

Glenhurst 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

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



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

We rated Glenhurst Lodge as good because:

- The service provided a clean and safe environment that contained equipment and facilities that allowed staff to deliver all aspects of treatment and care. Appropriate staffing levels ensured patients were safe, supported and had access to a full range of interventions to support their recovery and rehabilitation.
- The service carried out comprehensive risk assessments on all patients. Staff were skilled in calming distressed patients and were trained and knowledgeable in safeguarding procedures. The service had good systems in place to ensure incidents were discussed and lessons were learnt.
- The service had a good approach to assessing, and responding to, patients' physical health and nutritional needs. The service had a good approach to medicine management and supported patients to manage their medicine independently.
- Patients were actively involved in planning their care. Staff, from across the multi-disciplinary team, worked with patients to ensure that care was delivered based on individual need. They had comprehensive knowledge of patients' recovery needs and had organised systems in place to ensure these were monitored and reviewed regularly.
- Patients had access to a wide range of occupational and psychological groups and activities that were recovery focussed and tailored to their needs. Staff audited these interventions and used recognised rating scales to monitor patient progress.
- Mental Health Act requirements were completed in line with the Code of Practice. The multi-disciplinary team assessed patients' capacity to make decisions and arranged appropriate support if their capacity was lacking.
- Patients were treated with dignity and respect and had appropriate access to privacy. The service provided a calm and friendly environment for patients to be able to focus on their recovery. Patients had regular community meetings and patient forum where they had the opportunity to give feedback on the service.
- Patients' families and carers were involved in their care and the service had recently introduced a carers' forum.
- All patients had clear discharge plans and progress was reviewed by the multi-disciplinary team and shared with their community care coordinators. Patients had access to a wide range of activities and facilities to support their care and recovery.
- Patients were able to personalise their individual bedrooms and contribute to the wider hospital environment. Patients chose their own food to meet their dietary requirements. They had their own kitchen areas where they could make hot drinks and snacks 24 hours a day.
- The hospital responded to complaints and had a policy that staff and patients were aware of. Patients and staff received feedback on complaints and the hospital had a good approach to reflecting on complaints to improve standards of care.
- Staff were enthusiastic about the jobs, felt valued, and were kept up to date with developments in the service and wider organisation. Robust governance systems were in place and adhered to in line with organisational policy.
- The multi-disciplinary team were committed to quality improvement and delivering care and treatment in line with current evidence-based practice and national guidelines.

However:

- The service's fire risk assessment needed updating and emergency resuscitation bags required more thorough checking.
- Staff supervision records did not always capture sufficient detail of supervision sessions. Some therapeutic care workers had limited knowledge of the Mental Health Act and Mental Capacity Act.
- One patient told us there could be delays in them receiving their money entitlements. The service was aware of this issue and had added it to the risk register and was looking into making the system more robust.

Summary of findings

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Good 

Glenhurst Lodge

Services we looked at

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

Summary of this inspection

Our inspection team

Team leader: Scott Huckle, CQC Inspector

The team that inspected the service comprised one CQC Inspector, one CQC Inspection Manager, a Mental Health Act Reviewer, a nurse and an occupational therapist.

Why we carried out this inspection

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

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 reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited both wards at the service, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with eight patients who were using the service
- spoke with the hospital manager and director of nursing

- spoke with 14 other staff members; including doctors, nurses, an occupational therapist and psychologists
- spoke with the pharmacist who visited the service
- spoke with the providers assessment and clinical audit nurse
- received feedback about the service from two care coordinators
- attended and observed two hand-over meetings, two multi-disciplinary meetings and a number of therapeutic groups and activities
- collected feedback from six patients and two using comment cards
- looked at 10 care and treatment records of patients
- carried out a specific check of the medication management on both wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Glenhurst Lodge

Glenhurst Lodge is registered to provide the regulated activities: assessment or medical treatment for persons detained under the Mental health Act 1983; accommodation for persons who require nursing or personal care; treatment of disease, disorder or injury; and diagnostic and screening procedures.

Glenhurst Lodge is a high dependency rehabilitation unit with two locked wards for working age adults. Davenport

ward has 11 beds for men and Sandown ward has 11 beds for women. During our inspection, the service was providing care and treatment to 11 men and seven women.

We have inspected Glenhurst Lodge eight times since registration with the care Quality Commission in 2011. Our last comprehensive inspection was in September

Summary of this inspection

2015 where we rated the domains of safe, caring, responsive and well-led as good; and the domain of effective as requires improvement. This gave the service a rating of good overall.

We carried out a focussed inspection in September 2016 and a follow up to this inspection in February 2017. Following this latest inspection we issued the provider with two requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 – Person-centred care.
- Regulation 14 – Meeting nutritional and hydration needs.

We told the provider that it must take the following actions to improve long stay/rehabilitation mental health wards for working age adults:

- The provider must ensure patient care plans are rehabilitation or recovery focussed. Care plans must reflect individual needs and goals, level of support needed and how these are to be achieved.

- The provider must ensure they identify an appropriate risk-screening tool for nutrition and hydration.
- The provider must ensure patients receiving care and treatment for dietary issues have their nutritional needs assessed and reviewed.
- The provider must ensure care plans include nutritional and hydration needs and what support is needed.

We also told the provider that it should take the following actions to improve long stay/rehabilitation mental health wards for working age adults:

- The provider should ensure all parts of 'The Model of Human Occupational Screening tool' are fully completed and documented when used to assess patients.
- The provider should ensure they have robust audit processes in place to check for errors on MEWS charts.
- The provider should ensure the outcome of the GASS assessment is documented in the patients' daily nursing notes.

What people who use the service say

We spoke with eight patients during our inspection who were generally happy with the care and treatment the service provided. They acknowledged that staff were committed to supporting their recovery and rehabilitation and recognised they were making progress.

We collected six comment cards from patients using the service, five of which were positive and one which was neutral.

We also received two comment cards from the carers of one patient. They both felt their relative was safe and receiving the best care in a long time. They were confident in the service's ability to support their relative's recovery.

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?

We rated safe as good because:

- The service provided clean, well equipped wards that allowed staff to deliver all aspects of treatment and care. Ward layouts allowed staff to easily monitor patients' whereabouts. Wards environments were fully risk assessed to maintain patients' safety.
- Staff had access to personal alarms. Nurse call alarms were located in all bedrooms and communal areas to ensure patients could alert staff if they needed support.
- The service had systems to ensure staffing levels were sufficient to provide safe patient care, offer patients regular one to ones and facilitate activities and escorted leave.
- Staff were appropriately qualified for their roles and attended regularly training relevant to their roles. Patients were provided with medical cover 24 hours a day.
- The service carried out comprehensive risk assessments on all patients. They were regularly reviewed and updated in line with incidents. The quality of risk assessments was audited to ensure standards were maintained.
- Staff were skilled in calming distressed patients in the least restrictive way. The service had introduced new training that supported this practice. There were low incidents of restraint across both wards.
- Staff received training, and had a good understanding of procedures, on how to safeguard patients against abusive treatment. The service kept a record of all safeguarding referrals and had good links with the local authority safeguarding team.
- Staff had a good approach to reporting incidents. The service had good systems in place to ensure incidents were discussed and lessons were learnt.

However:

- The emergency resuscitation bag on Davenport ward did not contain all the equipment recorded on the checklist.
- The service's fire risk assessment needed updating as it contained information that was out of date. The service did not have any staff that had completed fire warden training.

Good



Are services effective?

We rated effective as good because:

Good



Summary of this inspection

- The service had a good approach to assessing, and responding to, patients' physical health and nutritional needs. The ward psychiatrist carried out physical health screening for many conditions associated with taking antipsychotic medicines. The service had a system in place to ensure patients received regular dental and eyesight checks.
- Patients were actively involved in planning their care. Staff, from across the multi-disciplinary team, worked with patients to ensure that care was delivered based on individual need.
- The service had a good approach to medicine management. They were supported by a pharmacist who carried out audits and provided staff training. The service supported patients to work towards managing their medicine independently.
- Patients had access to a wide range of occupational and psychological groups and activities that were recovery focussed and tailored to their needs. Psychological and occupational therapy staff audited their interventions and used recognised rating scales to monitor patient progress.
- The multi-disciplinary team worked cohesively and had comprehensive oversight of all aspects of patients' care and treatment needs. They had organised systems in place to ensure these were monitored and reviewed regularly.
- The service employed a Mental Health Act administrator that ensured Mental Health Act requirements were completed in line with the Code of Practice. The multi-disciplinary team assessed patients' capacity to make decisions and arranged appropriate support if their capacity was lacking.

However:

- Although staff received regular supervision, we found it varied in detail and quality. Staff appraisals were not kept at the service which meant staff could not easily refer to their current performance goals.
- Therapeutic care workers had limited knowledge of the Mental Health Act and Mental Capacity Act. They were aware of their limitations and accessed support from senior staff if required.

Are services caring?

We rated caring as good because:

- Patients were treated with dignity and respect and had appropriate access to privacy. Staff provided good levels of support whilst adhering to professional boundaries. The service provided a good environment for patients to be able to focus on their recovery.

Good



Summary of this inspection

- Staff throughout the service understood the needs of individual patients. Care plans were co-produced and this led to consistent care and treatment. Patients welcomed staff encouragement and overall patient staff relationships had improved.
- Patients' families and carers were involved in their care and the service had recently introduced a carers' forum.
- Patients had regular community meetings and patient forum where they had the opportunity to give feedback on the service. Patients were involved in staff interviewing and decisions about the ward environment.

Are services responsive?

We rated responsive as good because:

- The service had a robust approach to discharge planning. All patients had clear discharge plans and progress was reviewed by the multi-disciplinary team and shared with their community care coordinators.
- Patients had access to a wide range of activities and facilities to support their care, recovery and ability to live independently. Information of importance and interest to patients was clearly displayed within ward areas.
- Patients were able to personalise their individual bedrooms and contribute to the wider hospital environment. Both wards had separate garden areas that patients contributed to maintaining.
- Patients chose their own food to meet their dietary requirements. They had their own kitchen areas where they could make hot drinks and snacks 24 hours a day.
- The service made a comprehensive assessment of referred patients to ensure they could meet their needs. Patients could access services such as advocacy and interpreters. The service had links with the local community to ensure patients could meet any religious needs.
- The hospital responded to complaints and had a policy that staff and patients were aware of. Patients and staff received feedback on complaints and the hospital had a good approach to reflecting on complaints to improve standards of care.

However:

- One patient told us there could be delays in them receiving their money entitlements. The service was aware of this issue and had added it to the risk register and was looking to improve the system.

Good



Summary of this inspection

Are services well-led?

We rated well-led as good because:

- Staff were enthusiastic about the direction the service was heading and felt involved in recent improvements in patients' care and treatment. They were kept up to date with developments in the service and wider organisation.
- The service had governance systems which were adhered to in line with the wider organisation. The hospital manager had an organised approach to auditing and quality assurance and delegated these duties to the most appropriate members of the team.
- Morale was generally high among staff members who told us they felt valued. Staff had opportunities to develop their roles and were encouraged to take on extra responsibility. They were aware how to raise concerns and felt confident to do so.
- The multi-disciplinary team were committed to quality improvement and delivering care and treatment in line with current evidence-based practice and national guidelines.

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.

- The service provided training in the Mental Health Act (MHA) and 82% of staff had completed this. Senior staff members had good knowledge of the MHA but therapeutic care workers had varied knowledge. However, we found their knowledge in areas they dealt with on a regular basis, such as reading patients their rights and knowing patients' leave requirements, was sufficient.
- Mental Health Act documentation to certify whether a detained patient had consented to treatment or to certify that a patient did not consent, or lacked capacity to consent, to treatment were available and completed correctly. They were kept in patients' care records and attached to their medicine charts.
- We spoke with the service's MHA administrator who had exemplary knowledge of the MHA. They were available to staff for advice and conducted regular audits that scrutinised MHA paperwork. We found MHA paperwork was in place within patients' care records and was completed correctly.
- Staff reminded patients of their section 132 rights in line with the provider's policy and the MHA Code of Practice. This was clearly documented within corresponding care plans.
- The service had access to an independent mental health advocate (IMHA), and their contacted details were displayed on both wards. All detained patients were automatically referred to them. The IMHA visited the ward weekly and was currently supporting a number of patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training in the Mental Capacity Act (MCA). Senior members of the multi-disciplinary team (MDT) had a good understanding of MCA principles and processes in ensuring patients capacity had been fully assessed. However, we found the MCA knowledge of therapeutic care workers to be poor. They recognised their lack of knowledge and told us they would discuss any issues they had concerning patients' capacity with senior staff.
- The service had a MCA and Deprivation of Liberty Safeguards (DoLS) policy for staff to refer to. The service currently had no patients who were subject to a DoLS authorisation or awaiting a DoLS assessment.
- Patients' care records demonstrated evidence of informed consent, for example to share medical records, have their photographs taken and consent to treatment.
- The multi-disciplinary team had completed capacity assessments for all patients. We saw that these were decision specific and that detailed discussions had taken place to decide in what areas patients lacked capacity.
- The MDT arranged best interest meetings to support patients to make decisions. We saw how a patient, who was prescribed a medicine that was potentially harmful, was supported in deciding whether they wanted to continue taking it. The MDT involved nearest relatives, advocates and physical health specialists to ensure the decision was in the patient's best interest. We saw how this process continued to a second meeting to review the initial decision.

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	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good 

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

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

Good 

Safe and clean environment

- Both wards consisted of two corridors containing patients' bedrooms. A kitchen, dining room and day room were adjacent to each other. Staff had a clear view of both corridors and dining room from the area outside the nursing office. We consistently saw staff walking around the ward and checking on patients' whereabouts.
- Both wards had some door handles that could potentially be used to attach a ligature to assist self-harm. These were clearly identified on a comprehensive ligature risk assessment and associated risks were managed. We saw that patients' en-suite bathroom were fitted with anti-ligature doors and fittings. Sandown ward had adapted one bedroom to be completely anti-ligature and could be used to support patients presenting with a risk of using ligatures as a way to self-harm.
- The service supported men and women on separate wards, with separate garden access, to ensure they complied with same-sex guidance. Some activities and groups were open to patients from both wards. In these circumstances there was sufficient staff presence.
- Both wards had fully equipped clinic rooms that were clean and tidy. Staff recorded temperatures of medicine fridges daily to ensure they were safe for use. Both wards had emergency drug bags that were checked

regularly by an external pharmacist. We found the wards were currently sharing access to the defibrillator and electronic weighing scales whilst additional machines were on order. We found some inconsistencies within the contents of the resuscitation bag and the relating checklist on Davenport ward. Both clinic rooms did not contain an examination couch meaning some physical examinations were carried out in their rooms or within their GP surgery if required.

- Both wards were clean and received daily cleaning from domestic staff. Furnishings were well maintained and this included recently replaced chairs and an updated air conditioning system.
- Domestic staff carried out daily cleaning on the patients' kitchen area. We checked fridges and found food was stored safely. All opened food was sealed appropriately and contained a sticker to identify when it was opened and expiry date. Staff regularly checked and recorded temperatures of fridges and freezers used to store patients' food. The hospital manager audited these and done regular spot checks to ensure they were accurate.
- Staff and patients had access to hand sanitising gel on entry to the wards. Staff also had this facility within the nursing offices and basement office area.
- The service carried out regular environmental risk assessments of the building and garden areas that identified potential risks and plans in place to reduce these risks. The service had a fire risk assessment in place that had been carried out in January 2008. It stated this had been reviewed yearly but still contained details of a now obsolete registered gas engineer and details of the provider's previous name. We were unable to find details of any current staff that had completed

Long stay/rehabilitation mental health wards for working age adults

Good 

fire warden training and who was the identified lead for fire safety on each shift. However, fire alarm systems and fire extinguishers were regularly checked and fire drills were undertaken.

- All staff and visitors had access to personal alarms to enable them summons support if required. The service had nurse call alarms in all patients' bedrooms and communal areas. If activated a panel next to the nursing office on both wards displayed the area of concern.

Safe staffing

- The service currently employed seven registered mental health nurses, with two vacancies, and 22 therapeutic care workers, with two vacancies. We were told the therapeutic care worker vacancies had been filled but had not commenced working. The other multi-disciplinary members were a full-time specialist doctor, a full-time clinical psychologist, a full-time assistant psychologist and a full-time occupational therapist.
- Between 1 May 2017 and 31 July 2017 the service used bank and agency staff to fill 159 nursing shifts and 218 therapeutic care worker shifts. This comprised of regular staff doing extra shifts and agency staff who were familiar with the service and patients. The service had no shifts unfilled during this period.
- Between 1 May 2016 and 30 April 2017, the service had a staff turnover rate of 50% and a staff sickness rate of 6%. The hospital manager told us that staff turnover was high due to many therapeutic care workers working short term over educational holiday periods.
- Staff worked twelve hour shifts between 8am and 8pm. The service implemented a safe staffing model which provided one staff member for every three patients on a day shift. Each ward had one nurse with additional staff being therapeutic care workers. The service had one nurse and two therapeutic care workers on all night shifts regardless of patient numbers.
- The hospital manager was able to use additional staff if required. They gave examples of extra staff being used to take patients on leave or to hospital appointments. An example was also given of extra staff being used to support a patient who was on increased observations a few months ago.

- We saw staff presence on the wards at all times during our inspection. This included the ward nurse. When staff were not required to be writing care records in the nursing office they were on the ward carrying out observations and interacting with the patients.
- Staff told us they were able to have regular one to one time with patients. This often happened in the afternoon or at weekends. Patients confirmed that staff were available for them when they needed.
- Staff told us that escorted leave was never cancelled. If it was delayed patients were made aware of this. If patients required leave that involved staff escorting them long distances, this would be prearranged and extra staff used if needed. Ward activities and therapeutic groups were rarely cancelled apart from when attendance levels were low.
- The service received medical cover out of hours from a two-tier system. The first tier was made up from doctors who could attend the site if required and the second tier made up from consultants who could be contacted if extra advice was required.
- Staff received mandatory training in 22 areas relevant to their roles. These included safeguarding adults and children; the Mental Health Act; the Mental Capacity Act; management of aggression, communication and engagement; positive behavioural management; epilepsy awareness and intermediate life support. Staff had completion rates of above 80% for all courses apart from intermediate life support that was at 40%. We were told that new staff members were due to carry out this training in the near future.

Assessing and managing risk to patients and staff

- Between 1 November 2016 and 30 April 2017 there had been no incidents of seclusion or long term segregation at the service. There had been two reported incidents of restraint on Davenport ward with neither of these being in the prone position.
- We reviewed 10 patients' care records and all contained an up to date risk assessment. The service used the short term assessment of risk and treatability (START) that detailed 20 risk items that were scored and detailed the patient's strengths and weaknesses. START identified risks in areas that may impact rehabilitation and recovery such as, social skills, relationships, occupational, self-care, medication adherence, insight and coping and treatability. It also contained signature risk signs for each patient. Patient's view on the risk

Long stay/rehabilitation mental health wards for working age adults

Good 

assessments were also included and detailed. Risk management plans were present which identified specific groups and interventions the service was offering to patients. We saw these coincided with patients' care plans. Risk assessments were all signed and completed by the ward doctor, qualified nurse and assistant psychologist and were reviewed quarterly.

- The service restricted patients from using some items such as lighters, toiletries and phone chargers. These items were collected after use and kept in lockers in the nursing office. However, patients did not have restrictions on the times they could use these items. The service explained this process to all patients on admission.
- During our inspection there were three patients on Davenport ward who were not detained under the Mental Health Act. Although the ward was locked these patients were aware they could ask a member of staff to leave the ward at any time. Both wards had clear signage by the entrance door which explained this clearly. Staff told us they would do a brief risk assessment before allowing informal patients to leave the ward.
- Therapeutic care workers carried out regular observations and recorded the whereabouts of patients during the day. The service had appropriate policies to allow them to increase observation levels if risks were identified. Staff would search patients returning from unescorted leave to ensure they were not bringing contraband items, such as lighters, on the ward. Staff told us that since the hospital had gone smoke free there had been incidents of patients smoking in bedrooms. They also were aware of patients returning to the ward under the influence of legal highs. The service had responded to this by increasing searches and restricting unescorted leave where appropriate. Staff had access to a magnetic wand to assist searches if they were concerned weapons may be bought onto the ward.
- Staff told us that the new management of aggression, communication and engagement training had improved their skills in de-escalating patients who were becoming agitated or aggressive. They said that incidents of restraint were rare and only two had been reported in the last nine months.
- Between 1 November 2016 and 30 April 2017 there had been no incidents of patients receiving rapid tranquilisation by injection. However, the service had

protocol for supporting patients after this intervention clearly displayed in the clinic rooms. Staff were aware of The National Institute for Health and Care Excellence guidance that regular physical observations needed to be monitored following rapid tranquilisation until the patient was fully alert.

- Staff had received training in safeguarding adults and children and had a good understanding on what warranted a safeguarding referral and the process of making a referral. The service kept a record of all safeguarding referrals made and we saw recent examples of how they had followed these up with the local authority. Staff were aware of the local authority safeguarding lead and how to contact them if they needed advise.
- The service had robust systems in place to ensure medicine was stored and monitored appropriately. This included regular monitoring of drugs liable for misuse. A local pharmacist was contracted to visit the wards bi weekly to carry out audits, check the emergency drug supplies and safely dispose of medicine if required. The pharmacist was also contracted to provide training sessions in areas such as the management of clozapine (a medicine that has strict management to ensure patient safety) and diabetes. Qualified staff undertook a medicine competency test during their induction.
- The service had reported six medicine errors between 1 November 2016 and 30 April 2017. Three involved incorrect recording on medicine charts, one due a spillage and two due to medicines being out of stock. Staff told us that following a recent medicine error by an agency staff they were encouraged to use two staff to check injectable medicine before administration.
- The service had a policy that did not allow visitors under 18 to enter the wards. However, the service had a visitors' room in the basement where children could visit relatives. Staff told us they preferred visitors to inform them when they intended to visit but where able to accommodate last minute visits as long it wasn't thought to have an adverse effect on the patient or visitors.

Track record on safety

- The service had not reported any serious incidents within the last 12 months. However, in the event of incidents being deemed as serious, staff were aware they needed to be escalated to senior management.

Long stay/rehabilitation mental health wards for working age adults

Good 

Reporting incidents and learning from when things go wrong

- The service reported incidents appropriately. Staff were aware of the process and which senior staff needed to be informed depending on the nature of the incident. We viewed the incident log for the last three months and saw that sufficient information was recorded along with initial actions taken.
- The service had a duty of candour policy and followed this appropriately. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify people (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw an example where family members were contacted following a patient being given the wrong medicine. They had been given a clear explanation and the opportunity to ask questions or make a complaint.
- The hospital manager reviewed all incidents and they were further discussed at clinical governance meetings. The service monitored incidents that occurred regularly, such as smoking on site and patients going absent without leave. We saw that these were discussed at team meetings. Staff had been encouraged to look for patterns in patients' behaviour that preceded these incidents. They were also reminded to record sufficient information when reporting incidents.
- Staff felt supported after incidents and were given opportunities to debrief. Psychology staff were available to staff for support. They also supported staff to complete behavioural charts so they could analyse patients' behaviour. Staff told us this had helped the team act more consistently towards incidents that needed de-escalating.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We looked at ten patients' care records across both wards. All contained comprehensive assessments of the patients' social and medical history upon admission to the ward. The occupational therapist completed an occupational functional assessment which identified areas that needed to be addressed to support patients' recovery and rehabilitation.
- The psychiatrist carried out a comprehensive physical health assessment on all patients annually. They had sound knowledge of all patients' health issues and individualised physical health checks dependent on need. For example, patients on certain medicines, or high doses of medicine, had more regular checks in areas such as metabolism, renal functioning and risk of constipation. Staff completed and recorded physical health observations on all patients at least weekly and more often if required. The service recorded patients' physical health details in their health action plan folder.
- Following our inspection in February 2017, we told the provider they must ensure patients' care plans are rehabilitation or recovery focused and that care plans must reflect individual needs and goals, level of support needed and how these are to be achieved. During this inspection we found significant improvement in this area. Patients' care records contained a 'this is me' document that listed likes and dislikes, my preferred routine, serious physical health needs, communication needs and any other relevant information. These were completed by the patient and supported staff to individualise care needs and recovery goals. All patients' care plans were up to date, personalised, holistic and recovery focussed. They contained patients' views and their strengths and weaknesses. Patients had a copy of their care plans or it was stated if they had refused. The multi-disciplinary discussed care plans with patients weekly and updated them accordingly. The also carried out quarterly comprehensive care plan reviews.
- The service used a paper system to record daily progress notes. All care records we viewed were organised and information was easy to locate. Staff recorded daily progress notes in line with patients' individual care plans. Staff told us this system had helped them become more familiar with the care plans and, subsequently, support patients in line with them. The multi-disciplinary team told us this had improved the information communicated to them at daily handovers.

Long stay/rehabilitation mental health wards for working age adults

Good 

Best practice in treatment and care

- Medical staff followed national guidance when prescribing medication. One patient, who was on a higher than recommended dose of anti-psychotic medicine, had the advised blood tests to ensure their blood levels were within normal range. Some patients were prescribed clozapine, an antipsychotic medicine which requires strict blood monitoring. We saw that they had been unsuccessfully treated other antipsychotics previously and that clozapine was only used as a last resort.
- The service used a four stage approach to moving patients towards self-medicating to promote their independence. All self-medicating patients had been initially assessed by the psychiatrist to ensure they were suitable and safe to self-medicate, and had clear care plans which identified how they would move to the next stage. There was a policy that guided this practice.
- The service employed a full time clinical psychologist and assistant psychologist. All patients received a psychological assessment upon admission. This included completing recognised scales to monitor patients' mood and anxiety levels. The psychology team provided groups such as, hearing voices, expressive art, social skills, mindfulness and sleep hygiene. We were told how a patient who engaged well with mindfulness was supported to purchase a CD so they could continue practicing outside of the group. Patients were encouraged to participate and were given appointment cards to remind them of when and where groups were being held. Emails were sent to nursing staff to ensure patients did not take leave when they were due in a group. The psychology team kept attendance records and gave patients the opportunity to give feedback. The team had some capacity to provide a few one to one psychology sessions a month. All psychological input was captured in patients' care plans.
- The service employed a full time occupational therapist (OT). They carried out a number of recognised assessments with patients, such as 'the model of human occupational screening tool', that determines the extent to which individual and environmental factors facilitate or restrict an individual's participation in daily life. Patients also had assessments to ascertain their community living and kitchen skills. The OT provided many groups such as walking, current affairs, gardening, goal setting and fitness. They also provided recreational activities such as smoothie making and pampering sessions. Ward staff worked alongside the OT to facilitate these groups. Each morning patients attended a planning meeting where they decided which groups/activities they would attend. This information was displayed on the ward to remind patients and staff who was attending. The OT kept a record of patients who attended groups and fed this back to the multi-disciplinary team at daily meetings. They told us that attendance had improved recently and felt that ward staff had improved patient motivation.
- Patients were registered with a local GP if their own was out of area. The service recorded when patients were next due to attend specialists such as dentists or opticians. A nurse ran a monthly physical health clinic which provided health promotion advice to patients. They were also trained in smoking cessation and were able to provide this support to patients.
- Following our inspection in February 2017, we told the provider they must ensure they identify an appropriate risk-screening tool for nutrition and hydration. They must ensure patients receiving care and treatment for dietary issues have their nutritional and hydration needs assessed and reviewed. They must ensure care plans include nutritional and hydration needs and what support is needed. During this inspection we found significant improvements in this area. All patients had their nutritional needs screened using the 'malnutrition universal screening tool', which identifies whether patients are at risk of malnutrition or obesity. Furthermore, the service had revised its self-catering policy to ensure patients had staff support in preparing the majority of their meals. Self-catering was expected for four meals a week and patients who were deemed to be self-catering successfully could extend this. The service had introduced a nutrition meeting where patients' individual nutrition needs were discussed to ensure staff were aware of any patients' needs in this area. All patients had care plans to support their nutritional needs.
- The service had recently implemented the use of World Health Organization disability assessment schedule. This tool measures health and disability and looks at an individual's level of functioning in major life domains such as mobility, self-care, participation and life activities. The multi-disciplinary team reviewed this quarterly and used it to gauge patients' readiness for discharge.

Long stay/rehabilitation mental health wards for working age adults

Good 

- Following our inspection in February 2017, we told the provider they should ensure the outcome of the 'Glasgow antipsychotic side-effect scale' (GASS) was documented in the patient's daily nursing notes. This assessment monitors whether patients are experiencing adverse side-effects due to using antipsychotic medicine. During this inspection we found improvements in this area. The GASS score was being completed by patients with support from staff. The multi-disciplinary team kept a record of previous scores so they could monitor progress and when the assessment needed to be repeated.
- Staff carried out a number of clinical audits around areas such as care plans, safe staffing and physical health. The pharmacist who visited weekly carried out audits of prescription charts and medicine management.

Skilled staff to deliver care

- Staff we spoke to were appropriately qualified for the roles they were carrying out.
- Staff received a corporate induction and a local induction to ensure they are suitably prepared for their role. New staff were allocated a mentor and spent time shadowing experienced staff before they were counted in staff numbers. They are required to complete an induction pack which monitors when they have reached required competencies. Qualified nurses complete a medicine competency test before they administer medicine. Therapeutic care workers were expected to complete the care certificate standards. These are standards that should be covered as part of induction training for new health and social care workers.
- Staff received regular supervision. The service had a system that ensured all staff were allocated an appropriate supervisor dependent on their discipline and level of qualification. The service aimed to provide supervision on a monthly basis and we saw all staff had received supervision in the last two months. We reviewed the quality of supervision records for five staff and found it varied in detail. However, it addressed appropriate domains, such as caseload management, training needs and work life balance.
- We saw that all staff, who qualified for an appraisal, had received one. The hospital manager kept a record when next appraisals were due. We viewed an appraisal template and saw that it reviewed performance, monitored skills and knowledge and supported staff to

make a personal development plan. We were unable to view any completed appraisals as these were kept by staff or at the provider's head office. All qualified staff had revalidated their registration under the Nursing and Midwifery Council and next due dates were recorded.

- Staff told us the provider supported them to complete specialist training. Three staff, including the occupational therapist, were being supported to complete their mentorship training. Staff were trained in areas such as smoking cessation and diabetes management. The assistant psychologist had been supported to attend conferences within her normal working hours.
- The hospital manager was experienced at addressing poor staff performance. They had previously worked in services which had been underperforming and successfully made improvements. They had no current issues with staff performance at the service.

Multi-disciplinary and inter-agency team work

- The service had an excellent multi-disciplinary team (MDT) that worked cohesively to ensure care and treatment was provided in a safe and effective way. They had daily handover meetings and all members attended patients' reviews. They had solid systems in place to ensure all aspects of patient care was completed and reviewed regularly. The majority of the MDT shared the same office which allowed them to share information as it happened.
- The service had a robust system to ensure information was shared across the team. Ward staff had two daily handovers and this information was handed over to the MDT by the wards' nurses in charge every morning. We observed them during meetings and handovers and found their discussions to be patient-centred and recovery focussed.
- We spoke with two community care coordinators who, between them, had six patients currently at the service. They told us they received regular updates on their patients in the form of detailed reports. They felt the service was addressing their patients' recovery needs and preparing them for discharge back into the community.
- The service had links with the local GP service. We saw many examples where the psychiatrist had liaised with GP services to ensure patients were getting support for physical health issues. The service had a named contact with the local authority safeguarding team and all staff

Long stay/rehabilitation mental health wards for working age adults

Good 

knew how to contact them. The service had links with local mental health charities and some patients attended their community therapy groups. Patients also attended local gyms, swimming pools and the local community college.

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

- The service provided training in the Mental Health Act (MHA) and 82% of staff had completed this. Senior staff members had good knowledge of the MHA but therapeutic care workers had varied knowledge. However, we found their knowledge in areas they dealt with on a regular basis, such as reading patients their rights and knowing patients' leave requirements, was sufficient.
- Mental Health Act documentation to certify whether a detained patient had consented to treatment or to certify that a patient did not consent, or lacked capacity to consent, to treatment were available and completed correctly. They were kept in patients' care records and attached to their medicine charts.
- We spoke with the service's MHA administrator who had exemplary knowledge of the MHA. They were available to staff for advice and conducted regular audits that scrutinised MHA paperwork. We found MHA paperwork was in place within patients' care records and was completed correctly.
- Staff reminded patients of their section 132 rights in line with the provider's policy and the MHA Code of Practice. This was clearly documented within corresponding care plans.
- The service had access to an independent mental health advocate (IMHA), and their contacted details were displayed on both wards. All detained patients were automatically referred to them. The IMHA visited the ward weekly and was currently supporting a number of patients.

Good practice in applying the Mental Capacity Act

- All staff had received training in the Mental Capacity Act (MCA). Senior members of the multi-disciplinary team (MDT) had a good understanding of MCA principles and processes in ensuring patients capacity had been fully assessed. However, we found the MCA knowledge of

therapeutic care workers to be poor. They recognised their lack of knowledge and told us they would discuss any issues they had concerning patients' capacity with senior staff.

- The service had a MCA and Deprivation of Liberty Safeguards (DoLS) policy for staff to refer to. The service currently had no patients who were subject to a DoLS authorisation or awaiting a DoLS assessment.
- Patients' care records demonstrated evidence of informed consent, for example to share medical records, have their photographs taken and consent to treatment.
- The multi-disciplinary team had completed capacity assessments for all patients. We saw that these were decision specific and that detailed discussions had taken place to decide in what areas patients lacked capacity.
- The MDT arranged best interest meetings to support patients to make decisions. We saw how a patient, who was prescribed a medicine that was potentially harmful, was supported in deciding whether they wanted to continue taking it. The MDT involved nearest relatives, advocates and physical health specialists to ensure the decision was in the patient's best interest. We saw how this process continued to a second meeting to review the initial decision.

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

Good 

Kindness, dignity, respect and support

- We observed staff engaging with patients in a respectful manner and we found the wards to be calm and friendly environments. Staff made themselves available and there was an emphasis on ensuring detained patients were receiving escorted section 17 leave.
- We observed many examples of positive interactions between staff and patients whilst observing groups and activities. We observed two patient reviews where the multi-disciplinary team (MDT) fully involved the patients and gave them the opportunity to ask questions. The MDT was able to change their approach to suit different patients' needs and presentation.

Long stay/rehabilitation mental health wards for working age adults

Good 

- The majority of patients we spoke with felt that staff treated them with dignity and respect. They felt that recently staff had been more effective at motivating and reminding them to attend groups and activities. They told us that staff always knocked before entering their bedrooms. Patients' bedroom doors did not have observation panels, this meant staff had to enter bedrooms, if doors were closed, to carry out observations.
- Staff throughout the service understood the needs of individual patients. They told us that the recent focus on improving patients' care plans had helped them provide consistent care and treatment. They felt some patients were initially resistant to this approach but generally patients welcomed staff encouragement and overall patient staff relationships had improved.

The involvement of people in the care they receive

- The service had a clear admission process that included patients being fully orientated to ward and being provided with a welcome pack.
- Patients and staff co-produced care plans and risk assessments ensuring that patients' view were clearly captured. The multi-disciplinary team actively involved patients in all aspects of their care and treatment during bi weekly reviews. This was supported by the use of an overhead projector that allowed patients to see any changes or updates that were implemented.
- The service encouraged independence in a number of ways. Patients had the opportunity to work towards self-medicating and all had been supported by the occupational therapist to apply for a free bus pass. Patients had the opportunity to engage in therapeutic working in which they received minimum wage payment via high street vouchers. We saw examples of patients being taken off section as soon as appropriate to improve their access to the community.
- Advocacy services were available to support patients. We saw examples how they had been involved in best interest meeting and how an advocate was attending a patient's review on their behalf as they had delusional thoughts about certain staff members. Advocacy details were clearly displayed within both wards.
- The service had recently introduced a quarterly carers' forum. Three carers attended and four members of the multi-disciplinary team were available to answer questions. We saw minutes that showed carers asked lots of questions and were provided with information about their relatives' progress. We spoke with five carers who told us they felt their relatives were making good progress at the service. During our inspection we heard staff respond to a phone call from a carer that related to another service. They supported the carer and agreed to look into the issue on their behalf.
- The service invited patients and carers to complete the 'friends and family test' every six months. This survey asks how likely you would be to recommend the service to friends or family. Results for June 2017 showed that 62% of participants were likely or extremely likely to recommend, 15% were extremely unlikely to recommend and 23% were indifferent. The survey attracted 13 participants, all of who were patients. This was an increase from six participants from the previous survey.
- The service held a weekly community meeting that patients were invited to chair. We viewed minutes from recent meeting and saw that attendance was regularly high. Patients gave feedback about recent issues and staff updated patients and asked for suggestions on any forthcoming trips or activities. The service also held a monthly patient forum. This was chaired by the hospital manager who informed patients of any updates in the service.
- The service actively involved patients in the running of the service where possible. Patients have sat on staff interview panels and also been asked what questions the candidates should be asked. Patients also orientate new staff to the ward as part of their induction. The service also invites patients to attend the monthly clinical governance meeting.
- Patients had recently been involved in choosing the new ward furniture. One patient had been facilitating a healthy living group with staff support. Patients also had active input in maintaining the garden and participate in all annual garden competition organised by the provider.

Long stay/rehabilitation mental health wards for working age adults

Good 

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

Good 

Access and discharge

- Between 1 February 2017 and 31 August 2017, the average bed occupancy was 100% for Davenport ward and 68% for Sandown ward. Bed occupancy rates are a measure of available bed capacity and identify the percentage of beds that were occupied by patients during this time period.
- The service was able to admit patients from across the country; however, the majority of current patients lived and had their support networks locally.
- Patients were encouraged to take extended leave as part of their discharge plan. The service had a policy to ensure they would always return to their same bedroom.
- We saw an example of a patient being referred to the service's sister site in a neighbouring county. This had been discussed by the multi-disciplinary team and felt this improved the patient's opportunities for recovery. The patient had been able to visit the sister site before agreeing to the transfer.
- The hospital manager told us that a recent patient had required psychiatric intensive care services due to a relapse in their mental state. The service were able to find them an appropriate bed although this took a few weeks and required the service to put management plans and increased observations in place to support the patient.
- The service had a thorough approach to discharge planning. All patients had clear discharge plans and progress towards discharge was discussed during handovers, multi-disciplinary meetings and patients' reviews.
- The average length of stay for current patients was approximately two years. The service reported that five patients were currently ready for discharge but this was

delayed due to a lack of appropriate placements for them to move on to. The service had regular contact with care coordinators to ensure they were supporting discharge plans.

The facilities promote recovery, comfort, dignity and confidentiality

- Both wards had rooms where patients could be provided with therapeutic activities. They also contained a main kitchen where patients could prepare meals, a kitchenette to prepare hot drinks, a dining area and a day area with a television.
- Both wards had quiet rooms where patients could meet visitors. They also had access to a larger room in the basement if children were visiting. Most patients used their own mobile phones to make private calls if they agreed to disable the camera facility. Patients also had access to a phone on the ward if required.
- Both wards had access to separate outside garden areas that were well maintained.
- Patients told us the quality of food was good. All food was purchased by patients or the service at local supermarkets. The service was awarded a food hygiene rating of very good by the local authority in January 2017.
- Patients were able to access the main kitchen and kitchenette for snacks and hot drinks 24 hours a day.
- All patients had their own bedroom with en-suite facilities. There was a communal bathroom on each ward that contained a bath. Patients were able to personalise their bedrooms and allowed items such as televisions and radios providing they had appropriate appliance checks. Patients had keys to their bedrooms so they could take ownership on protecting their belongings. All bedrooms had a small lockable space where patients could keep valuables or their medicine if they were self-medicating.
- The service advised patients not to keep large amounts of money on their personals or in their bedrooms. They had a system in place which allowed them to distribute patients' personal and budgeting money to them. One patient told us that there was sometimes a delay in them getting their money. We discussed this with the hospital manager who was aware of this issue and showed us that it had been added to the local risk register.
- The service offered a full range of activities, both therapeutic and recreational. Patients had access to a

Long stay/rehabilitation mental health wards for working age adults

Good 

pool table and arranged competitions, karaoke nights, board games and film nights. The service also arranged activities and trips during the weekend. Patients had recently been on a boat trip and had activity days where birds of prey and reptiles had been bought into the service.

Meeting the needs of all people who use the service

- The service was accessible by patients or visitors with limited mobility and doors were wide enough to allow for wheelchair access. A lift accessed both wards and the basement area.
- We spoke with the provider's assessment and clinical audit nurse who told us that patients would only be excluded if they had chronic physical health conditions that required regular specialist support. This nurse had a background in physical health nursing, neurology and working experience of mental health. All assessments that they carried out were discussed with the multi-disciplinary team before they were accepted for admission.
- All current patients had English as a first language. We were told that patients with language needs could be supported by the service and were told that this had occurred at the sister site. Staff told us they would liaise with the advocacy service if they needed to access interpreter services.
- Both wards displayed information for patients on a range of subjects. These included how to contact local solicitors, advocacy services, how to make complaints, health living information and activities and group in the local area.
- Patients self-catered within their own food budget and were involved in social cooking on the ward. This allowed them to choose food that met their dietary or religious requirements.
- Patients had access to a multi-faith box which contained a prayer mat and a copy of the Quran. Some patients accessed local church services in the community and a chaplain visited the service fortnightly.

Listening to and learning from concerns and complaints

- Between 1 May 2016 and 30 April 2017 the service had received five complaints, four of which had been upheld. These related to patients disturbing neighbours whilst in the garden area, visitors being unhappy with customer service and a patient being unhappy with how

they were spoken to by staff. The service addressed these complaints with actions such as apologies and extra staff training. Within the same period the service received five compliments.

- Patients were aware that the complaints process was included in their welcome packs and displayed on the ward.
- Staff knew how to handle complaints appropriately. The community meeting was used to discuss informal complaints. However, they were aware that patients should be advised to write to the hospital manager if the complaint could not be managed informally. The hospital manager would then send the patient an acknowledgement letter and have the complaint investigated by someone independent from the ward.
- The hospital manager told us that complaints would be discussed at team meetings and used to identify learning.

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

Good 

Vision and values

- The provider did not have a specific statement of vision and values. However, staff told us their aim was to support patients to achieve their maximum potential. Staff enthusiastically told us about recent improvements made in areas such as care plans, physical health monitoring and patients' nutritional needs. They were proud of their work and the progress patients were making.
- All staff spoke highly of the hospital manager and found them approachable. They were often on the wards supporting day to day clinical practice. Staff were aware who other senior managers were who worked across the provider's sites. They told us they regularly visited the service and were generally approachable.

Good governance

Long stay/rehabilitation mental health wards for working age adults

Good 

- The service had systems in place to ensure staff training and supervision remained up-to-date. The hospital manager conducted audits to ensure staffing levels were sufficient to deliver patients care safely. Staff were involved in clinical audits relevant to their roles.
- Regular meetings and systems were in place to ensure incidents, complaints and safeguarding referrals were discussed across the service and wider organisation.
- The service adhered to a comprehensive programme of audits that were centrally led by the provider. Senior managers used these effectively to monitor the performance of the team.
- The hospital manager received sufficient administration support from a general manager and Mental Health Act administrator. The service had senior nursing staff who maintained oversight of day to day ward activity.
- There was a service level and organisation level risk register. Senior managers updated these and discussed them at governance meetings. The hospital manager knew what needed to be added to or removed from the risk register, and whether it required escalating to the organisation level risk register. The risk register for the service, including action plan, was accessible to staff and they were encouraged to add to it.
- Staff did not report any concerns with bullying or harassment. However, some members of staff felt excluded from communication links after they had expressed their intention to leave the service.
- Staff were aware of the whistleblowing policy and all were confident to report concerns to their managers without fear of victimisation. Staff were also aware they could whistle blow externally to the Care Quality Commission to maintain anonymity. This information was clearly displayed on both wards.
- Staff morale was generally high. Staff spoke enthusiastically about their jobs and the satisfaction they received from seeing patients make progress. The whole staff team worked well together and complimented each other's good practice.
- The service had recently developed a senior therapeutic care worker role to increase opportunities for staff progression and encourage staff retention. The service was supporting nursing staff to achieve their mentorship qualification and was keen to attract student nurses in the future.
- Staff had the opportunity to give feedback. An example of this was how the whole team had collectively improved patients' care plans and their approach to addressing their nutritional needs.

Leadership, morale and staff engagement

- Between 1 May 2016 and 30 April 2017, the service had a staff sickness rate of 6%. The hospital manager monitored staff sickness and absence rates. They had appropriate support from the provider's human resources team. Staff that required extended time off due to illness or personal issues were appropriately supported.

Commitment to quality improvement and innovation

- The service was not currently participating in any national quality assurance programmes. However, the multi-disciplinary team delivered care and treatment in line with current evidence-based practice and national guidelines.

Outstanding practice and areas for improvement

Outstanding practice

The multi-disciplinary team had absolute oversight of all their patients. This ensured that patients had a well-defined pathway towards recovery and rehabilitation. The team involved patients in all aspects

of their care and treatment. Particular attention was paid to important areas such as, physical health monitoring, nutritional needs, promoting independence and discharge planning.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that information on the building's fire risk assessment is up to date and accurately reflects organisations that have carried out the most recent safety checks. There should be an identified fire safety lead on each shift.

- The provider should ensure that therapeutic care workers are supported to gain a clear understanding of the Mental Health Act and Mental Capacity Act and how it relates to their practice.
- The provider should ensure the system by which patients gain access to their money is robust and mitigates against potential delays.