Spring Wood Lodge

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

The Care Quality Commission are placing this service into special measures.

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

We rated Spring Wood Lodge as **inadequate** because:

- Safety was not a sufficient priority, and there was limited measurement and monitoring of safety. The management of risks in the environment was poor and we found several concerns about the management of medication. Staff were not properly trained and senior staff were not adequately supervised. We found that patients prescribed medications with serious side effects were not monitored appropriately. There were a number of blanket restrictions in place which had led to staff creating punitive punishments for patients.
- Patients were at risk of not receiving effective care and treatment. Staff did not always adhere to the Mental Health Act Code of Practice and consent was not always obtained or recorded in line with the Mental Health Act Code of Practice. Staff were not trained in either Act and their lack of understanding meant that we saw examples of significant impacts on patients whose rights had not been properly upheld. Care plans did not contain the voice of the patient or their views and the language used was directive. There was no evidence that staff completed them collaboratively with patients and their needs, wishes and long term goals were not always measurable or clear. Care plans were not recovery focussed and not all patients had discharge plans in place. This did not fit with a recovery model of care.
- We saw that there were times when people did not feel well supported or cared for because staff did not always see patient's dignity as a priority. The service was highly restrictive and although patients were involved in the service their concerns were not always responded to in a timely manner. Some care provided to patients was not dignified or respectful, and some restrictions had been put in place for the benefit of staff not patients such as designated staff restricted times when patients were not allowed to request smoking breaks.
- The service was not responsive to the needs of all patients. There were shortfalls in how the needs of different people were taken into account on the grounds of religion or belief. There was no spiritual room available to patients on site, and patients with spiritual and cultural needs did not have care plans which documented and addressed these needs.
- The governance systems in place did not ensure the delivery of safe and high quality care. At the time of inspection the service did not have a manager in post that was registered with the Care Quality Commission and the service did not have an accountable officer to monitor the use of controlled drugs. There was not an effective system in place which identified, captured and managed risks such as audits, training, supervision and environmental risks. The significant issues we found during our inspection had not been identified by the service's own governance systems. There was no credible statement of values and vision for the service which had been shared with staff.

Summary of findings

Contents

Inadequate

Spring Wood Lodge

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Spring Wood Lodge

Spring Wood Lodge has been registered with the Care Quality Commission since October 2016 to carry out the following regulated activities:

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

Prior to this, the service was registered with a different provider. This was the first time we have inspected this service.

Spring Wood Lodge is a community inpatient locked rehabilitation service, a location of Elysium Healthcare Ltd. The service is able to provide care to a maximum of 22 female patients. There are two wards, Bronte and Byron. At the time of inspection the service had admitted nine patients to Bronte ward, and had closed Byron ward for refurbishment.

The Care Quality Commission has not previously inspected this location.

The service was visited by our Mental Health Act reviewer who completed a Mental Health Act monitoring visit in October 2016. The reviewer raised the concerns about; a lack of physical healthcare checks when patients were admitted, staff not always completing capacity assessments regarding consent to treatment, blanket restrictions, a lack of internet access for patients, a lack of information displayed relating to the Care Quality Commission, and lack of patient access to advocacy services. Although the provider was not managed this service at the time of the visit, they created an action plan in December 2016 but had not addressed all of these concerns at the time of this inspection. We reviewed these concerns during this inspection.

At the time of the inspection, a registered manager was not in place at the location. Although a hospital director was in post and acting as the registered manager, they were not yet registered with the Care Quality Commission. The previous manager had left the organisation in November 2016. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010. A condition of allowing a provider to register is that they must ensure that an individual who is registered as a manager in respect of that activity manages the regulated activities.

The service did not have an accountable officer. The accountable officer is a senior manager who is responsible and accountable for the supervision, management and use of controlled drugs. Without an accountable officer a service cannot ensure the safety of medication processes and procedures.

Our inspection team

Team Leader: Gemma Berry, Inspector (Mental Health) Care Quality Commission

The team that inspected the service comprised three CQC inspectors which included the team leader, two CQC pharmacist inspectors, an occupational therapist and a mental health nurse.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we looked at a range of information we already held about the service.

During the inspection visit, the inspection team:

- visited both wards at the service, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with one carer or relative of people using the service
- spoke with the hospital director, ward manager, and responsible clinician
- spoke with nine other staff members, including nurses, support workers, the psychologist and occupational therapist.
- looked at the care and treatment records of all nine patients
- carried out a specific review of the management of medicines at the service
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three of the nine patients using the service. We offered to speak with all patients, but not everyone wanted to speak with us.

All three patients told us that they felt safe, and that their possessions were safe. Patients said that they had not suffered any abuse or harassment at the service.

Patients told us that the building was always clean.

Patients spoke highly of the staff and said that they were always available when they needed them; they said 'this is a nice place'. Two patients told us that they liked the activities and groups available to them. However, one patient was less positive and felt that there could be more activity available. One of three patients told us that they did not like the food but the other patients spoke positively about it. Patients said that they were able to access kitchen areas and make themselves drinks. However, one patient told us that staff locked their snack food away and they had to have this signed out to them by staff.

We received conflicting views when we asked patients if they thought staff treated them with dignity and respect. All patients told us were staff knocked on their bedroom doors before entering. Our observations during inspection supported this. However, one patient told us that at times they were kept waiting for their medicines.

We spoke with one carer of a patient using the service. We asked the service to provide us with details of more carers who would like to speak with us, but they were unable to do so. The feedback was positive. The carer said that his relative was safe and settled at the service, and it was one of the better services the family had experienced. The carer spoke of good facilities, activities and therapies. The carer spoke of staff who were respectful to their relative and welcoming towards them when they visited weekly. However they felt that the service could improve the provision of information.

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?

Inadequate

We rated safe as **inadequate** because:

- The management of medicines was poor. The service had a non-medical prescriber who they were not monitoring or supervising adequately. We found out of date medications stored in the clinic room fridge and emergency medications noted in the provider's own policy were not within the emergency grab bag as they should be. There was a lack of clinical pharmacy support and oversight at the service. The service did not have an accountable officer to monitor the use of controlled drugs.
- The monitoring of patients' physical healthcare needs was poor. Staff did not consistently and routinely monitor the physical healthcare of patients because they did not complete or record patients' physical observations on a monthly basis as per the provider's own policy. Staff did not use recognised tools to monitor the side effects of medication. There was no monitoring system in place for the checking of patient's blood results. Staff were unable to provide us with evidence until after the inspection of blood monitoring of one patient.
- Not all staff had undertaken mandatory training, less than 65% of staff had undertaken training in; prevent, conflict resolution, breakaway, management of aggression and violence and security. The provider had not trained staff in key areas for example; the Mental Health Act, Mental Capacity Act, Duty of candour and medications management.
- The provider had not trained staff in the Duty of candour regulation. This meant that staff were not always open, honest and made apologies when things went wrong. We saw one episode where the service had made an error within Mental Health Act processes which had a long lasting impact on the patient. The service did not record that they had apologised verbally, or in writing nor did they offer support and advice to the patient. The service told us that they did not think this error met the threshold to use Duty of candour with the patient.
- Patient bedrooms, communal and visitor areas contained ligature points. The service had not entirely mitigated the risks as they had not included them all on the ligature risk

Summary of this inspection

assessment completed by the service. Staff (including senior staff members) were not aware of ligature risks within the environment and the provider had not trained staff in ligature awareness.

However:

- There was a good staff to patient ratio and no vacancies or concerns about staffing levels or the use of temporary staff.
- There was low use of restraint, and we saw that staff had de-escalated episodes of patient aggression with the introduction of positive behaviour support planning.
- When incidents were reported, staff reports were clear and detailed and we saw that patients and staff were offered de-briefs.

The service was clean and a therapeutic environment for patients.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- The service did not have appropriate or robust systems in place for monitoring the application of the Mental Health Act and use of the Mental Capacity Act. This meant that staff did not always protect patients' rights. A lack of audits had led to a number of errors which the service had not identified. The service had not identified an experienced and trained lead person to manage the application and monitor the use of either legislation.
- There was no evidence that staff had received training on the Mental Health Act or the Mental Capacity Act. The provider's own policy stated that they should train all staff in accordance with their role. The Mental Health Act policy used by the service was not thorough and not in line with Code of Practice (2015).
- Staff did not follow Mental Capacity Act legislation and guidance. Staff did not always undertake capacity assessments with patients when there was an identified need to do so. Staff did not always correctly document best interest's decisions and staff did not always include all relevant people when they made decisions about patients' care and treatment.
- There was a lack of service wide audit and leadership regarding the use and application of the Mental Health Act and Mental Capacity Act. This meant that the service had not picked up the issues we identified in these areas of practice.
- Staff did not ensure that patients with long term physical health needs had a holistic care plan and risk assessment which included these needs. We reviewed the care of three patients

Summary of this inspection

with physical healthcare needs, and saw that staff had not made timely referrals to professionals outside of the organisation to support their long term needs in physiotherapy, blood borne viruses or diet and nutritional needs.
- Care plans were not recovery focussed and did not always contain the voice of the patient or their views and the language used in some care plans was directive. We did see evidence of patients being offered copies of their care plans.
- The service had a comprehensive two week induction programme, and the service told us that all staff had attended the induction. However the service was unable to provide evidence that staff had completed it such as in staff training records.
- The service had not ensured that the non-medical prescriber had adequate supervision and support.

However:

- The service had a secure electronic system for recording and storing information about the care of patients.
- There was a multidisciplinary team made up of a variety of experienced professionals to meet the needs of all patients accessing the service. Patients attended and participated in discussions about their care and treatment. However we saw that staff did not always reflect the decisions from these meetings in patient care plans.
- Nursing staff said they received regular clinical supervision and appraisal.
- Patients were able to access regular therapy such as dialectical behaviour support therapy, and occupational therapy.

Are services caring?

Requires improvement

We rated caring as **requires improvement** because:

- We saw evidence of staff discussing directing measures of punitive care where patients were treated differently as a result of them expressing more challenging behaviour.
- We saw evidence in minutes of community meetings that patients were not always listened to when they made reasonable requests. The service sometimes put staff needs before patient needs.
- Care plans were not always person centred as they did not all contain the patient's voice and some used directive language.

However:

Summary of this inspection

- Our observations of one to one staff interactions with patients showed that they were caring, and patients said that staff were caring and supportive.
- Patients had access to advocacy services. The service displayed information relating to this in the ward areas.
- Patients used the information technology suite to produce a magazine to share on the ward, it contained information about recovery and patients shared ideas such as recipes.
- The service had undertaken a patient satisfaction survey, the results of which were being analysed by the service at the time of the inspection.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- Not all patients had discharge plans, and where patients did have plans they were unclear as to what the patient would need to achieve to leave the service. Staff told us that they were recorded on another system, however this meant they were not available to patients as part of ongoing care plans to enable them to review their goals.
- The service was not able to meet the needs of all patients using the service as there was not a spiritual room available on site. This meant that patients without access to section 17 leave were unable to meet these needs.
- We did not see that information was available on the wards for patients, such as how to complain to the provider, and patient rights.
- Patients told us in person and in the patient satisfaction survey that there was a low level of activity available during the weekends.

However:

- During week days, the service had a range of activities for patients to access and the psychology and occupational therapy teams ensured that patients were able to participate in activities to aid their recovery.
- There was adequate space for activities, spending time outside and learning new skills.

Are services well-led?

Inadequate

We rated well-led as **inadequate** because:

- At the time of the inspection the provider did not have a registered manager in post, and had not for the previous eight months. Although the hospital director was undertaking this

role, it is a requirement of registration with the Care Quality Commission. The provider had also not ensured that there was an accountable officer in post at the service to monitor the use of controlled drugs.

- The governance systems in place were not effective and did not ensure the delivery of safe and high quality care. There was no audit schedule in place and where audits were completed they were ineffective and did not identify the issues we found on inspection, including risks relating to the application of the Mental Capacity Act, medication management, training, supervision and environmental risks. An administrator from another part of the organisation had completed an audit one week prior to inspection in relation to the Mental Health Act but an action plan was not in place to assure us that the service had addressed the issues.
- The provider had failed to ensure that they had a system to record and monitor compliance with mandatory training and induction. The mandatory training matrix did not ensure that the service offered staff training in all relevant areas of their role to ensure they provided safe care and treatment to patients.
- There was no credible statement of values and vision for the service which the service had shared with staff. The senior leadership team were not yet clear on the clinical model and purpose of the service, as this was still in development.
- The provider had not ensured that there were robust on site clinical supervision procedures in place for the non-medical prescriber.
- The service was a restrictive environment which did not meet with a recovery model of care. We saw a number of blanket restrictions in place which the service had not reviewed or made changes to. The restrictions had led to the provision of care which was undignified for patients.
- The provider was unable to provide us with evidence of outcomes of key performance indicators which they work towards.
- The service risk register did not include any of the concerns raised by this inspection.
- The service had not checked that all staff recruited within the service had appropriate references when they took them into employment.

However:

- Staff told us that senior managers were open and approachable, and that they were seeing an improvement in the service. Staff morale and engagement was good.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

At the time of the inspection nine patients had been admitted to the service, and all of the patients were detained under the Mental Health Act.

The service did not have systems in place to support the proper implementation of the Mental Health Act and its Code of Practice. The service did not audit and monitor documentation they kept in respect of detention under the Mental Health Act. The regional lead for the provider had carried out an audit of the Mental Health Act paperwork a week before our inspection which identified errors. This included one patient who the previous provider had incorrectly detained between July 2016 and June 2017.

For renewals of detention, and hospital managers' hearings we found that the system in place was not robust. We identified one incident where a patient had their detention renewed before the identified time. We reviewed consent to treatment documentation and found that staff had prescribed patients' medicines which were not included on the relevant treatment certificate in two cases. This meant staff had given them treatment which was not in accordance with the Mental Health Act.

Mental Health Act training was not mandatory for staff and the service was unable to tell us if any staff had completed training. Dedicated Mental Health Act administrative support from a trained member of staff was not available within the service.

Care records showed that staff routinely explained to patients what their rights were under the Mental Health Act. This happened on admission to the unit, after 10 days and thereafter every three months. Patients said that they understood their rights and that the responsible clinician had explained their treatment plan and medications to them.

During our review of the medication administration records we saw that the responsible clinician had completed capacity assessments regarding consent to treatment.

Mental Capacity Act and Deprivation of Liberty Safeguards

None of the staff at the hospital had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We found that knowledge of the Mental Capacity Act was variable. This meant that the service did not always ensure that it upheld the rights of patients.

Capacity assessments were not always completed and recorded when patients lacked capacity to make important decisions and we saw examples of staff not following the process for best interests decisions outlined in the Mental Capacity Act Code of Practice.

There was no Mental Capacity Act lead identified within the service, and there were no arrangements in place to review and monitor adherence to the Act.

However, our observation of a multidisciplinary meeting also showed that patients' capacity was part of the discussion held for all patients.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate

Long stay/rehabilitation mental health wards for working age adults

Inadequate

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

The service consisted of two wards, Bronte ward (17 beds) and Byron ward (5 beds). At the time of the inspection, only Bronte ward was in use and the service had closed Byron ward for refurbishment. We checked the environment of both wards to consider whether they were safe and clean.

The provider had decorated and furnished the service to a high standard and all ward areas and patient bedrooms were clean. The service employed two full time cleaners and a maintenance worker who kept the building clean and in good repair. Patients agreed that the service was always clean. The maintenance worker undertook daily health and safety checks and updated the environmental risk assessment on a weekly basis.

Both wards had an 'L' shape layout which did not allow staff a clear line of sight to observe patients. Staff mitigated this risk by having one member of staff allocated to observe patients throughout the day and night.

All areas of the service contained ligature points including, corridors, communal spaces and patient bedrooms (a ligature point is something that a patient intent on self-harm could use to tie something to in order to strangle themselves). Maintenance staff had completed an environmental ligature risk assessment dated 31 May 2017. There was no evidence that this assessment was completed jointly with clinician as per national guidance. This was to identify potential ligature points and mitigate risks. However, the service had not ensured that the risk assessment addressed all areas of concern. For example, staff told us that seven of the patient bedrooms were ligature free. However, when we checked two of these rooms we found that they contained a number of ligature points which staff were not aware of. These included; window and door handles, grills on the top of radiators and the pipework below them. We also spoke with two senior members of staff and one qualified staff member who were unaware of the ligatures risks identified on the service's own risk assessment, and therefore had not mitigated against these.

Staff told us that they used patient's individual risk assessments to determine their level of observation and reduce the risk of them using ligatures. However, the risk was not mitigated due to the lack of staff oversight of the location and risk of ligatures.

However, in response to our inspection and the feedback we gave to the service, the hospital director arranged for additional staff training in ligature awareness, a staff poster to raise awareness and showed us a revised ligature audit procedure in draft format.

The service admitted female patients only so was compliant with Department of Health same sex accommodation guidance and guidance contained within the Mental Health Act Code of Practice.

The service had two clinic rooms; one was used as the main clinic in a central area which staff used primarily for physical examinations and for clinics with the visiting GP. The room was clean and tidy and contained weighing scales, an examination couch with privacy screen, a first aid kit and equipment for taking blood and measuring blood

pressure. The second clinic room was also clean, tidy and well ordered. Staff locked both rooms and the nurse in charge held the key. Both rooms contained ligature cutters with another set held in the staff office. Both clinic rooms were air conditioned to keep the room at a controlled temperature and staff measured the temperature daily. Staff also undertook weekly audits of controlled drugs, medication stocks, waste management, and personal protective equipment stocks.

There were adequate supplies of emergency equipment. Oxygen and a defibrillator were kept in an emergency grab bag within the staff office which was accessible to all staff. A system was in place to ensure these remained fit for use by staff undertaking daily checks, although we saw that staff had not completed these checks on three occasions in May 2017. The hospital policy stated that a medicine used to treat overdose with opiates should be included in the emergency medicines bag, however none was present on the day of our inspection. This had not been picked up by staff who had signed to state that they had completed a daily check of this equipment.

We saw that staff adhered to infection control and handwashing procedures and hand gel was available on the ward and in entrance and visitor areas. An infection control policy was in place to guide staff. However, we saw no evidence that the service had trained staff in the principles of infection control.

The service did not have a seclusion room. The service had a de-escalation room. The room contained soft couches and the service had designed it as a safe space for patients to move away from others should they need space to become calm. Patients and staff told us that when this room was in use it was never locked.

All staff carried personal alarms, which they could use to seek assistance in an emergency.

Safe staffing

Prior to inspection the hospital submitted data about staffing levels. The hospital had 34 substantive staff in total including clinical, managerial, administrative and ancillary staff. This included 10 whole time equivalent qualified nurses and 12 whole time equivalent nursing assistants.

The data showed that there was a reduction in vacancies from 50% between January 2017and March 2017 for both registered nurses and nursing assistants. At the time of the inspection in June 2017 there were no vacancies for nurses of for nursing assistants and only one vacancy for ancillary staff.

The average sickness rate for the hospital between January 2017 and March 2017 was 2%; this was lower than the provider's target of 3%.

Between January 2017 and March 2017, the service had covered 319 shifts using bank or agency staff. There were no shifts which either regular, bank or agency staff could not cover because of sickness, absence or vacancies during the same reporting period. The service told us that agency staff use had reduced further and at the time of the inspection the hospital only used one agency staff member, who was awaiting a permanent position within the service. The service also had its own bank staff system. The hospital director confirmed that the service only used bank staff to cover sickness or absence as there were no vacancies for qualified nurses or unqualified nursing assistants.

Due to the high staff to patient ratio at the service, patients all had a named nurse who they were able to spend regular one to one time with. Whilst two thirds of patients we spoke with told us that they had not experienced cancelled activities or section 17 leave. The service provided us with data which stated that between 01 December 2016 and 01 May 2017, they had only cancelled two sessions of section 17 leave or activities.

The service had a full time consultant psychiatrist who was able to respond to emergency calls throughout the day whilst they were on site. When the consultant was not on site or unable to respond there was an on-call rota during the day and night which included doctors from other sites managed by the provider. The nearest other hospital was within a 30 minute journey. We saw that the service displayed this rota in staff areas to allow them to make contact as they needed.

Prior to the inspection we asked the service to provide us with evidence of staff training. Initially the service stated they were unable to provide us with details because they did not yet have a system which allowed them to record and monitor staff training and induction. After the inspection, the service advised of the following training figures for mandatory training:

Prevent strategy (3%)

Conflict resolution (64%)

Breakaway (64%)

Management of aggression and violence (64%)

Security (64%)

Safeguarding (95%)

Basic life support (90%)

Immediate life support (100%)

Less than 65% of staff had completed some areas of mandatory training. This meant that the service could not ensure the safety of patients because they had not ensured that they had trained all staff adequately to perform their role. The service also had no method of monitoring staff training. The hospital director told us that booking and completion of training had been difficult because the provider is new and the system for training is not entirely organised and embedded. They said that staff had booked to complete conflict resolution, breakaway, management of aggression and violence and security training. The service said that they were arranging further basic life support training and prevent training.

The provider had not included a number of important topics in the list of mandatory training. These included the Mental Health Act, Mental Capacity Act, health and safety, fire, infection control, duty of candour and medication management. The hospital director told us that all staff that were responsible for serving food to patients had completed food hygiene training. However, we have not received any evidence to support this.

Assessing and managing risk to patients and staff

The service did not have a seclusion facility and had not recorded any episodes of seclusion. Staff used the de-escalation room appropriately with patients and we did not see evidence that staff had secluded patients in this room.

The service had a good system of recording and measuring the use of restraint. The use of restraint at the service was low and there had been a reduction in the use of restraint at the service. The service had used restraint techniques 17 times in the period 01 December 2016 to 01 June 2017, compared to 35 uses of restraint with patients between 12 September 2016 and 30 November 2016. It was clear from the incidents of restraints reported that staff had used de-escalation techniques to a good effect and that significant incidents were often de-escalated with the use of verbal distraction, changing staff members and the use of prescribed medications, they rarely escalated to a restraint episode.

Of the 17 uses of restraint, one of these involved the use of prone restraint between 01 December 2016 and 01 June 2017. Prone restraint is holding a person chest down and staff placing patients prone onto any surface. Prone restraint carries a high risk of asphyxiation to patients and services have reported a number of deaths. We reviewed this episode of prone restraint and found that staff recording was clear, and the use of prone restraint was only until other staff could assist to turn the individual into a supine (face up) position.

The service had not used any rapid tranquilisation with patients between December 2016 and June 2017. Rapid tranquilisation is when staff give medicines to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. We checked incident reports and found that all medication used with patients in distress was 'as required' medication which was accepted by the patient. The service had a rapid tranquilisation policy in place; however the previous provider had completed this. It was up to date and contained guidance from the National Institute for Health and Care Excellence and included information relating to ensuring staff used rapid tranquilisation as a last resort in the least restrictive way possible with careful monitoring.

We reviewed the risk assessments of all nine patients admitted to the service. Staff used recognised risk assessment tools with patients. The one patient admitted since the service changed provider had undertaken a risk assessment with staff on admission. Staff had updated six of the nine patients' risk assessments in the month prior to inspection. Prior to this risk assessments had been updated between two and six monthly. The provider policy stated that risk assessments should be updated on a six monthly basis.

The service had a number of blanket restrictions in place. A blanket restriction is rule which a provider puts into place for all patients regardless of their risk level or detention status. For example, all patients used polystyrene rather than ceramic cups, due to the risk of patients smashing them and using them to harm themselves or others. This was a risk for one of the nine patients but applied to all.

The service told us that they had started to resolve this issue in April 2017 by asking patients to purchase their own cups. However the cups had not been replaced at the time of our inspection, but the service replaced them the day after our inspection.

There were stringent security measures in place which included some of the doors to the communal areas being locked, all outside doors being locked, and all staff members collecting and signing out keys and alarms from reception each morning.

The service conducted weekly searches of all patient rooms, regardless of risk level. The admission policy for the service stated that all patients admitted to the ward should be subject to a 'pat down' search before admittance. However, staff said that blanket searches of patients' persons were not taking place and that they searched patients dependent on their level of risk. When random searches were completed, these were carried out by two staff and one of these was always a qualified nurse.

The practices at the service were restrictive and this model of care did not fit with a rehabilitative model of treatment for patients who the service would soon discharge into community settings. The provider did not have a specific programme of reducing restrictions although the service manager had drafted a local policy in April 2017 this did not include the review of blanket restrictions. We saw evidence in minutes of patients' community meetings, that patients were asked for their opinions about restrictions. However, when they had requested changes to these blanket restrictions the service had not addressed the patients' concerns.

Information was not available on the ward to tell informal patients of their right to leave to service and how they might go about leaving. The ward manager told us that this was because there were no informal patients admitted, and felt it would be unlikely there would be informal patients at the service and that there was a policy which would be implemented for informal patients as necessary.

Between March 2016 and March 2017, the Care Quality Commission received one safeguarding concern relating to this provider at Springwood Lodge. Due to the low level of safeguarding incidents reported, we reviewed all incidents on the provider's system. We found one incident of patient on patient assault on 4 June 2017 which staff had not recorded as a safeguarding incident and there was no discussion on the incident report as to whether staff had submitted, or felt that it was necessary to submit a referral to the local authority. Staff did discuss this in the morning meeting and felt that a safeguarding referral was not required as the incident did not meet local authority criteria. However this discussion was not noted on the incident reporting form. We also saw that a staff did not report a security breach which resulted in a patient missing for more than 24 hours to the safeguarding authority (due to the risk posed to the patient by staff actions) nor did they notify the Care Quality Commission of this as a police incident. Staff told us that they had received safeguarding training, and the provider told us that 95% of staff had completed safeguarding training. However staff were not making referrals as they should in order to protect vulnerable patients. The hospital director told us that they were the safeguarding lead and trying to build relationships with the local authority for more regular contact and safeguarding advice and a safeagurding leaflet had been provided to staff to support them.

Our specialist pharmacists checked the arrangements for managing medicines at the service and found significant problems. They reviewed four patient medication records and spoke with nursing staff responsible for medicines. A community pharmacy contractor supplied medicines under a service level agreement. The hospital director told us that the provider was making new arrangements. The service level agreement did not include clinical pharmacy support. Pharmacists did not attend patient meetings; their role was supply and stock of medicines and a weekly audit of medication cards. There was not clinical oversight of pharmacy and medicines arrangements.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely with access restricted to authorised staff. Staff recorded medicines fridge temperatures daily in accordance with national guidance. During our inspection, we found some injections stored in the fridge which staff could use to quickly calm agitated patients, these had expired in May 2017. These were the only available medicines of this type available on the day of the inspection. Staff told us that they had not used these with patients, but were unaware that this medication was out of date despite staff stating they had completed the daily and weekly fridge and medicine checks. Staff also completed audits such as checking fridge and clinic room temperatures weekly and daily checks of the emergency equipment. Staff also

completed weekly stock orders of equipment. A pharmacist visited the service weekly to audit medication stocks and patient medication cards. However there was no audit schedule in place to monitor and review the quality and safety of the service. This meant that the service had not identified the concerns we found during our inspection.

Controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored, managed, and recorded appropriately. We saw evidence of routine balance checks of controlled drugs. However, the service did not have an accountable officer for controlled drugs, meaning that there was not one person responsible for their management and security. However the service was following good practice guidance in relation to the management of controlled drugs.

During our inspection, we also reviewed records of physical health monitoring for patients who staff had prescribed antipsychotic medicines. We found that physical health checks did not include the use of a recognised tool to assess the side effects which may arise from treatment with these medicines. This meant that patients were at risk of harm of developing side effects which were undetected.

We reviewed the records of three patients who staff had prescribed medicines which required routine monitoring. There was no system in place to ensure that staff had carried out the required blood tests, or to ensure the responsible clinician reviewed blood test results before prescribing further medicines. For example, staff had prescribed one patient a medicine which required monitoring of blood levels at least every three months. National Institute for Health and Care Excellence (June 2017) states that for this medication, routine serum monitoring should take place three monthly, with renal cardiac and thyroid function taken six monthly as a minimum. We asked staff to provide us with evidence that this monitoring had taken place and they were unable to do so from their own system both during the inspection and within two weeks after the inspection. The service did provide this evidence six weeks after the inspection. Although the checks had taken place, this evidenced the lack of a robust system and this carries a risk that patients may become unwell due to unmonitored side effects of medication.

The service employed a nurse who was qualified as a non-medical prescriber. The service told us that the non-medical prescriber worked in collaboration with the responsible clinician. They said that the responsible clinician decided upon and created the initial treatment plan and then the non- medical prescriber transcribed medication cards but did not review or makes changes to treatment plans independently. However we found evidence during the inspection that the non-medical prescriber was prescribing nicotine replacement medications independently and they told us that a GP had asked them to increase a patient's dose for a physical health medication outside of their scope of experience. The Nursing and Midwifery Council guidance states that independent prescribers must only prescribe within their sphere of competence. The provider was unable to demonstrate when we asked them, what the prescriber's competence level or training was. The service had not clearly defined their role and there were no formal arrangements in place for their supervision or monitoring of their practice. This meant the provider did not have systems in place to ensure the prescriber had the relevant knowledge, skills and experience in the conditions they were treating, and they could not ensure that patients were safe. The responsible clinician told us that although regular patient discussions took place they did not supervise the prescriber.

Patients' family and friends were able to visit the ward, and designated visitor's rooms were available. One of these rooms contained a television and toys for children who wished to visit and was away from the main ward area to increase safety.

Track record on safety

Between January and March 2017 there was one serious incident at the service, this related to a patient being able to absent themselves from the hospital for 36 hours.

The provider had a system in place to review serious incidents which included using root cause analysis to find if the incident could provide future learning for staff to reduce the risk of reoccurrence. We were unable to review the serious incident report and root cause analysis for this incident as the report had not been completed because it was a recent incident. We did not see any evidence that the service had made changes to safety arrangements in response to this serious incident.

Reporting incidents and learning from when things go wrong

Long stay/rehabilitation mental health wards for working age adults

Inadequate

During the inspection we reviewed 16 incidents in detail which had occurred at the service between 14 March 2017 and 12 June 2017. We found that the incident reporting system was clear and logical and used by all designations of staff. Staff inputted detailed reports into the system which explained clearly which staff and patients were involved.

Staff told us that they received feedback following an incident, both internal and external to the service. The provider disseminated a learning lessons newsletter to all staff members explaining what changes services needed to make as a result of incidents across all sites. The service offered both staff and patients de-briefs following an incident and staff said that they could use supervision sessions to discuss incidents they were concerned about. We saw evidence of patients having one to one sessions with staff to discuss incidents.

However, we found a second serious incident where a patient had been detained incorrectly under the Mental Health Act for 12 months. Although this had initially occurred prior to this provider becoming responsible for the service, the hospital had not reported or recorded this as a serious incident or an incident when they discovered the error. The hospital director informed us that they felt this did not meet the incident reporting threshold.

Duty of Candour

Information we received from the provider stated, 'In order to meet the requirements of Duty of candour legislation, Elysium Healthcare ensures that all staff should be open with service users when any incident has occurred and promotes a culture that encourages candour, openness and honesty at all levels. Elysium Healthcare provides policy and guidance to ensure that communication is open, honest and occurs as soon as possible following an incident. We are assured that Duty of candour is being implemented due to our training records and staff completion and attendance of training.' However, we found one example of where a serious incident had occurred in relation to the lack of monitoring of the Mental Health Act and the provider was not open and transparent with the person affected, they could not provide evidence of a verbal or written apology to the patient and did not offer support such as legal advice or guidance. The provider told us that this did not meet their threshold for use of Duty of candour legislation. This was a significant failing with a direct impact on the patient and it evidenced that the service had not embedded an open and honest culture. Training records submitted by the provider after the inspection showed that staff had not completed training on Duty of candour which had impacted on their understanding of its use.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

A comprehensive assessment for each patient had been completed on admission in all nine patient records we reviewed, as well as physical health checks, patient observations and blood tests which were completed within 72 hours of admission. However, staff did not consistently complete ongoing routine checks and monitoring of patients' physical healthcare needs. Information we received in the provider information return stated, "All patients will have a physical health check every 12 months and staff will record weight and blood pressure on a monthly basis." Care records we reviewed did not demonstrate this as we found gaps in six of the nine records reviewed of up to five months between which no physical health monitoring had taken place.

The nine care plans reviewed had gaps in their updates of six months and so goals were not specific, measurable, recovery orientated, resourced or time bound to promote recovery and rehabilitation as you would expect in a rehabilitation service. In addition, they did not all contain evidence of patient involvement in their care plans, use of a person centred approach, identification of cultural needs and how the service would meet these, or demonstrate family contact and involvement. Staff told us that discharge planning was recorded on another system rather than within individual care plans, however this meant that it was not embedded in patient care plans to create clear goals. However, we saw evidence of regular multi-disciplinary team meetings where care planning was discussed.

The service had a secure system to store and record patient information. This was clear and understandable and used by all designations of staff.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Best practice in treatment and care

Patient care plans and medication practices referred to guidance from the National Institute of Health and Care Excellence; for example in the management of violence and aggression (NG10). However, prescribing procedures did not always follow guidance because the service did not ensure correct supervision and monitoring for the staff with extended roles. Monitoring of the physical health of patients taking medications was not taking place as recommended by national guidance.

The service offered a range of psychological therapies to patients. Staff delivered these in both group and individual sessions and they included a substance misuse group, anxiety management group, mindfulness group, woman's group, mental health awareness group and relapse prevention group. The two assistant psychology staff at the service worked with all nine patients. They told us there was a dialectical behaviour approach to treatment. Dialectical behaviour therapy is a specific type of cognitive behaviour therapy which aims to support patients with long term mental health needs. Three of the whole staff team had completed training to deliver this therapy, and were the only staff available to deliver it.

The service was working towards a model of positive behavioural support with patients. Positive behavioural support is a way of using assessment and planning to understand the reasons why an individual exhibits behaviours which others find challenging. This allows staff to support and address the issues that trigger the behaviour. The use of this model of care often leads to a reduction in incidents and the need for physical interventions with patients. Of the nine records we reviewed, four patients had clear and detailed positive behavioural support plans which were personalised and laid out clearly the techniques to use to reduce the risk of behaviours which challenge. We saw evidence in incident reports and data provided by the service of a reduction in the use of physical intervention, which staff attributed to the use of positive behavioural support and the use of de-escalation techniques.

We found evidence of completion of outcome measurement tools and assessment tools recognised by the National Institute of Health and Care Excellence and Department of Health. These were; Health of the Nation Outcome Scales, which measures the health and social functioning of people with severe mental illness. The Malnutrition Universal Screening Tool, which is a five-step screening tool to identify patients who are malnourished and at risk of malnutrition and the Historical, Clinical, Risk Management-20 (HCR-20) which is an assessment tool that helps mental health professionals estimate a person's probability of violence. The service also measured individual patient outcomes before and after their attendance at psychology sessions.

Skilled staff to deliver care

Nursing staff told us they had regular clinical and managerial supervision. Information submitted in the provider information return showed that 95% of staff had received clinical supervision. The hospital target is 100%. However, following our inspection, we received additional information which showed that 100% of nursing staff had received supervision, and 86% of non-clinical staff had received supervision. This is below the provider's own target.

However we were concerned that there was a lack of clinical supervision and support for the non-medical prescriber. The service had not clearly defined the non-medical prescriber's role and there were no formal arrangements in place for their supervision or monitoring of their practice. The responsible clinician told us that although regular patient discussions took place they did not supervise the prescriber.

The hospital director told us that when the provider had taken over the service in December 2016, the systems in use to monitor staff training were no longer available. This meant at the time of the inspection, there were no training records available for us to review. Following our inspection, we received additional information relating to training. This included a list of mandatory training for staff and the percentage of staff that were up to date with this training. Not all staff were up to date with this mandatory training and the mandatory training did not include important areas such as the Mental Health Act and Mental Capacity Act.

Some staff had undertaken additional training. One staff member had completed a health and safety qualification, two staff had completed the train the trainer basic life support and one the train the trainer 'prevent' course. Prevent is a government agenda designed to tackle

extremism. Three psychology staff had completed the dialectical behaviour therapy training and two psychology staff were trained in the historical, clinical risk management - 20 risk assessment.

The hospital director told us that all staff had completed a two week induction programme. We reviewed a detailed induction programme which covered areas such as mental health awareness, basic life support, and conflict resolution. The induction noted that all staff completed a four day course in management of aggression and violence in their second week of induction. Staff confirmed that they had completed inductions at the start of their employment. However, the service had not recorded which staff had undertaken the induction so we could not confirm this.

All non-clinical staff had an annual appraisal. Whilst the service recorded that 71% of clinical staff had completed an appraisal, all nursing staff had completed an annual appraisal.

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines available that made up the multidisciplinary team at the hospital. These included a full time psychiatrist, psychology assistants an occupational therapist, occupational therapy assistant, qualified nurses and nursing assistants. The multidisciplinary team were based at the hospital and met weekly to discuss patient care in multi-disciplinary team meetings. There was also a daily morning meeting where senior staff met to review any significant events or changes from the previous day. Staff handovers occurred at each shift change. Staff said that they discussed all patients within these and that they found the handovers were informative and prepared them for the shift ahead.

Regular multi-disciplinary meetings took place and members of the multidisciplinary team and patients attended them consistently. We observed one meeting and saw there was a good range of knowledge and expertise present. Patients contributed their views by either attending or writing down their thoughts beforehand for discussion. Where patients chose not to attend, staff fed back the meeting discussions to them afterwards. There was good participation from all staff present at the meeting. Staff discussed patients in detail and exchanges between the team were positive and respectful. Discussions were goal focussed and individualised to the patient's needs. Patients we spoke with told us they had opportunity to contribute and staff kept them updated with outcomes from the meetings. However, decisions made at these meetings did not result in staff updating patient risk assessments and care plans meaning that decisions were unclear to staff not attending.

Staff did not always not complete referrals to appropriate health care professionals when patients had additional health needs. For example, staff had put care plans in place for a patient in relation to diet and nutrition prior to seeking the advice of health professionals. We found that another patient had ongoing mobility needs and saw no evidence of referral to appropriate healthcare professionals such as physiotherapists to ensure the patient was receiving holistic care. Another patient had a long term health condition which staff had not discussed in their risk assessment and staff had not requested any assistance outside of the service.

However the service had built relationships with the local drug and alcohol service that planned to visit the service and deliver training to staff regarding substance misuse and relapse prevention.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Training information we reviewed showed that Mental Health Act training was not mandatory. Staff told us that had received some training but the provider was unable to show us records of this.

The service had given a member of administrative staff the responsibility of scrutinising Mental Health Act paperwork when the service admitted patients. The service had not provided them with any training in relation to this and we saw errors in documentation which they had not identified.

We reviewed the Mental Health Act policy for the service. The previous provider had written it in 2015 and it contained the previous provider's values. The policy was not thorough and contained no evidence or reference to the updated Code of Practice (2015). We found that the service was not adhering to areas of this policy such as;

- All relevant staff receive training at least annually in aspects of the Mental Health legislation relevant to their role

- Adhere to the policies and procedures relating to the Mental Health legislation and put in place a system to monitor adherence, with patients involved in that process as necessary and appropriate.

We checked the Mental Health Act documentation for all nine patients who were detained. In our checks of the records, we identified that one patient had been detained without proper authorisation between July 2016 and June 2017 which meant that their detention had been unlawful for 12 months until the provider had recognised the error. The provider had recognised this error the week prior to our inspection visit. We were concerned that following this incident, the patient did not receive an apology from the service and the service did not offer them legal advice. Staff did not follow the principles of the Act in this case because they had written in a letter to the patient that they had been 'detained under a section 5:2' of the Act (doctors holding powers) immediately that it became clear that patient was not detained. The Mental Health Act Code of Practice states that the purpose of this section is to allow Doctors 72 hours to detain a patient whilst the service makes an application for detention under the Act. There was no record that the decision maker had considered other least restrictive alternatives such as allowing the patient to become informal as per the principles of the Act.

We reviewed consent to treatment documentation and found that staff had prescribed medication for patients which were not included on the relevant treatment certificates in two cases. This meant that staff were giving patients treatment which was not authorised in accordance with the Mental Health Act.

We saw that the provider's regional lead for the Mental Health Act had carried out an audit of this Mental Health Act documentation a week before our inspection. We did not find evidence that the service had completed previous audits, or that the service had made changes and improved practice as a result of these audits. This most recent audit was not available for us to review during the inspection but we spoke with the regional Mental Health Act lead who told us that there had been a number of issues identified in this audit and confirmed that these were the same as the issues we identified when we had reviewed the records. The regional lead told us that they were compiling a report based on the audit results and submitting this to their line manager. They said they had reported it to the hospital director but we were not given any assurances around actions that the service would implement to prevent reoccurrence of issues.

Our Mental Health Act reviewer visited the service in October 2016. This visit raised concerns about; physical healthcare checks on admission, capacity assessments of consent to treatment, blanket restrictions, internet access, information relating to the Care Quality Commission, access to an independent mental health advocate. Although Elysium Healthcare were not the provider at the time of this visit, they did review the report and create an action plan in December 2016. However, they had not fully addressed all of these concerns at the time of the inspection.

The service had displayed information on the rights of people who were detained on the ward and independent advocacy services were available to support people. Section 17 leave authorisations were in place as needed and recorded appropriately. The independent advocate attended the weekly community meeting to ensure they could meet with all patients. We saw evidence that all nine patients had their rights under the Act explained to them on a regular basis.

During our review of the medication administration records we saw that the responsible clinician had completed capacity assessments regarding consent to treatment.

Good practice in applying the MCA

Information we reviewed showed that none of the staff at the hospital had completed training in the Mental Capacity Act. There was no lead identified within the service to provide guidance and support to staff and there were no arrangements in place to review and monitor adherence to the Act.

The service had not made any applications under Deprivation of Liberty Safeguards.

We found that knowledge of the Mental Capacity Act was variable across the service. Some staff we spoke with were able to explain the principles of the Act. However, there was no mention of patients' capacity or the Act in any of the nine care records we reviewed. We would expect to have

Long stay/rehabilitation mental health wards for working age adults

Inadequate

seen evidence of discussions, particularly when staff had taken significant decisions to implement a restrictive diet with patients when these decisions were not related to their mental disorder.

The service had not embedded the process of supporting patients to make decisions or an understanding of the best interest's process. The ward manager told us that there had been two best interest meetings held at the hospital for patients. However, when we reviewed the documentation in relation to these meetings, we saw that they consisted of the creation of a care plan with the multi-disciplinary team, to address the identified need of the patient concerned. There was no evidence that a best interest meeting or discussion had taken place with the patient or their representative in line with the Mental Capacity Act Code of Practice. Staff had not recorded that they had completed a capacity assessment before they made a best interest's decision.

The previous provider had written the Mental Capacity Act policy which was in place at the time of our inspection and dated June 2015; it too contained the previous provider's values. The hospital director told us there were plans to review policies and rename them in line with the new provider, but there were no dates for when they would complete this. However the policy staff used was thorough and contained all the relevant information to guide staff in implementing the Mental Capacity Act.

Our observation of a multidisciplinary meeting showed that patients capacity was part of the discussion held for all patients.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Requires improvement

Kindness, dignity, respect and support

We offered all nine patients the opportunity to speak with us during the inspection. Three patients spoke with us directly, and the remaining patients chose not to. Two patients described staff as caring and supportive. The same two patients said that they felt staff listened to them but the other patient did not. When discussing whether staff treated them with dignity and respect, two patients told us that staff knocked on their bedroom doors before entering; another told us that they always knocked but entered immediately without waiting.

We observed interactions with patients and staff on the ward, and during meetings and saw that staff spoke to patients respectfully. We observed that staff spent time with patients in communal areas undertaking activities. The atmosphere was calm and relaxed across the ward. Staff demonstrated an understanding of patients' needs when we spoke with them.

We saw some practices in the service which we felt did not display dignity and respect to patients, and did not display that staff considered individual patients' needs. For example, we saw that staff had discussed using punishments such as treating one patient who had repeatedly smoked in their bedroom differently to other patients by giving them a 'smoking ban', whilst other patients continued to smoke in the hospital grounds. We saw minutes of a morning staff meeting where a staff discussed a decision for the same patient to be 'nursed in a stripped room' to reduce the risk of them breaking smoking rules. Another patient told us that staff locked their snack food away and they had to have this signed out to them by staff. Staff told us that this was in relation to physical health concerns, however, there was no documentation to show whether the patient had consented to this.

Using these types of restrictions with patients reduces their quality of life, self-esteem and dignity, and does not promote a recovery model of care and treatment.

The involvement of people in the care they receive

Patient admission booklets were available at the hospital. The service had not updated them to reflect the change to the provider of the service. However, the admission information was detailed and explained to patients all they would need to know about the service. One of the patients we spoke with told us they had not received any information on their admission to the service.

We reviewed care plans of all nine patients. They did not always include evidence of patient involvement. The involvement of patients in writing these was inconsistent, we saw some examples of patient involvement, however staff had not always written them in a person centred manner. In six of nine care plans we saw that staff used language such as 'miss X will'. We could not easily identify

information regarding what was important to all patients, their likes, dislikes, strengths and wishes for the future. However, staff offered patients copies of their care plans, and we saw that they were involved in multi-disciplinary reviews and care programme approach meetings where they were able to express their opinions. Whilst some patients had positive behavioural support plans which were holistic and person centred using the patient's own words and their preferences for their care, this was not yet embedded throughout the service and not in place for all patients.

The service displayed details of the local advocacy service on the ward, and the advocacy service attended weekly community meetings. This enabled them to meet all patients and offer their services as required by patients. Staff told us that advocates would attend meetings to support a patient at their request. The advocacy service offered independent mental health advocacy for patients detained under the Mental Health Act.

Information we received from provider stated, "there is a relative and carer survey which is completed annually and is given out/sent to family and friends of the service users. We also have a good relationship with relatives and carers and encourage them to contact the unit if they have any concerns or compliments about the care and treatment which is being provided for their family members." However, we could not identify clearly in patients' care plans what the level of involvement with family and friends was, what strength this added to the patient's recovery, and what the patient's needs and wishes were for family and friend contacts. Relative and carer involvement is an important part of recovery. We asked the service to provide us with details of carers we could speak with to discuss their experience of the service. The service was only able to provide us with details of one carer who was willing to speak with us.

The service held weekly community meetings on the ward to ensure patients were able to give feedback about the service. Patients and members of the multidisciplinary team attended the meetings. We reviewed minutes of these meetings and saw instances when the outcomes of the meetings were more staff focussed than patient focussed. For example on 06 April 2017, patients asked about 'protected time,' where staff do not allow patients to smoke to enable them to concentrate on therapies. Staff said in the meeting that it "had been decided that this will be kept in place at the moment and will be reviewed in two months because nurses have commented on how they are able to get more work done as the ward is more peaceful and they are not being asked to facilitate smoke breaks all the time." Also, on 30 March 2017, we saw that patients had asked for staff to extend smoking breaks to nine rather than eight o' clock at night. The minutes stated that 'nursing staff fed back risks and difficulties around facilitating this'. However in June 2017 the hospital director had agreed to extend this to nine o' clock. The hospital director felt that the service did respond to requests and told us that following a patient request the restrictions on takeaways had moved from one to two per week being allowed on the ward.

We also noted that the service had not completed some agreed changes. Patients had requested the change from polystyrene to ceramic drinking mugs since March 2017 and the service had made no changes. The meeting minutes on 01 June 2017 stated 'ceramics – will be added to security checklist and checked three times a day. Each patient will have to have their own name on a mug, can buy or decorate your own. Patient made aware that if client group / risk changes this may not continue'. Staff told us that these were in place the day after our inspection and that the delay was caused by patients not purchasing their own mugs.

The level of restriction discussed in the meetings, and the lack of response to patient requests for reasonable changes meant that patients were not entirely involved in their care and staff did not always respect their choices and opinions.

The provider had made attempts to understand patients' satisfaction with their care, by conducting a patient satisfaction survey. The survey had six respondents (75% of patients) and asked questions about admission, involvement in care and treatment, activities, the environment, therapies, patient rights, friends and family contact and an overall rating of care. Thirty-three percent of the patients rated care as excellent, 50% as very good, and 17% as good. Responses to the survey were positive overall. All of patients felt involved with their multi-disciplinary team, and felt that nurses supported them through the care programme approach process. All patients knew what their medication was for and felt that they had their rights explained to them and knew how to make a complaint.

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Inadequate

The least positive response was in relation to the food and the number of activities, with 33% of responses being negative. Half of patients said that they did not receive enough information on admission.

The service also encouraged patient involvement via a patient magazine. Patients wrote this monthly and produced it in the information technology suite at the service. We reviewed two of these magazines and saw that they contained information patients wished to share about recovery, mindfulness and lessons they had learned in occupational therapy.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

At the time of our inspection, Bronte ward had nine patients, and the service had closed Bryon ward for refurbishment. This meant that only 40% of beds were occupied. The hospital director told us that this was because they continued to build relationships with service commissioners and that they had turned down referrals for patients deemed inappropriate for the service.

The service reported they accepted placements from outside of the local area, but due to the low level of occupancy at the service beds were available to patients in the local area if other services requested them.

The service had discharged one patient between 01 December 2016 and 01 June 2017, and had moved three other patients to other services more suitable to meet their needs. In the same period Bronte Ward had one patient who the service had classified as a delayed discharge. The service told us that the wait for an appropriate future placement for a patient was the reason for the delay.

The average length of stay for patients currently admitted to the service on the day of inspection was 308 days. The longest length of stay was 455 days and the shortest was 126 days.

We reviewed the care plans of all nine patients admitted to the service. Of the nine care plans reviewed, only one had a detailed discharge plan which described the goals and long term treatment plan for the patient. The other eight records did not contain a specific discharge plan but had a variety of plans used by staff such as a recovery plan, an independent living plan, and a feasible care plan. Where plans were evident they did not identify clear goals for the patient of what they needed to achieve to complete treatment and for the service to discharge them. Staff told us that they discussed discharge at multi-disciplinary team meetings and that discharge planning was recorded on a separate system. However this meant that care plans were not goal orientated. We observed one meeting and found that staff only discussed discharge planning in relation to one of three patients during this meeting. The hospital manager also told us that each patient had a recovery plan which they were working on and reviewing with their key worker.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a wide range of facilities and equipment to support treatment and care. This included visitors' rooms, activity rooms, an information technology suite, therapy kitchen, gym and communal lounges with activities for patients. The service told us that they had plans to develop its salon space and a café area into real life work opportunities for patients to learn skills and obtain qualifications. There was no timescale in place for when this would be accessible to patients.

Patients had their own mobile phones, and were able to use them to make phone calls in private. However patients were unable to use Wi-Fi within the service because the contractor had not set this up. Patients had raised this as an issue at the Mental Health Act review in October 2016 and this remained an outstanding action.

Patients had access to outside space which consisted of an internal courtyard which was unlocked throughout the day and closed at night to promote good sleep hygiene. The courtyard was a no smoking area and the service required patients who wished to smoke to have section 17 leave to access the grounds outside the hospital boundaries. If patients did not have section 17 and wished to smoke, staff offered them nicotine replacement therapies.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

The service had a large well equipped kitchen with two full time members of catering staff. Despite the outcome of the patient survey where 33% of patients gave it a poor rating, patients we spoke with during the inspection had no complaints about the food. We saw there was a menu in the dining room where patients could choose meals, which met a variety of dietary requirements. However this menu had not changed in the last three months.

The dining area was open to patients throughout the day and night, and patients could make their own hot and cold drinks using the 'beverage bar'. We saw that sometimes staff locked this due to the risk of one patient. Patients had open access to cutlery in the dining room, but staff had prevented them from using ceramic cups due to the risk of patients using them for self-harm. This appeared an unbalanced response and the hospital director stated that they would order ceramic cups for patients. We noted that this had been an action in community meeting minutes since March 2017. Staff told us that these were in place the day after our inspection and that the delay was caused by patients not purchasing their own mugs.

Patients were able to personalise their bedrooms, and had safe places in their room to store their possessions. Patients told us that they felt their possessions were safe.

The service had a dedicated occupational therapy and psychology department. The service offered each patient a range of group and individual activities between Monday and Friday. These included dialectical behavioural therapy, mindfulness, life skills programmes, substance misuse programmes, choir, coffee morning, smoothie making, patient magazine, community meetings, baking, gardening and woman's groups. At the weekends there was an expectation that nurses and support workers would provide patients with activities. One of the provider's targets was to provide each patient with 25 hours per week of meaningful activity sessions. Between December 2016 and April 2017 the provider had collected data that evidenced that the service had not achieved this. However all patients were accessing psychological and talking therapies in the same time period.

During the inspection we observed patients undertaking activities with staff and attending patient groups. Patients gave mixed feedback about access to activities on the ward and three patients gave a negative response about the available activities in the patient survey. One patient told us there were lots of things to do on the ward. This included using the library, attending groups and further education. Another told us that activities were not available at weekends.

Meeting the needs of all people who use the service

Both wards were located on the ground floor of the building and accessible to patients who had mobility needs. The first floor of the building was not accessible as there was no lift, however it only contained staff offices and sometimes meetings with patient took place in these rooms. If a patient was unable to use the stairs, staff would move the meeting downstairs to accommodate their needs.

During the inspection, we did not see information on display for patients including information about how to complain, how to contact the Care Quality Commission and the rights of informal patients to leave the building. This remained an outstanding action from the Mental Health Act Review visit in October 2016. However we did see a patient comments box located on the ward to encourage feedback and a poster was visible to all patients to advise them of how to contact the independent mental health advocacy service.

The service did not have a spiritual room for patients. The service said that this was to encourage patients to go out into the community. However this meant that those patients who were not well enough for leave or had no allocated leave did not have any access to a spiritual room.

Listening to and learning from concerns and complaints

The service had not recorded any complaints or compliments since 01 December 2016. Staff did not log comments and suggestions made by patients in community meetings were as complaints or compliments.

Patients knew how to complain, they were able to raise concerns in community meetings, morning meetings and all had access to an advocate during their admission.

The service had a complaints and compliments policy, and staff told us that the manager had displayed the complaints procedure in staff areas, and that they encouraged patients to use the comments boxes on the ward to raise concerns.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Inadequate

Vision and values

Elysium Healthcare was in the process of launching its values at the time of the inspection the organisational values of the previous provider were still in place and were:

- Valuing people: respecting our staff, patients, their families and communities
- Caring safely: caring safely for ourselves, people in our care, our customers and communities
- Integrity: uncompromising integrity, respect and honesty
- Working together: working together with everyone
- Quality: taking quality to the highest level.

The hospital director planned to embed the values in the organisation by having a clear governance structure and clear and open lines of communication between the wards of the hospital and the provider's senior board of directors. A plan was in place to agree and launch the service's vision and values to its staff team by September 2017. At the time of the inspection, staff were not aware of the visions and values of the organisation nor their own objectives.

Good governance

There were a number of issues we found during this inspection which meant that the governance structures within the service were not effective and did not ensure patient safety.

The service did not have a manager who was registered with the Care Quality Commission. Although the hospital director was undertaking this role, they had not submitted an application at the time of inspection (six months after the previous manager had left the organisation). It is a condition of the provider's registration that a registered manager is in post to provide oversight of the service and ensure they carry out regulated activities in line with our regulation. The service was unable to provide a valid reason that they had not been completed it. The service also did not have an accountable officer to monitor the use of controlled drugs. We are addressing these issues via a separate enforcement process.

Although ward level staff received appraisal and supervision, and told us that this was a positive experience, we were concerned about the lack of supervision and support for some members of the staff team. For example, the psychology assistants only had access to telephone supervision sessions, with no on-site support as did the senior occupational therapist who was new into their post. There were no formal monitoring or supervision arrangements for the practice of the non-medical prescriber which was a significant concern.

A number of important training areas were not included within the organisation's training matrix. The service did not have a system which allowed them to report and monitor which training staff had undertaken and therefore could not monitor the safety of the service. We saw a direct impact of this issue in relation to staff's understanding of the Mental Health Act, Mental Capacity Act and Duty of candour legislation.

The provider had not updated some of the day to day policies since they took over the service in December 2016. The Mental Health Act policy was not thorough and lacked significant detail and direction for staff it was not in line with the Code of Practice (2015). The hospital director told us that policies were being updated and ratified at provider level and this was taking time whilst the provider became established, they were aware of the issues this caused for the direction of the service.

The service did not always submit notifications to the Care Quality Commission. We saw that two serious incidents had taken place between 01 December 2017 and 01 June 2017. The service had not reported either of these incidents to the Care Quality Commission as expected due to their serious nature and the involvement of the police, both incidents meant our reporting criteria. The service had not recorded whether a safeguarding alert had been made to the local authority, (or why a decision had been made not to make a referral) for a patient on patient assault which occurred in the same time period.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

We did not have any concerns about staffing levels. Due to the low level of patients currently admitted to the service, staff were able to spend time with patients completing direct care and activities.

There was no audit schedule in place to monitor and review the quality and safety of the service and so the service had not identified the issues we found during our inspection. The practice of poor medications management, and poor management of physical health was a significant concern to us, but this had not been picked up by the provider's own internal systems. There was no system in place for managing the results of blood tests or ensuring side effects monitoring was taking place. Where audits did take place they did not pick up significant issues such as out of date medication, and missing emergency drugs. The checks and balances in place were not sufficient to ensure this service was safe.

The service had not ensured that the staff member tasked with auditing and checking Mental Health Act documentation was sufficiently trained or experienced. Only one Mental Health Act audit had taken place the week prior to our inspection which had uncovered significant mistakes. The service had left some of these mistakes undetected for up to 12 months because the service had not put systems into place to manage this.

There were a number of blanket restrictions in place at the service, staff told us that this was changing and that service was removing restrictions. However we could not see evidence of this. The service was highly restrictive and the model of care provided did not fit with the secure management of the service. The provider did not have a plan to reduce restrictive interventions. The hospital director had drafted a local reducing restrictive intervention plan, but this did not included the ongoing review of blanket restrictions in place.

Although Elysium Healthcare were not the provider of the service at the time of the most recent Mental Health Act Review visit, they did review the report and create an action plan in December 2016. However, they had not fully addressed all of the concerns at the time of the inspection.

However, where incidents had been reported learning lessons from incidents both within and outside of the service was positive. The organisation used a lessons learned bulletin which they gave to all staff. We saw in governance meetings that staff discussed serious incidents and made changes to services following the outcomes of investigations.

We saw that each month the hospital director produced a 'ward to board unit report' which provided an analysis of incidents. The report detailed for each incident the time taken between the incident and staff completing the incident report; the severity of the incident, and the number of incidents which involved physical intervention. The local hospital governance meeting reviewed the 'ward to board unit report'. This was a useful tool for the service in identifying themes and trends of incidents and concerns.

The hospital manager told us that they felt they had adequate administration support to complete their role.

The hospital director told us that the service worked towards a number of key performance indicators both internally and requested by the commissioners that have placed patients in the care of the service. The service was unable to provide data which evidenced whether these targets were being met both prior to and following the inspection.

Spring Wood Lodge had a risk register which the service last updated in June 2017. The hospital also had a risk analysis matrix which graded for each risk the 'likelihood of occurrence' and the 'significance of hazard'. Risks identified has having the highest grade of significance of hazard were automatically included on the risk register. There were 11 risks on the risk register. The risk register did not raise any of the concerns we collated during our inspection such as the risks posed by ligatures. Staff told us that if they had concerns about risks, they would discuss these in supervision and the hospital director would discuss them at governance meetings to make a decision about their addition to the risk register.

The hospital director told us that there were monthly local, regional and national clinical governance meetings. We reviewed meeting minutes for the local hospital governance meeting for February 2017, March 2017 and April 2017. The hospital director told us that no meeting took place in May 2017 and that minutes for the June 2017 meeting were not yet available. From March 2017 meetings

followed the same corporate agenda template which covered governance, quality assurance and safety, operational and financial performance, and strategy development.

The meeting minutes for April 2017 provided updates for actions identified in the previous minutes; however the minutes contained a number of items which were repeated without additional detail or amendment from the previous month. We also saw that a number of actions from the meeting in March 2017 were repeated in the April 2017 without evidence that the actions were completed. Examples of this were:

- In March the hospital did not have a member of staff who they had named as infection control lead which was still the case in April.
- In March the meeting noted that staff were still not inputting primary nursing sessions into timetables on care notes. This was still an issue in April.
- In March the meeting noted the clinical improvement strategy schedule review as 'coming soon'. This was still the case in April.

The hospital director told us that actions were not taken due to them being absent from the service in April. The three sets of meeting minutes did not include an action plan or list of identified actions with a lead member of staff who was responsible. Meeting minutes did not include evidence that all actions were identified and reviewed during subsequent meetings. The hospital director told us that from June 2017 they would structure the meeting agenda to include an action plan in order to monitor identified actions from each meeting. The service made meeting minutes from June 2017 available following the inspection which showed that the hospital had already recognised this issue and had taken action to address it.

We reviewed five staff files during this inspection. Two of the five staff files did not have evidence that the service had undertaken requests for two references from previous employers. The hospital director told us that this was because a previous organisation had employed these staff members. This meant that the service had not undertaken adequate recruitment and suitability checks when they took over this service and therefore could not ensure its safety.

Leadership, morale and staff engagement

We saw positive staff morale and engagement at the service. Staff told us that there had been a shift in culture, and staff employed by the previous provider told us that there had been a real change and that they felt supported in their role. They talked of a teamwork culture, and a culture of using less physical intervention. Staff told us that senior leaders and members of the multi-disciplinary team were approachable and offered supervision and support.

The service had undertaken a local staff survey named the 'culture of care barometer'. The results were wholly positive that staff feel valued and would recommend being employed by Elysium. We noted that there was one staff member of 18 respondents who gave negative answers which have impacted on the figures due to the small sample size of the survey. Sickness and absence rates were low at the service. All of the staff we spoke with said that were happy in their job; they felt valued and positive about the future of the service. Staff talked about good working relationships and a culture where they felt safe to raise concerns. No staff had reported bullying or harassment and all staff we spoke with knew how to use the raising concerns process should they need to.

Staff told us that the service gave them opportunities for training and development and managers asked them in staff meetings to give ideas for service improvement and development.

Commitment to quality improvement and innovation

The service was not involved in any quality improvement networks, but did state that they hoped to work towards accreditation for inpatient mental health services. Staff told us about innovative ideas for the service, such as the implementation of a recovery college and real work and training opportunities on site. Unfortunately these were not in place at the time of our inspection, but the service had a clear idea of its vision for the future.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care and treatment is appropriate, meets patient needs and reflects their preferences, including personalised recovery focussed care plans which include plans for discharge.
- The provider must ensure that patients' treatment is line with legislation with the Mental Health Act and Mental Capacity Act to ensure they uphold patients' rights. A nominated and suitably experienced person must monitor the use of legislation.
- The provider must ensure that it identifies and monitors environmental risks, such as ligature points to protect patients from harm.
- The provider must ensure that the management of medications is safe and carefully monitored.
- The provider must ensure that it manages the physical health needs of patients.
- The provider must ensure that it provides care and treatment in a dignified and person centred manner and that acts to control and restrain patients are proportionate to the risk identified. The provider must ensure that it never provides care in a way which is degrading for patients.
- The provider must ensure that governance systems in place ensure the safety of the service by completing assessment, monitoring and improvement in the quality of the service provided.
- The provider must ensure that they report safeguarding concerns as per their policy to the local authority and that they follow the correct Care Quality Commission notifications procedure.
- The provider must ensure that it appropriately trains, inducts and supervises all staff and that there is a system in place to monitor this.
- The provider must ensure that it meets patients' cultural and spiritual needs appropriately.

Action the provider SHOULD take to improve

- The service should ensure that staff seek support from experienced health professionals outside of the service to support patients with long term health needs.
- The service should review its process for community patient meetings and ensure that the outcomes are patient focussed.
- The provider should ensure that its vision and values are clear to all staff and embedded within the service.
- The provider should review its internal policies and procedures in a timely manner to provide guidance and direction to staff

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **How the regulation was not being met:** **The care and treatment of patients was not person centred and the service did not design care plans to meet their needs and reflect their preferences.** **Staff did not carry out care plans collaboratively with patients and they were not designed to support patients to achieve their preferences for discharge from the service or their spiritual and cultural needs.** **The provider did not ensure that it enabled patients to participate in decisions relating to their care and treatment in accordance with the Mental Capacity Act.** **This was a breach of regulation 9 (1) (a) (c) (d) (3) (a) (b)**

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 **How the regulation was not being met:** **Care and treatment was not provided in a safe way for patients because the service was not regularly assessing the risks to the health and safety of patients and doing all that was practicable to mitigate those risks.** **The service did not ensure the premises were safe.** **There was not proper and safe management of medicines and their side effects.**

This section is primarily information for the provider

Enforcement actions

This was a breach of regulation 12 (1) (2) (a) (b) (d) (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** **Patients were not always protected from abuse and improper treatment** **Care or treatment of service users was provided in a way that included acts intended to control or restrain a service user were not necessary or proportionate response to the risk. Some treatment was degrading for patients.** **This was a breach of regulation 13 (1) (4) (b) (c)**

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 **How the regulation was not being met:** **The provider had not ensured that systems and processes were established to ensure they could assess, monitor and improve the quality of the service, assess monitor and mitigate risk and evaluate and improve practice.** **The provider did not ensure that an accurate and contemporaneous record was kept in respect of each patient and decisions taken in relation to the care and treatment provided.** **This was a breach of regulation 17 (1) (2) (a) (b) (c) (f)**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. Persons employed by the service did not receive appropriate support, training and professional development and supervision.

This was a breach of regulation 18 (1) (2) (a)