

We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Slade House

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✘	Action needed
Consent to care and treatment	✔	Met this standard
Care and welfare of people who use services	✔	Met this standard
Safeguarding people who use services from abuse	✔	Met this standard
Management of medicines	✔	Met this standard
Assessing and monitoring the quality of service provision	✔	Met this standard
Records	✔	Met this standard

Details about this location

Registered Provider	Southern Health NHS Foundation Trust
Overview of the service	<p>Slade House comprises of two separate units on the Slade site in Headington, Oxford.</p> <p>John Sharich House is an eight bedded assessment and treatment unit for adults over the age of 18 years who require treatment for a period longer than six months.</p> <p>The Short Term Treatment and Assessment Team Unit (STATT) is a seven bedded facility for people requiring treatment for less than six months. It was not open to admissions at the time of this inspection.</p> <p>Patients can be admitted both formally and informally.</p>
Type of services	<p>Community healthcare service</p> <p>Hospital services for people with mental health needs, learning disabilities and problems with substance misuse</p>
Regulated activities	<p>Assessment or medical treatment for persons detained under the Mental Health Act 1983</p> <p>Treatment of disease, disorder or injury</p>

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Slade House had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Management of medicines
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 March 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We inspected Slade House (John Sharich House) on 03 March 2014. This was a responsive inspection to check if the compliance actions and warning notices we had issued after our inspection in September 2013 had been followed up completely and appropriately. In September, Slade House comprised of two separate units; the Short Term and Assessment Team unit (known as STATT) and John Sharich House (known as JSH).

The Trust chose to stop admissions to both units following our inspection in September 2013. They were told by the Commission they could re-admit when they felt fully confident they had completed their compliance actions. They have not yet admitted anyone to either of these locations.

After the last patient on STATT moved out in December 2013, the Trust closed that unit. We were therefore only able to view care within John Sharich House on this inspection.

On our arrival, we were shown around JSH. We saw that there were five staff on duty for five patients. The staff told us that four of the five patients being cared for would be discharged soon and arrangements were being made for this. We were able to speak with

some patients in John Sharich House, but one patient did not wish to speak with us. We asked them about the assessment, treatment, care and support they received. One person told us it was "okay" and said they were happy being cared for there.

Another patient told us they were not happy to have had their baths stopped. We were surprised to hear that bathing was not allowed for anyone. We asked why this was. We were told this had been a response to a death in the unit last summer when a young man had died in the bath. We asked if this decision had been made with input from all relevant professionals and from the patients it concerned. We were told it had not.

Patients told us that their consent was sought before any care or treatment was commenced. However, it had not been sought regarding the decision on bathing and one patient was able to tell us they were "upset" about this.

We spent time observing the daily work of the unit. Although we heard warm personal interactions between staff and patients, we noted little obvious therapeutic activity throughout the day. Staff stayed in the staff room for considerable lengths of time, working on administrative tasks. This surprised us, as this had been an area of rigorous discussion after the previous inspection.

We asked members of staff what the purpose of the unit was. We received a variety of answers from senior clinicians and other members of staff. We asked how treatment success or failure was measured. We were told there were no specific pathways, but that care was nevertheless tailored to the individual patient.

We discussed safeguarding training and knowledge. The staff told us they felt confident in this area.

We inspected the medicines policy and procedures and found that these were correct.

We looked at the quality monitoring checks that took place. These are used to enable senior staff to check the unit was functioning safely and well, and if it was providing good care and appropriate support. We saw that a family information group had recently started.

We examined records of people, of staff and of equipment. These were mostly satisfactory.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 13 June 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services × Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy and dignity were respected. However, people's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. The provider was not meeting this standard. People's independence was not always respected.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Patients understood the care and treatment choices available to them. There were clear examples of them being involved in most of their care and treatment and that was reflected within their care plans.

However, there were examples where patients had had no involvement in significant personal decisions. An example of this was the recent blanket decision made that they would not be allowed to have a bath, they would have showers only.

This was a decision made by a senior professional working on the unit. This decision was announced at the end of a multi-disciplinary team meeting. There was no opportunity for patient opinion or multi-disciplinary discussion around the best way to implement such a directive.

We asked how patients had been assessed as being at risk when using these baths, and what the perceived risk was. The staff told us that these patients had no significant illness factors in their care plans and risk assessments on which to base this decision.

Several of the patients had capacity and there was no consideration given to their views. This demonstrated a lack of involvement in making decisions about their care, treatment and support. Their independence was not respected.

Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were usually asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider usually acted in accordance with their wishes. There was a clear consent policy, and correct use of the process for a person to be supported in the least restrictive way, under best interest. There were Mental Capacity Act 2005 policies in place for various treatment options.

However, there was no use of the consent policy in relation to the decision to withdraw the use of baths on the unit. One person told us they "were upset" by this decision as they would have liked to have a bath. No discussion had taken place with people who used the service before this decision was implemented.

The provider may wish to note that this meant that people who used services had not given valid consent to this aspect of the care, treatment and support they received. They did not know how to change any decisions about the care, treatment and support that had been made without their consent.

Staff we spoke with, with the exception of the person who had made this decision, understood the correct use of the consent policy. They told us they felt able to use this effectively, with the exception of the newly implemented bathing policy with which they expressed disagreement.

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spent time observing the daily work of the unit. Although we heard warm personal interactions between staff and patients, we noted little obvious therapeutic activity throughout our inspection. Nursing and care staff stayed in the staff room for considerable lengths of time, working on administrative tasks. This surprised us, as this had been an area of discussion after the previous inspection.

Patients were seen to spend long periods of time on their own, sometimes wandering in an apparently aimless manner. However, we did note one member of staff continuously working with one person on his behaviour strategies throughout our inspection, and another staff member completing documents for a planned discharge. This was evidence of safe care and treatment and there was good use of appropriate referral to therapy services. We saw therapists on the unit, but not actively working with patients whilst we were there.

We asked members of staff what the purpose of the unit was. We heard a variety of answers from senior clinicians and other staff. We asked how treatment success or failure was measured in this Assessment and Treatment unit. We were told there were no specific pathways, but that care was nevertheless tailored to the individual. We read recently updated care plans and risk assessments and noted that these were appropriate to individuals who were about to be discharged.

It was not possible to ascertain the level of compliance with their initial assessments and planned pathways, as these patients had been in this assessment unit for some years, and their initial assessment needs had changed. Their current discharge arrangements were documented and undergoing progress and on-going risk assessments as appropriate placements were found.

The provider may find it useful to note that patients in John Sharich House did not require active assessment and treatment in that particular type of specialist unit. The length of stay on an assessment and treatment unit should be as long as it takes to assess. Guidelines are that this is from around 12 weeks for a short term unit, and approximately 6 months upwards for a longer term unit.

One patient had been resident on the unit for five years. Other patient's care records showed they had been assessed as ready for discharge. This was not an appropriate place to treat their physical health needs and support their learning disability needs. This meant that although their needs were being met on the unit, it was not the most appropriate setting for their care to be delivered.

People's current needs were assessed and care and treatment was planned and delivered in line with their individual care plan. There was evidence within care plans that staff were able to respond and change to the developing needs of the patient. For example, one patient had a length of TV cable in their room. This could have been viewed as a personal hazard, but the staff were able to demonstrate that this had been carefully risk assessed against a set of specific behaviours. These behaviours were continuously monitored to ensure the person's safety.

Patients we spoke with had a copy of their care plan, or had been offered a copy of it. One person we spoke with was clearly able to articulate that they were allowed to leave the unit, and what they did when they went out. This information was reflected within their care plan and risk assessments. Risk assessments were in place and effective for the patients within the unit.

We noted that there was limited evidence of information available in easy read format, for example, some information on the noticeboard was not written in this manner. This meant there may have been some information unable to be accessed by people who stayed in the unit.

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We inspected this outcome because of non-compliance on the previous inspection.

The provider had comprehensive procedures in place to safeguard people who used the service, and to respond to any allegations of abuse. This was available to all people being treated there and was available in Easy Read format. A copy was located on the noticeboard in the main corridor of the house.

We spoke with two support workers and two nurses who were on duty at the time of the inspection. They had attended training appropriate to their roles and had a clear understanding of their responsibilities. They told us they would raise any concerns with their immediate manager and a new Modern Matron, and they felt assured this would be dealt with promptly through the correct channels. There were no outstanding safeguarding alerts the day we inspected.

We spoke with two people who used the service. They told us they felt safe with the staff in JSH. They said they would speak to staff if they had concerns about anything. One person said they felt "listened to". We noted there was a poster about advocacy on the noticeboard, and this provided a means for further support.

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We inspected this outcome because of non-compliance in the previous inspection. During this visit, we read the Trust medicine policies, looked at medicine records, spoke with staff and patients, and observed the administration and recording of medicines.

Appropriate arrangements were in place for the ordering and supply of medicines. This meant that sufficient medicines were kept in stock. Expiry date checking had not been consistent on the previous inspection, and we had found an emergency cylinder of oxygen 15 months out of date. On this visit, the nursing staff were able to correctly describe the procedure around the administration of oxygen as a prescribed medicine. The emergency oxygen was in-date and correctly stored.

Arrangements were in place in relation to the recording of medicine. We observed medicines being checked and administered to people who used the service. Medicines were handled appropriately and were prescribed and given to people in the correct manner.

Staff had access to up to date information on medicines they used. We saw a copy of the latest pharmaceutical formulary; this ensured that the available information was recent.

Out of date clinical guidelines which had been in place during the previous inspection had been removed and replaced with more current documents. On the day of our inspection, staff were able to quickly retrieve useful and current guidance on medications management.

Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others

Reasons for our judgement

We inspected this outcome because we took enforcement activity against the Trust after the inspection in September 2013. On that occasion, they had demonstrated non-compliance with an effective system to regularly assess and monitor the quality of service that people received.

During this inspection we looked at audit records, Matron's Walk Around records, infection control and cleaning records, staff rotas, care plans, training records and policies and procedures. On this inspection, we noted that governance checks such as Matron Walk Arouns and quality audits provided a level of assurance previously absent. This meant that senior managers could reflect that the false positive assurance of previous months had been replaced by checks that demonstrated an accurate reflection of the situation it purported to measure. This had been achieved by the use of a "Turn-Around Team". This was a team of senior staff who had been put in place to ensure areas of good practice were introduced and embedded.

Staff were now fully aware that checks must always reflect accurate information rather than inaccurate or un-checked data. The previous systemic failure of process to follow through to completion had been replaced by a more robust use of cross-checked and verifiable data.

Patients, their representatives and staff were asked for their views about their care and treatment and they were acted on. This was rudimentary, but involved a new family feedback meeting. This had just started before the inspection date, but was an assurance of some progress.

We asked senior managers about the staff's views on improving the service they were able to provide to people. They agreed that staff morale was "variable" and attributed this to the events of the previous six months.

We checked all emergency equipment including fire doors, fire extinguishers, cardiac defibrillators and emergency oxygen cylinders. These were all in working order. Verifiable

and cross referenced checks had taken place. This meant that these quality assurance checks were in place and updated appropriately.

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

We inspected this outcome because we had taken enforcement action against the Trust after the last inspection because of its' poor record keeping.

During this inspection we read records of people who used the service. These were in paper and electronic format, and comprised care plans, medicine charts, risk assessments and day to day records of daily activities. These were written in an appropriate and professional manner, and signed and dated by appropriate staff where required.

Patient's personal records including medical records were accurate and fit for purpose. Electronic records were password protected and saved on back up. This meant that in the event of a power loss, the data would be retrievable and able to be accessed by someone with the correct permissions.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. During the last inspection we saw that emergency equipment record keeping was inaccurate and inadequate to keep people safe in an emergency. This meant that the information could not be relied upon to be wholly accurate. On this inspection, records were signed as necessary to ensure the safe running of the service. These records were checked by senior staff on a regular basis to ensure safety and compliance.

We asked to view patient records, records of equipment checking, annual contract records and staff training records. These were kept securely and could be located promptly when needed.

The provider may wish to note that a large mixed pile of documentation was found on the Charge Nurse's desk. This documentation included unfiled staff sickness records, paper training records and medication assessment records. Although these did not pertain to the safety of patients or the building, it should be noted that due to the haphazard storage of this documentation, specific information would not have been able to have been found quickly if it had been required.

This section is primarily information for the provider

✕ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services
Treatment of disease, disorder or injury	How the regulation was not being met: People were not consistently provided with appropriate information or support related to their care and treatment. They were not involved in all decisions about their care and treatment. Regulation 17(1)(c)(i) and (ii) and 17(2)(b)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 13 June 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ Met this standard This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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