involvement from patients in their development.

• However, some patients did not yet feel fully involved and discussions at the clinical team meeting did not demonstrate involvement of patients.

• The staff we observed on the day of our visit were working in a caring a respectful way towards their patients. When they spoke about their patients they did so in a respectful manner.

Summary of this inspection

Are services responsive?

• This was a focussed inspection to review progress made since the last inspection. We did not review the responsiveness of the service.

Are services well-led?

• The service had made a number of improvements since our last inspection. Staff were very positive about the impact the newly appointed Operations manager had made. They felt the service was now more organised. However, the service did not yet have an effective system or process to assess, monitor and improve the quality and safety of the services provided.

• There was no system to review incidents, including those of restraint.

• Team meetings were not happening regularly.

• Issues with regards to the management of medications had not been identified.

• The service did not yet have a registered manager.

Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for people with acquired brain injury	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Services for people with acquired brain injury

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are services for people with acquired brain injury safe?

Our findings

Assessing and managing risk to patients and staff

• We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable patients to have their medicines when they needed them. We checked the medicines for each of the 10 patients and saw no medicines were out of stock. Medicines prescribed by the consultant psychiatrist employed by the provider were now purchased directly from a local pharmacy on a stock basis.

• We saw medication was stored securely. Medicines requiring cool storage where stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.

• Since the last inspection we saw the provider had started to use its own medication administration and prescription chart (MAR) which was signed by the doctor who had prescribed the medicines. Each patient had separate MAR chart for medicines prescribed by their GP and one for medicines prescribed by their consultant psychiatrist.

• As part of this inspection we looked at the medicine administration records for all 10 patients. The records showed people were normally getting their medicines when they needed them, and any reasons for not giving patients their medicines were recorded. However we saw that one patient who was prescribed warfarin was not having the actual dose administered recorded on the MAR chart and one patient had blank spaces on their MAR chart for their morning medication for one day.

• We saw two patients needed an authorisation to administer medicines (T3 form). For both patients we found discrepancies between the medicines prescribed and those on the authorised consent form. We saw sedative medication for rapid tranquilisation prescribed when required, which was not included in the authorisations and one patient had been administered both promethazine and Lorazepam under these circumstances.

• Staff undertook risk assessments on admission to the hospital. All four patient files we reviewed had up to date risk assessments, which were completed on an individual basis and reflected the identified risks to patients. However, it was not clear how frequently risk assessments were updated. They had not been updated after every incident. However, the risk assessments completed also incorporated detailed management plans to address the risks identified.

• Records relating to restraint were not comprehensive. For example, one daily record for a patient referred to them having “hold restraint” and “seated hand hold and accepted PRN [‘as and when’] medication”. This did not reference an incident report, explain how long the restraint had been used for, or detail the debrief held after the restraint took place. Another record recorded that in the month prior to the inspection, one patient had been held in a prone restraint. This had been recorded with the length of time of restraint and the reason for the restraint to administer PRN medication. The restraint to administer PRN medication had not been recognised as a ‘rapid tranquillisation’ therefore this could not be followed up as such.

• Restraint was discussed during multi-disciplinary team meetings. However, the outcome of those discussions was not reflected in the care notes or care plan that staff would have access to.

Services for people with acquired brain injury

Are services for people with acquired brain injury effective?
(for example, treatment is effective)

Our findings

Assessment of needs and planning of care

• The hospital had moved to a new care plan structure at the time of our inspection. Care plans which had been completed were comprehensive and reflected the individual needs of patients. There was clear evidence of involvement of patients and the wider team in the development of these plans.

• Care records were kept in a secure, locked office area. Information on a day to day basis was kept in paper files. The size of these files meant that information was not always easy to find. Some files had paperwork which was blank in them, for example, blank behaviour record sheets. Behaviour management plans were stored in the files but not immediately accessible.

Good practice in applying the Mental Capacity Act (MCA)

• At the last inspection we identified that the provider had not acted in accordance with legal requirements in the MCA (2005) and the MCA Code of Practice. At this inspection we found there had been a number of improvements and the service was now meeting this standard. However, there remained a number of areas for improvement.

• Appropriate referrals had been made to the local supervisory body in relating to applications to authorise deprivation of liberty safeguards orders. In one record we saw that an extension of an urgent authorisation had been requested due to the delays in assessment from the supervisory body. We also saw that a request had been made in advance to a supervisory body where a deprivation of liberty safeguard order was due to expire. This was an improvement from the last inspection visit.

• Since the last inspection, there had not been specific training related to the use of the MCA in day to day practice.

• Some assessments of capacity continued in not reflecting the principles of the MCA. For example, one assessment of capacity stated "[patient] is unable to understand, recall or communicate interactions, therefore lacks any capacity in respect to MCA 2005". This is a blanket assessment of capacity and not a decision-specific capacity assessment.

Are services for people with acquired brain injury caring?

Our findings

The involvement of people in the care that they receive

• At our last inspection the provider was required to take action because there was a lack of evidence that people were involved in their care planning process. The provider was now meeting this standard. New care plans, which had been developed with the wider team and patients, had been introduced.

• However, no patients were invited to the clinical team meeting to discuss or review their care plan and there was minimal evidence of patient involvement or person centred care planning in the meeting. Three patients we spoke with told us they did not always feel involved in decisions.

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

Our findings

• This was a focussed inspection to review progress made since the last inspection. We did not review the responsiveness of the service.

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

Our findings

Good governance

• The service had implemented a number of changes since the last inspection and systems were being implemented to improve some paperwork. Staff informed us that since

the new operations manager came into post two months there was now more structure and systems in place in terms of documentation, care planning, policies and multidisciplinary team meetings.

• However, these were not yet embedded and there were still some significant gaps. For example, while incidents were being recorded in individual files, there was no system in place to monitor numbers and types of restraints and other incidents across the service.

• Team meetings were not yet happening. Staff told us they would appreciate these occurring.

• Medication management had improved and the service had met the warning notice issued by CQC. However, there were still some gaps in the records, which had not been identified by the service.

• The service has not yet appointed a registered manager. At our last inspection we took action because the service had not kept up informed of changes to management. Since the inspection the service kept us informed about changes. It was in the process of appointing a registered manager.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve
The provider must ensure that

• Medicines are only given to patients in accordance with legislation and correct procedures for medicines management.

• Records of medicines administered are completed fully and accurately.

• It has an effective system or process to assess, monitor and improve the quality and safety of the services provided.

Action the provider SHOULD take to improve
The provider should ensure that

• It continues to embed staff understanding of the Mental Capacity Act (2005).

• It continues to improve the involvement of patients in decisions about their care.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **The provider did not have systems in place to ensure the safe and proper management of medicines because medicines were being given to patients without the authorisation to do so and records of medicines administered were incomplete.** **The provider was failing to meet regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance** **The service did not have an effective system or process to assess, monitor and improve the quality and safety of the services provided.** **The provider was failing to meet regulation 17 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**