Eleanor EHC Limited

Eleanor

Inspection report

Harnham House
134 Palatine Road,West Didsbury
Manchester
M20 3ZA
Tel: 01614481851
www.ehcjigsaw.co.uk

Date of inspection visit: 20 June 2023
Date of publication: 06/10/2023

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?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as inadequate because:

- We had concerns about the oversight and governance in this service and we have issued a warning notice to the provider. There were issues with the assurances from clinical audits. We reviewed eight personnel records. We found all had missing or incomplete information. Staff had not completed all mandatory training and we were not assured that training was consistently taught and covered all standard requirements. The oversight of training meant it was difficult to be sure that staff were suitably trained. The training system and spreadsheet did not match with induction data.
- There was little evidence in patient records of senior medical reviews taking place. The speciality doctor was leaving and there was no replacement cover. We were not assured that a doctor could attend at night in an emergency.
- Observation levels were not always reviewed following incidents and observation forms were not always fully completed with frequency and reasons for observations.
- There was no legal authority in place for one patient who had received rapid tranquillisation on a number of occasions.
- Capacity assessments relating to consent to treatment were not fully completed and did not evidence a meaningful discussion had taken place.

However:

- Athena ward had been refurbished and redecorated to a high standard.
- Staffing in the service had improved and the service had enough nursing and support staff to keep patients safe.
- All patients had positive behaviour support plans which were developed by the psychology and wider multidisciplinary team members.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Personality disorder services	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Eleanor

This was an urgent focused inspection, due to concerns we had around the safety of patients within the service and the care they were receiving. The focus of the inspection was on the assessment and management of patient risk.

Eleanor Independent Hospital provides care and treatment for up to 34 patients.

At the time of the inspection there were two patients at the hospital.

The provider was registered to provide the following regulated activities:

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

We visited Athena ward on the ground floor of the hospital. There were two further wards at the hospital, Eos and Harmonia wards, which were not in use at the time of this inspection.

The service was inspected on 12 May 2022 and was rated as inadequate in safe, caring and well led. A further inspection on 22 July 2022 led to the serving of a section 29 warning notice in relation to Regulation 12 of the Health and Social Care Act Regulations 2014.There were serious issues regarding staffing, risk assessment and risk management and restraint training.

The service had undergone significant change since these inspections, and had not had patients resident in the service until May 2023.

A registered manager was in post and a controlled drugs accountable officer registered with CQC.

We raised some specific issues immediately following this inspection and received assurances from the provider about actions they had taken.

What people who use the service say

We spoke to both patients in the service at inspection. We received mixed feedback. There was positive feedback for staff and support on the ward, including use of “the stop” (an area of the ward where patients could sit to highlight they were needing support rather than having to find/ask staff) for additional support. Patients knew who their named nurse was and had regular individual sessions with them. Patients had been able to personalise their room before admission, including the colour of the walls. The frequency of multidisciplinary team meetings was raised; these were fortnightly at the time of inspection and not felt to be frequent enough. The lack of ward based activities and occupational therapy input was also raised. Patients were aware of blanket restrictions (ward based rules in place) and understood the rationale for some of these, but restricted access to the garden and rules around the frequency of vaping were raised as issues.

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited Athena ward at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with staff members; including doctors, nurses, psychologists, occupational therapy staff and support workers
- spoke with the registered manager and clinical managers
- reviewed two care and treatment records
- reviewed medicines management and checked two medication charts
- reviewed a range of policies, procedures and other documents relating to the running 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.

Outstanding practice

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action the service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Regulation 12 Safe care and Treatment.

- The service must ensure that staff are aware of the location of all emergency equipment
- The service must ensure that staff are aware of the contents of the emergency bags
- The service must ensure that there is sufficient medical cover for the service, including in an emergency
- The service must ensure that care plans incorporate high risk physical health concerns and offer guidance to staff in ensuring risks are managed appropriately
- The service must ensure that where rapid tranquillisation is prescribed this is reviewed promptly
- The service must ensure that they review blanket restrictions which are not individually risk assessed

Regulation 13 Safeguarding service users from abuse and improper treatment.

Summary of this inspection

- The service must ensure that the principles of the Mental Health Act (MHA) code of practice are followed in relation to consent to treatment
- The service must ensure that capacity assessments relating to consent to treatment are detailed, include evidence of a meaningful discussion and where possible are signed by the patient

Regulation 17 Good governance.

- The service must ensure that checks of clinical equipment are undertaken on a daily basis
- The service must ensure that clinical equipment is calibrated and in working order
- The service must ensure that all staff complete observation competency assessments
- The service must ensure that observation forms are fully completed
- The service must ensure that there is effective oversight of training undertaken
- The service must ensure that clinical audits are completed accurately and actions taken on the findings

Regulation 18 Staffing.

- The service must ensure that staff complete all mandatory training, including bank staff
- The service must ensure that staff are trained in basic life support including cardiopulmonary resuscitation techniques

Regulation19 Fit and proper person employed.

- The service must ensure that recruitment of staff is in line with Schedule 3, Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Action the service SHOULD take to improve:

- The service should ensure that observation levels are reviewed following incidents
- The service should continue to review blanket restrictions in operation

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Personality disorder services	Requires Improvement	Insufficient evidence to rate	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

Inadequate

Personality disorder services

Safe	Requires Improvement
Effective	Insufficient evidence to rate
Well-led	Inadequate

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas, and removed or reduced any risks they identified. Athena ward had been refurbished earlier in the year and managers had completed environmental assessments throughout and again once work was completed.

Where staff were unable to observe patients, parabolic mirrors were used to cover blind spots. Staff had good lines of sight from communal areas along a single bedroom area. The service had closed circuit cameras installed in communal areas, this was not used on the ward but managers could access if needed for safeguarding or incident review purposes.

The ward complied with guidance and there was no mixed sex accommodation. All three wards were for female patients.

Staff knew about most potential ligature anchor points and mitigated the risks to keep patients safe. At previous inspections, staff were not aware of where ligature risk assessments were kept or what information they contained and the assessments we saw were out of date. At this inspection, the risk assessment had been updated during refurbishment, a completed copy of the assessment was stored on the ward, alongside the policy and printed information which had been covered in training for staff to refer to.

One risk had not been identified within the assessment and this was fed back during our inspection visit. The provider immediately rectified this issue.

There was good risk mitigation in terms of fixtures and fittings in use on the ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Staff were provided with alarms and keys at the start of each shift by a designated member of staff for security. Patients were able to summon assistance using wall mounted alarms.

Inadequate

Personality disorder services

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. The ward was recently refurbished and all areas were clean and tidy. All bedrooms were ensuite.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

Clinic room and equipment

The clinic room was located beside the main doors to the ward. The room was small but there was sufficient storage for regular medicines and a small stock cupboard. Resuscitation equipment was stored in the ward office to ensure it was accessible to all staff. The emergency bag, defibrillator and suction equipment were all stored separately and we asked the provider how they were assured staff would know to access all items quickly if needed. We checked the emergency bag, which contained prepacked kits for anaphylaxis, hypoglycaemia, asthma etc but the bag would usually have sealed tags and it was clear staff were not familiar with the contents. We were concerned that in an emergency staff may not access the contents quickly as they did not know what the bag contained.

Checks of the equipment were part of the daily night staff checks. We reviewed the records for June 2023 and found medicines checks had not been completed on five occasions, clinic checks had not been completed on two occasions and checks were partially completed on three occasions.

Staff did not always check equipment. Managers had purchased new clinical equipment for the service and a servicing schedule was set up. We noted a glucometer with an old ward name written on, out of date test strips and no calibration book or liquids. We brought this to the providers attention and the glucometer was removed immediately and agreed to be replaced. There was also a second glucometer that could be used in the meantime.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. The service had recruited and trained staff throughout the early part of 2023. An induction programme had been established to ensure staff completed mandatory and additional training when they started work at the service.

The service had low vacancy rates. Recruitment was ongoing to ensure sufficient staff were employed as the service provision grew.

The service had low rates of bank and agency use for nurses and support workers. Managers covered shifts by offering these to permanent staff first and had a small regular bank of staff who worked shifts. The service had used agency staff to cover for two shifts since patients had started to be admitted. The service had a contract with one specific agency and had completed due diligence to ensure staff were trained to the same level as permanent staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed completed induction forms for agency staff.

The service had low turnover rates. Managers supported staff who needed time off for ill health. Managers told us of specific individualised support put in place to deal with a serious incident for staff and plans for support for the whole staff team.

Levels of sickness were low. There had been no staff off work over the last four weeks. Prior to this staff had been working at other locations in the company.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The service had set staffing levels according to the numbers of patients. The staffing levels were met for each shift. There was a plan to increase staffing levels as more patients were admitted.

The managers could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse. and other members of staff on each shift.

Patients rarely had their escorted leave or activities cancelled. Neither of the patients in the service had external leave at the time of this inspection. Activities and visits were not cancelled.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. Staff completed comprehensive handover forms including a medicines check and handover between nurses. There was also a security handover between shifts where all keys and alarms were checked and an environmental check of the ward took place.

Medical staff

The service had enough daytime medical cover and a doctor available to go to the ward quickly in an emergency during the day. A consultant and speciality doctor worked within the service during the day. At night, there was a doctor available on call but they would not be able to attend urgently if needed or as guidance suggests when restrictive interventions were used. NICE NG10 guidance advises a doctor should be immediately available to attend an emergency if restrictive interventions might be used.

The consultant did not show as having signed in to the building on any of the signing in sheets since patients were admitted. Ward rounds on 8/6/2023 were noted in the morning meeting as booked via Teams and there were no written records of these reviews in the electronic or patient notes. In both patient records we reviewed, the first entry made by the consultant was two to three weeks after admission. All records requiring a consultant signature have an electronic scanned signature. In addition to this the speciality doctor had given notice and was due to leave in the next few weeks, this meant that if the consultant was not in the building during the day there would be no doctor cover on site.

Mandatory training

Staff had not completed and kept up-to-date with their mandatory training.

The managers shared training figures which showed most staff were near 100% complaint with training. However, the detail of this included new starters who were counted as “within completion period” despite having not attended mandatory training yet. These staff were working regular shifts within the service. Two permanent staff were marked as unavailable.

All five qualified nurses who had worked shifts on the ward had completed immediate life support training in the last 12 months, although one nurse had completed this with a previous employer so we were not assured about the quality of this training. One qualified nurse worked on the bank system and had completed this training.

Three permanent support workers had not completed basic life support training, nor had five bank support workers. The permanent support workers had attended an induction session titled "physical health monitoring and scenario training including policy review" but this did not include cardiopulmonary resuscitation techniques or practice. This meant that only 63% of support workers had completed basic life support training.

For online and face to face fire safety training, 11 staff were shown as having completed this. This would equal 68% of permanent staff. One member of bank staff had also completed this.

Staff completed face to face physical intervention training, with overall completion of this at 73% of permanent staff. One member of bank staff had completed this training.

Personality disorder training was mandatory for staff working in the service, 50% of permanent staff had completed this training face to face and 68% had completed an online module. No bank staff had completed this training.

Medication administration awareness training was mandatory and 68% of staff had completed this training. Two qualified nurses had completed this training. No bank staff had completed this training.

Staff completing induction to the service in May 2023 had attended a half day training session on autism awareness. The signing in sheet for the day showed 18 staff signed in. The provider supplied figures indicating two staff were up to date with this face to face training. Additionally eleven staff had completed an online module titled autism awareness.

Eight staff were recruited to the staff bank and six had worked regular bank shifts within the service at the time of this inspection. Three of these had attended induction training but four bank support workers were listed on the training spreadsheet as "bank" and had not attended any further training. One member of bank staff working in the service did not appear at all in the training figures supplied.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival. Staff reviewed this regularly, but not after every incident.

Each patient had an initial risk assessment completed on admission. In-depth risk assessment tools and formulations were started at admission led by the psychology team with these timed for completion at the four to six week mark.

The risk assessment tool in use captured current and historical risks, triggers and early warning signs. These were fully completed in patient records and mirrored the care plans and positive behaviour support plans in use.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff were aware of patient risks and were skilled in de-escalation and preventative strategies. When incidents occurred, the service model was to support patients to regain control over behaviours themselves, with staff intervention only when needed, for example, encouraging patients to loosen and untie ligatures. We were concerned that for some patients with significant physical health risks, staff should intervene sooner to prevent significant physical health risks increasing. Care plans and positive behaviour support plans did not give staff specific guidance to follow.

Staff identified and responded to some changes in risks to, or posed by, patients. Staff knew patients well and we saw incidents which had been prevented from escalating due to the quick responses of staff.

Observation levels were not always reviewed following incidents, and whilst we saw one occasion of observation levels reviewed following a series of incidents, this was not recorded for most. The service indicated following inspection that they would introduce a standard review prompt for incident reporting to ensure this took place.

Staff followed procedures to minimise risks where they could not easily observe patients. There were good lines of sight from communal areas of the ward to the bedroom corridor. Staff followed the provider observation policy to keep patients safe. Staff had their understanding and competency around observation assessed but we were unable to find completed assessments for five members of staff working on the ward.

Observation forms in use had sections to indicate the frequency of observations, bathroom privacy prompts and indications for observation. On reviewing completed observation forms, six observation forms reviewed did not indicate the frequency of observations, with no category circled or ticked. Four observation forms had the box marked 'other' ticked as a risk, with no indication of the nature of this additional risk. Observation forms were fully completed in terms of staff making entries for their periods of observation although over time these had less content about the patient's mood and mental state and were more a description of their location on the ward.

Staff followed policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There had been no recent searches of patients or bedrooms noted at this inspection.

Use of restrictive interventions

There had been 20 incidents of restraint in the three weeks prior to inspection. Ten incidents had resulted in prolonged restraint of over 10 minutes including two episodes over an hour. There had been no use of prone restraint.

There had been 14 incidents which involved rapid tranquillisation.

Staff completed debriefs with patients following incidents and these were loaded into the records systems.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff entries in patient records showed skilled de-escalation and following of positive behaviour plans and patients wishes.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. Nursing staff were completing observations following administration of rapid tranquillisation.

We saw on occasions patients would be stopped from using their bedrooms and would have to stay in communal areas of the ward. Whilst good practice guidance, for example the Mental Health Act code of practice, says providers should encourage patients to avoid staying in their bedrooms for prolonged periods during the daytime, the guidance also notes that people should not be locked out of their bedrooms in an attempt to restrict their freedom of movement.

The hospital had a list of banned and restricted items which included items which would pose a risk to patients and was reasonable. Some areas of the ward were subject to restriction, including patients accessing the kitchen which required risk assessing, use of plastic cutlery outside mealtimes, laundry room accessed with staff and otherwise locked and no garden access after dark. The hospital reducing restrictive practice group minutes also refer to restrictions on caffeine and a blanket rule relating to incoming mail which were not individually risk assessed.

Safeguarding

Some staff received training on how to recognise and report abuse, appropriate for their role.

Figures supplied by the provider showed 50% of permanent staff had completed level three safeguarding adults and children training. No bank staff had completed this training. Only two qualified nurses had completed this training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw safeguarding actions recorded in patient records.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff maintained regular contact with commissioners and care-co-ordinators, including any safeguarding actions.

Staff followed clear procedures to keep children visiting the ward safe. The hospital had a separate family visiting room which could be used for children visiting.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a safeguarding policy which had been devised to follow the local authority processes.

There had been no serious case reviews in this service.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The hospital had introduced an electronic records system which contained ongoing progress notes and care plans. Risk assessments and other documents could be uploaded to the system and there were plans to incorporate these functions in the future. Staff also maintained paper files of pre-admission assessments and clinical filing, including archived observation forms, diet and fluid charts and physical health monitoring forms. Staff completed incident forms using a separate electronic system. Staff added incident form references to progress notes.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and mostly complete. Blood results and electrocardiogram (ECG) readings had not been added to patient records. This was rectified during this inspection.

Records were stored securely.

Inadequate

Personality disorder services

Medicines management

Staff did not follow systems and processes to prescribe and administer medicines safely.

At previous inspections there had been significant concerns about medicines management including missed doses of medication, prescriptions unsigned, controlled drugs errors and no recognition of high dose antipsychotic treatment or monitoring. These issues were not apparent at this inspection.

However, we noted that there was no legal authority in place for one patient who had received rapid tranquillisation on a number of occasions.

The consent to treatment form in place (T2 form) was invalid as the patient did not consent. Nursing and medical staff had not recognised this. The clinical notes included clear indication that the patient did not consent to this and refused. The Mental Health Act code of practice notes certificates cease to be effective if the patient no longer consents or no longer has capacity. Staff still considered treatment was authorised under the T2.

We saw other completed T2 forms which included medicines to be given intramuscularly. At the point where rapid tranquillisation was needed the patient was unlikely to be able to meaningfully consent to this.

The capacity assessments for consenting patients consisted of ticks indicating actions were completed with no additional detail, even when treatment plans included high dose antipsychotic therapy and use of intramuscular medication. There was no additional notes or questions by patients and no signature or indication that the patient had been consulted. These were typed and electronically signed. There were no corresponding entries in patient progress notes for these discussions.

Medicines were not being reviewed regularly and in line with consent to treatment. The NICE NG10 Violence and aggression: short-term management in mental health, health and community settings guidance advises that if rapid tranquillisation is being used, a senior doctor should review all medication at least once a day.

Staff completed medicines records accurately and kept them up-to-date.

The hospital had introduced an electronic medicines administration system which was linked to their pharmacy provider. This helped ensure sufficient stock management and prevented administration errors.

Staff stored and managed all medicines and prescribing documents safely.

All medicines were stored appropriately. The hospital had introduced a system which included remote monitoring of medicines fridges to ensure medicines requiring refrigeration where stored correctly.

The ward had a stock of commonly required medicines, including painkillers and antibiotic treatments, so that treatment could be started as soon as possible after these were prescribed.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Doctors and nurses ensured medicines reconciliation was carried out as patients were admitted.

Staff learned from safety alerts and incidents to improve practice. The hospital had introduced a medicines management meeting which took place monthly, safety alerts and learning was a standard item.

Inadequate

Personality disorder services

The service did not ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There was high use of as needed medicines and rapid tranquillisation in this service. The use of medicines was not in keeping with the NICE guidance CG78 which guides that drug treatment should not be used specifically for borderline personality disorder or for the individual symptoms or behaviour associated with the disorder; antipsychotic drugs should not be used for medium and long term treatment, sedative medication use should be short term (no longer than a week) and there should be an aim to reduce and stop unnecessary treatment.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff had access to side effect monitoring scales. We were concerned that the electrocardiogram readings produced by the hospital equipment were inadequate in terms of monitoring potentially fatal cardiac arrythmias which can develop with many psychiatric medicines, predominantly antipsychotic medicines. The provider has indicated they will purchase suitable equipment.

Reporting incidents and learning from when things go wrong

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.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with /provider policy. Staff reported serious incidents clearly and in line with policy.

Since 24 May 2023 there had been 142 incidents reported within the service. These were predominantly incidents of self injury.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. The service was aware of the requirements of Duty of Candour and had a policy to guide staff. The service had completed this for an incident identified at this inspection.

Managers debriefed and supported staff after any serious incident. Following a serious incident managers had supported staff by covering subsequent shifts, arranging individual support plans and arranging for an external organisation to offer debriefing and support for the whole staff team.

The service had not yet undertaken any serious incident investigations, but a policy was in place to guide staff in completing these. The provider was also undertaking work to plan for the introduction of the patient safety incident response framework later in the year.

Managers had completed an analysis of incidents in the service to explore potential themes and trends.

Is the service effective?

Insufficient evidence to rate

We did not inspect this domain but noted the following:

Inadequate

Personality disorder services

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We saw completed admission assessments in patient records.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Medical staff completed a full clerking assessment including physical health history, current conditions and a physical assessment.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated.

Staff developed care plans using a provider framework of eight overarching areas, including mental health, physical health, issues with substances, life skills, contact with friends and family and managing behaviours that communicate distress. The format of these was patient centred and included prompts including where the patient felt they were now, their goals and strengths. However because of this format, some care plans lacked detail and guidance for staff to follow, particularly when patients were distressed.
All patients additionally had positive behaviour support plans which were developed by the psychology and wider multidisciplinary team members.

Staff regularly reviewed and updated care plans when patients' needs changed. Nurses regularly reviewed care plans in the records reviewed.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service.

The hospital had developed a pathway approach based around therapeutic community principles. There was good access to psychology provision including individual and group work with a consultant psychologist and assistant psychologist working in the service.

Skilled staff to deliver care

The service did not have a full range of specialists to meet the needs of the patients on the ward. The occupational therapy establishment was for a lead occupational therapist, occupational therapy assistant and activity workers based in service. At the time of this inspection, there was an occupational therapy assistant working in the service who planned and delivered ward based activities.

Is the service well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as inadequate.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Inadequate

Personality disorder services

At previous inspections, the hospital did not have a registered manager. A hospital director and registered manager had now been in post for the last 10 months. There had also been recruitment for senior clinical staff with a deputy hospital director, clinical nurse manager and clinical services manager recruited to the service.

The hospital director, deputy director and clinical managers worked within the service and the ward and staff and patients knew them. Managers had experience in similar services previously and understood and explained the model for the service well.

Vision and strategy

Staff knew and understood the provider's vision and values and how they were applied to the work of their team.

The staff team were predominantly newly recruited to the service. They understood the service model and ethos. The values and vision of the service were promoted around the building.

Culture

Staff felt respected, supported and valued. Staff told us they felt there was a good supportive clinical team. Staff told us they had felt well supported when incidents occurred. Staff had valued having time to establish the service and model prior to patients being admitted.

Governance

Our findings from the other key questions demonstrated that here were ongoing issues with governance in this service which were present at previous inspections.

The oversight of training meant it was difficult to be sure that staff were suitably trained. The training system and spreadsheet did not match with induction data. At inspection we were given two different induction timetables for May 2023 with different sessions and content. The provider sent a further different timetable after the inspection.

Staff training data showed nearly all staff training completion at 100% but this included staff marked as "in completion period" and no bank staff training details were recorded. The system does not provide assurance to managers that staff have completed the correct training as staff show as trained even if they have not yet completed training. Further information sent following inspection suggested higher levels of fire training and basic life support training completion, but this included an additional session staff had attended at induction which was not on the original timetable. Two staff recorded as completing training on that date were not signed in that day. We could not be sure staff had completed training and it was clear that the oversight of this was poor. Neither of the medical staff had undertaken most mandatory training within the service and were not included in training oversight and recording. This had not been recognised by the provider.

There was no effective oversight of training delivery or the quality and consistency of training offered to staff. When we asked for further details about a physical emergencies sessional content, sessions did not have a set content or lesson plan so we were not assured that staff received consistent training or what the aims and outcomes for some training was.

There were issues with the assurances from clinical audits. We reviewed checklists from June 2023 but found clinic checks were not completed for two days and checks partially completed for three days. We reviewed medicines checks and these were not completed on five days in June 2023. Issues found with consent to treatment should have been

highlighted at medicines checks but these were all marked as valid consent in place. Whilst a check was in place it had not been recognised when these were not valid. The use of a glucometer with out of date testing strips and no calibration book or kit should also have been picked up through clinic checks but this section of the audits was ticked as checked.

Following concerns raised previously about staff competency to undertake observations, the provider had introduced an observation competency assessment that staff would complete prior to undertaking unsupervised therapeutic observations. We noted 11 staff competency assessments that were incomplete. Some were missing the signature of the person assessed, some had no signature completed by the assessor and nine forms had the final assessment of competence either incomplete or blank.

At previous inspections, there had been concerns about management of ligature risk. At this inspection, whilst there was improvement, there was an out of date ligature risk assessment in the file on Athena ward, a ligature risk on the ward that was not on the assessment and ligature cutters and their location was not covered within the staff induction checklist. This would be completed primarily for temporary or unfamiliar staff undertaking bank or agency shifts so is of importance.

We reviewed eight personnel records. We found all had missing or incomplete information. Two records had no disclosure and barring service checks, whilst a further one had a check from 2020. One qualified nurse had no NMC check documented. Six records had incomplete or no work history, including two records which contained no application or curriculum vitae. Two records had only one reference and three had references supplied by senior managers within this service. Four records contained no health screening. Two records had only one form of photo identification.

At the last inspections of this service, there had been a lack of oversight and the governance structure was not effective. The service had developed and implemented a new governance structure with one month's cycle partially completed at this inspection. A series of meetings had been planned to feed into a clinical governance committee with senior managers. Initial meetings of the risk and restrictive practice, medicines management, infection control and safeguarding groups had taken place and we reviewed the minutes for these. There were also forums for staff engagement and HR, health and safety and quality and clinical effectiveness which had not yet taken place.

A new audit schedule was in place to gather information around clinical performance and service quality including monthly environmental checks completed by the registered manager which had taken place over the last month. A weekly audit was also completed by the pharmacy provider and sent to the registered manager and qualified nurses in the service for actions.

Management of risk, issues and performance

The service did not have a risk register but risk register items were discussed and documented in the risk and restrictive practice group. The service had identified issues around recruitment, regulation and admissions as key risks.

Information management

Staff collected and analysed data about outcomes and performance.

Managers were able to gather information about the service using the electronic patient record system and incident reporting. From the risk meeting, an incident analysis had been undertaken to review themes and trends arising from incidents and potential service strategies to address these.

Inadequate

Personality disorder services

Engagement

The service maintained regular contact with the local lead commissioning team as well as individual patient commissioners. One individual commissioner fed back that contact from the service was positive and proactive and he was able to maintain good contact.

Staff told us they received information about the service through daily meetings and via a newsfeed built into the electronic system in use at the hospital. The service had introduced toolbox talks to introduce any changes during handovers or team meetings.
A staff survey had been completed last year and there were plans to repeat this once the service was established.

Learning, continuous improvement and innovation

The service had continued to adopt new technology to improve the service, for example, the system which staff used to log in to the building included facial recognition which helped ensure security and safety of the building and the electronic prescribing system.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The MHA code of practice was not being followed in relation to consent to treatment. Medicines were authorised inappropriately and staff didn't recognise when patients had the right to withdraw their consent. Assessments of capacity relating to consent to treatment contained no additional narrative or discussion with the patient, even when the resulting authorisation included rapid tranquillisation and/or high dose antipsychotic therapy. The service must ensure that capacity assessments relating to consent to treatment are detailed, include evidence of a meaningful discussion and where possible are signed by the patient

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 18 HSCA (RA) Regulations 2014 Staffing We were not assured that staff had completed mandatory training despite the records stating that the team were near 100% completetion. However, the detail of this included new starters who were counted as “within completion period” despite having not attended mandatory training yet. These staff were working regular shifts within the service. Two permanent staff were marked as unavailable. Three permanent support workers had not completed basic life support training, nor had five bank support workers. The permanent support workers had attended an induction session titled “physical health monitoring and

This section is primarily information for the provider

Requirement notices

scenario training including policy review" but this did not include cardiopulmonary resuscitation techniques or practice. This meant that only 63% of support workers had completed basic life support training.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment of staff was not in line with Schedule 3, Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff did not all have an up-to-date disclosure and barring service check completed when they were employed, staff did not all complete application forms and a full work history, staff did not all have two references obtained, staff did not all have health assessments.

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 We were not assured that staff knew where emergency equipment was kept as the emergency bag, defibrillator and suction equipment were stored separately to each other. Staff were not familiar with the contents of the emergency bag. Checks of clinical equipment and medicines were not taking place every day. Medical cover was not sufficient to ensure a doctor could attend the service in an emergency. Care plans did not offer sufficient guidance to staff in managing situations with high risk physical health factors. When rapid tranquillisation was prescribed, this was not reviewed promptly following use. Some blanket restrictions were in place which were not appropriate restrictions for all patients.

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 • We had concerns about the oversight and governance in this service and we have issued a warning notice to the provider. There were issues with the assurances from clinical audits. We reviewed eight personnel records. We found all had missing or incomplete information and managers had not addressed this or ensured solid recruitment practice. Staff had not completed all mandatory training and we were not assured that training was consistently taught and covered all standard requirements. The oversight of training meant it was difficult to be sure that staff were suitably trained. The training system and spreadsheet did not match with induction data.