Cambian - The Sedgleys Hospital (Sedgley Lodge & Sedgley House)

Quality Report

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

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.

Summary of findings

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

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

Overall summary

We rated the Sedgleys Hospital as good because:

- There had been a recent and detailed ligature risk audit of the service. Clinic rooms were well maintained, medication was stored appropriately and emergency equipment was checked daily. All communal areas and clinical areas were visibly clean and records to check this were maintained by domestic staff. Staff carried out Infection control audits frequently.
- Staff sickness rates for the previous twelve months were low. All shifts were covered by staff of a suitable skill mix and experience. Staff attendance at mandatory training was high and included training in the 2015 Mental Health Act updated Code of Practice, the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Risk assessments were present in all care records and were detailed and in date. Care plans were holistic and contained a wide range of identified needs to support patients during their recovery. Regular meetings took place to review patient risks and adapt the care provided.
- Medication audits and reconciliation were carried out regularly by qualified staff. Controlled drugs were audited daily and increased safeguards were in place when they were dispensed by staff.
- Recognised outcome measures, assessment tools and rating scales were used by all disciplines to measure the effectiveness of the interventions they were providing for patients. Psychological interventions were available for patients to access in line with guidance from the National Institute of Health and Care Excellence (NICE).
- Staff employed by the service were suitably qualified and skilled and the provider had carried out the necessary checks prior to staff commencing employment.
- Specialist training was available for staff to support them in their role alongside mandatory training offered by the provider.
- We observed high levels of interactions between patients and staff of all disciplines and grades. Staff demonstrated a good knowledge of individual patients needs and wishes and were respectful, kind and courteous towards them.
- Feedback from carers of people who used the service was excellent. Carers said they felt their opinions were listened to and valued. Stakeholders that we spoke to also provided very positive feedback.
- There was an established care pathway in place in the service and patients were able to identify goals for their recovery and future discharge.
- Activities were available seven days a week. Most patients we spoke with said that the food provided was of a good quality and sufficient variety. Dietary preferences were catered for and feedback was sought through weekly patient meetings and annual patient surveys.
- All complaints that had been received by the service had been investigated in accordance with the services complaints policy.
- Staff that we spoke with knew the organisations values and could tell us how they were used to provide high quality care. The registered manager said she had sufficient authority and autonomy to carry out her role.
- There were effective and robust systems for information and clinical governance in place at a local and provider level. Data regarding the performance of the service was collated regularly, reviewed and benchmarked against other services.
- Staff said they felt able to contribute to the running of the service and that their views were listened to and respected.

Summary of findings

Contents

Good

Cambian - The Sedgleys Hospital (Sedgley Lodge & Sedgley House)

Services we looked at:
Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Cambian - The Sedgleys Hospital (Sedgley Lodge & Sedgley House)

The Sedgleys Hospital has 34 beds in total.

- Sedgley house is a 20 bedded locked psychiatric rehabilitation hospital for men with mental health conditions. It caters for males from the age of 18 years upwards who require specialist care from nursing, support workers, psychiatry, occupational therapy and psychology. Patients may or may not be sectioned under the Mental Health Act 1983.
- Sedgley lodge is a 14 bedded locked psychiatric rehabilitation hospital and is the next step for recovery from Sedgley house. It caters for males who are 18 years old and above and who may or may not be sectioned under the Mental Health Act 1983. The environment helps to facilitate a greater level of community participation and the patients are encouraged to develop their skills further to help them prepare for life within a less supported environment.

Regulated activities that Sedgleys Hospital is registered with the CQC to provide are:

- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the mental health act 1983/2007.

At the time of our inspection a registered manager was in place and had been since 2015. The registered manager was in the process of applying for controlled drug accountable officer status.

There have been three previous inspections at the Sedgleys Hospital, the most recent of these was March 2013 using the CQC's previous inspection methodology, the essential standards. The Sedgleys Hospital was rated as compliant with the essential standards as of April 2013.

Our inspection team

Team leader: Jon Petty, CQC inspector (Mental Health).

The team that carried out this inspection comprised five CQC inspectors, a specialist nurse advisor, a specialist psychologist advisor, a Mental Health Act reviewer and an expert by experience.

Experts by experience are people who have experience of using or caring for someone who uses health and/or social care services. The role involves helping us hear the voices of people who use services during inspections and Mental Health Act visits.

Why we carried out this inspection

We inspected this service as part of our on-going 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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- carried out a tour of the ward environments, looked at the quality of the premises and observed how staff were caring for patients
- spoke with nine patients that were using the service
- reviewed twenty care and treatment records of patients
- spoke with three carers of patients using the service
- spoke with the registered manager of the service, the head of care for the lodge and the house and the regional director of operations for the provider
- spoke with twelve other members of staff including doctors, nurses, support workers, occupational therapists, domestic staff and psychologists
- carried out a specific check of the medication management including a review of twenty nine patient's prescription cards
- received feedback from a range of stakeholders, including the local independent mental health advocacy service
- attended a media group with patients
- attended and observed a morning handover meeting with the multi disciplinary team and a care review meeting
- carried out a Mental Health Act review of the paperwork of four patients detained under the Mental Health Act 1983/2007
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Most patients spoke very highly of staff and said they were treated well and liked the staff that worked with them. Two patients we spoke with raised concerns that the night staff did not interact with them, although, in both cases the patients were complimentary of the day staff.

Carers that we spoke with described the service as excellent. All carers said they felt involved in the care planning process, were regularly invited to review meetings, and their views and wishes were respected and listened to.

We spoke with a variety of stakeholders to gain their views prior to our inspection. Feedback from all stakeholders was positive. Community teams and commissioners described the hospital as having a flexible and committed approach to patient care. One stakeholder described the service offered by the multi-disciplinary team at the hospital as outstanding.

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?

Good

We rated safe as good because:

- Staff had completed a ligature risk audit of Sedgley lodge and Sedgley house in February 2016. An internal and external building risk assessment had been completed in June 2015 and all identified risks had plans in place to mitigate them.
- All communal and clinical areas were visibly clean and detailed records of the cleaning processes were complete. Emergency equipment was checked regularly and all records relating to this were also complete. Medication audits and reconciliation were carried frequently by qualified staff and all medication was stored securely.
- Staff sickness rates were low at 5% for the twelve month period prior to our inspection. Agency staff were not used and bank staff received inductions and mandatory training by the provider. Attendance at mandatory training was high.
- Out of hours medical cover for the service was provided by doctors familiar with the service and patients.
- Detailed risk assessments were available for all patients within their care records. These were updated frequently and patient's risk was reviewed on a daily basis by the clinical team.
- Blanket restrictions that had previously been in place were being discontinued. A contraband list was no longer in use and patients were not searched routinely on their return from leave.
- Staff and patients told us that restraint was only used as a last resort when all other interventions had failed. Staff involved in the restraint of patients had been suitably trained and governance systems were in place to record and audit the use of restraint in the service.
- Staff knew how to report incidents and there were robust governance structures in place to support them in doing so and for them to receive feedback from investigations.

However:

- Some staff said there was not always access to personal alarms, particularly if visitors to the hospital required them. The registered manager was aware of this however and extra personal alarms had been ordered to ensure staff safety.
- Four patient bedrooms had noticeable urine odours. This was brought to the managers attention at the time of our inspection and the manager subsequently confirmed it had been replaced.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Most care records contained detailed and holistic care plans. Discharge planning was evident in all care records reviewed and goals for recovery were jointly agreed with patients. Well structured and effective staff handovers and multi-disciplinary team meetings took place daily and included a review of all patients and an updated risk rating for the previous 24hr period when required.
- Standardised assessments and outcome measures were in use by members of the MDT. Psychological interventions were available for patients in line with guidance from the National Institute for Health and Care Excellence.
- There was evidence of physical health needs being assessed and monitored, and effective links had been established with the local general practice. Medication was prescribed in line with national guidance and regular audits were completed to monitor this.
- Care records were stored securely and staff said they could access them when needed. Electronic systems were used for the collation of data for key performance indicators for the service and this was benchmarked against national services by the provider.
- A full range of mental health disciplines were available to work with patients. Staff employed by the service had received appropriate checks to ensure they were skilled and qualified to provide quality care. Management systems were in place to monitor poor staff performance.
- Staff were able to access specialist training for professional development. Supervision was taking place frequently and 89% of staff had received this at the time of our visit.
- There was positive feedback from all stakeholders that worked with the service. They said that the service communicated effectively with them and offered a flexible and committed approach to patient care.

However:

- Appraisal rates were 70%. The registered manager was aware of this and was taking steps to resolve this.
- Some care plans were written in a way which did not always evidence collaborative working with patients and appeared prescriptive in style.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- We observed high levels of interactions between patients and staff of all disciplines and grades. Staff were respectful and displayed a good knowledge of individual patients and their needs.
- We observed staff maintaining confidentiality when discussing patient care and being vigilant when they felt confidentiality could be compromised.
- Patients that we spoke with said they had been offered copies of their care plans. Staff had also developed individual files for patients to store documentation including care programme approach paperwork. Patients were able to store this paperwork securely in their bedroom or in a locked cupboard in the nursing office.
- Access to independent mental health advocacy services were available for patient use and were commissioned by the local authority in adherence to guidance from the 2015 Mental Health Act Code of Practice. Feedback from the advocacy service relating to patient care was positive,
- Carers that we spoke with said that the service they received was excellent, they reported that their views were respected and valued and the service communicated regularly and effectively with them.
- Community meetings were held weekly. Annual patient surveys were commissioned by the service and the responses from patients were positive in most areas.

However:

- Two patients reported that they felt the night staff did not interact with them. They had raised this with the head of care at the time of our inspection.
- Patients had identified through the patient survey they would like further information about the providers complaints process.

Are services responsive?

Good

We rated responsive as good because:

- In the 12 months prior to our inspection the average bed occupancy for the hospital was 98%. There had been 14 admissions to the hospital and 18 patients had been discharged.

Summary of this inspection

- An established care pathway was in place and patients had an identified journey through the service from Sedgley house to Sedgley lodge.
- A range of rooms and facilities were available for patients including therapy kitchens, lounges and outside areas. There was also a multi faith room available for patient use and this had prayer mats available if required.
- There was access to group and individual activities seven days a week. Patients were given the opportunity to undertake paid activities contributing to the running of the service.
- Most patients that we spoke with said that the food was of good quality and there was sufficient variety of menu options provided. All meat used was halal approved although patients could choose to use alternatives when preparing meals as part of their therapeutic activity timetable.
- Interpreting services had been used to support patient and family involvement in the care planning process where English was not their first language.
- All complaints that had been received had been investigated in accordance with the services complaints policy. Duty of candour was evident and the registered manager had provided responses to complainants detailing outcomes and actions taken to resolve concerns.

However:

- Carers, patients and stakeholders raised concerns that the visitors room at Sedgley house was too small. The registered manager and staff acknowledged this however, and enabled visitors to use the services board room if necessary.

Are services well-led?

Good

We rated well-led as good because:

- Staff that we spoke with were aware of the organisations values. Staff knew who the senior managers were in the organisation and reported good working relationships with them.
- Mandatory training levels were high and the average attendance rate for all staff was 87%. Supervision happened regularly and in accordance with the providers policy.
- There were robust and effective governance systems in place on a local and provider level. Regular meetings took place to review data relating to the services key performance indicators.
- All shifts were covered by staff that were suitably skilled and in accordance with the provider's safe staffing tool. Sickness rates

were low at 5% for the twelve months prior to our inspection. At the time of our inspection there were no grievance procedures being pursued within the team and there were no allegations of bullying or harassment
- Systems were in place to audit the effectiveness of the service. There was a programme of planned audits to cover items including ligature risks assessments, medication management, completeness of care records, staff education and training and patient involvement in therapeutic activities.
- There were opportunities for staff development and the head of care for Sedgley lodge had been promoted internally. The care certificate standards were used with healthcare support workers and all staff had received an induction to the service.
- Morale within the staff team was good. Staff described being well supported and said there was a non hierarchical approach to patient care. Staff told us their views were listened to and respected by members of the multi-disciplinary team and the registered manager.

However:

- Appraisal rates were low at 70%. The registered manager was aware and taking steps to resolve this at the time of our inspection.
- Staff turnover had been high in the previous year and 24% of staff had left. This number included bank staff and staff that had failed to satisfactorily complete their probation period. Some members of the MDT had raised concerns that they were not always able to complete role specific work and could be asked to undertake generic tasks.

Detailed findings from this inspection

Mental Health Act responsibilities

- We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in reaching an overall judgement about the provider. At the time of our inspection, Sedgley hospital had 30 patients detained under the MHA and two patients that held informal status. A MHA reviewer visited the hospital as part of this inspection and completed a MHA monitoring visit and reviewed the detention documentation for four of the detained patients at Sedgely lodge. A MHA monitoring visit for Sedgley house was completed in September 2015.
- At the time of our inspection 74% of staff had received training in the updated 2015 MHA Code of Practice. Most staff were able to discuss with the inspection team what the guiding principles of the MHA were and how this impacted on patient care. Some staff we spoke to said they were awaiting training in the MHA, we fed this back to the registered manager who told us future training dates were being made available.
- There was evidence patients had been given information in accordance with Section 132 on admission. This included information about their right to an Independent Mental Health Advocate (IMHA). Patients told us they had been given information about their rights. According to a note on one file this information was supposed to be revisited every three months but we did not find evidence this always happened, one informal patient had also been offered information when he was re- admitted but had refused. There was no evidence this had been revisited.
- Copies of detention papers were available on patient files and were in order. However, we did not find copies of approved mental health practitioner reports on the file of one patient detained under Section 3 of the MHA.
- There was evidence managers' hearings had been held when detention for patients subject to the MHA was renewed. Patients told us they were aware of their right to appeal to a tribunal and an informal patient that we spoke with had been previously discharged via this process.
- All detained patients had medication authorised on either a form T2 or T3. Detained patients being administered medication for longer than three months must have a T2 or T3 form in place. A T2 form is used when a patient who has capacity agrees to take medication after three months detention. A T3 is provided by a second opinion appointed doctor (SOAD) when a person who lacks the capacity to consent to medication remains on medication after the first three months detention, or the patient has capacity but does not agree to taken their medication.
- All patients had been granted Section 17 leave which was authorised by the responsible clinician (RC) on standardised forms. The forms specified the length and frequency of leave and also the number of escorts required for those granted escorted leave. The forms stated the nurse in charge could withhold any episode of leave. Although leave was reviewed at monthly ward rounds we did not find evidence that episodes of leave were routinely reviewed with one patient. The leave forms of patients subject to restriction orders did not refer to Ministry of Justice approval although we found the appropriate letter authorising the RC to grant leave on the patient's file.
- On some files we did not find a clear assessment of capacity or record of discussion around consent. We noted that the T2 forms used required the RC to confirm they had made an entry in the medical records. On most files of patients reported to be consenting to treatment we were unable to find evidence they had been given the information required for them to give informed consent.
- We found no assessment of capacity or record of discussion about consent on the file of one patient who was no longer subject to detention.
- A MHA administrator was employed by the hospital and worked on a full time basis, they worked with staff to monitor completeness of the MHA paperwork and to carry our regular audits. Case tracking audits were completed three times a year. These reviewed MHA paperwork completeness, details of whether patients consent to treatment was contained within notes and whether section 132 rights had been read to patients on a regular basis and the most recent copy was in date.
- There was evidence that patients had access to the local IMHA and staff reported good links with the service. We spoke to an IMHA that worked with the hospital and

they reported they visited fairly regularly, patients were informed about their rights and had access to the complaints process if they had concerns, which they had seen in action and which worked well.

Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of our inspection 74% of staff had received training in the Mental Capacity Act (MCA).Most staff were able to discuss with the inspection team what the guiding principles of the MCA were and how they used these principles in their clinical work. Training in the MCA was completed as part of the induction process and annual refresher training sessions were mandatory.
- There had been no Deprivation of Liberty Safeguards (DoLS) applications made by the hospital in the twelve months prior to our inspection and no patients were subject to DoLS at the time of our inspection. The provider had a DoLs policy in place and this was available via the intranet for staff to access for guidance.

Overview of ratings

Our ratings for this location are:

	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:

- The layout at Sedgley lodge allowed staff to observe most parts of the ward. Where blind spots were identified, this was mitigated in most instances by either staff presence or the use of mirrors positioned on the walls and ceiling areas. During the inspection process we identified that there were blind spots on the first floor of Sedgley house without measures in place to safely mitigate them. The first floor of the house contained patient bedrooms and staff offices which mean there was a potential for staff to be lone working in this area. We raised our concerns with the registered manager who acknowledged that although staff used personal alarms and there was often a staff presence in the area it could be a risk. The estates department were contacted and were planning to visit the service on the day following our inspection to review and make adaptations where required. A follow up visit to the service a week after inspection showed that mirrors had been installed to mitigate the risks identified.
- The heads of care for each building completed a full ligature risk assessment in February 2016. The ligature audits were reviewed as part of our inspection process and included the internal and external environment of the lodge and the house. Each audit contained information of ligature risks identified and the actions that were required by staff to mitigate them. All patients referred to the service had a risk assessment completed which included historical risk of the use of ligatures and this was taken into account when deciding whether the service would be able to adequately maintain their safety. Staff we spoke with during the inspection described how the providers observation policy could be used to support patients that were felt to be at increased risk of the use of ligatures. All patients support needs were reviewed daily at shift handovers and at a multi-disciplinary handover attended by representatives from all professions and medics. During our inspection of Sedgley lodge, we identified that the taps in patients bedrooms could potentially be used to form ligatures and this did not have specific reference to it within the recent audit or actions required to mitigate the risk. This was brought to the attention of the registered manager and regional operations director and the audit was reviewed and updated. A copy of this was made available to us.
- The service provided care for male patients only. All patients had keys to their bedrooms and were able to access them 24 hours a day following a risk assessment by the MDT that they would be safe to do so. All bedrooms had en-suite facilities.
- The clinic room at Sedgley house was visibly clean, and completed cleaning records were available and checked by the inspection team. An examination couch was available for physical health assessments with single use aprons and replacement single use couch covers. Daily checks of the defibrillator equipment were recorded by staff and were reviewed and found to be completed without gaps for the previous three months. A controlled drugs register was in use and daily checks had been completed for the six months prior to our inspection without any checks being missed. Body fluid

spills kits were available for staff use and where sharps bins had been used these were not overfilled and a contract was in place with an external service for their safe disposal. Fridge temperature and room temperature checks were completed in the clinic room daily and no checks had been missed in the previous four months. The registered manager had recently submitted an application for controlled drugs accountable officer status. The key to the controlled drugs cupboard was held within a safe in the clinic room and the access code to the safe was available only to qualified nursing staff and managers. An alarm system was in place and sounded throughout the building to alert staff whenever the controlled drugs cupboard was accessed.

- All ward areas were visibly clean, had comfortable furnishings including sofas and fish tanks and were well maintained. A contract was in place for the fish tank to be cleaned by an external specialist company.
- A quarterly infection control checklist had been recently completed for Sedgley lodge and Sedgely house. The audit reviewed communal areas, bedrooms, clinical areas and domestic areas including the laundry and sluice room and 85% of areas were found to meet the required standard for cleanliness and maintenance. Areas that did not meet the required standard had action plans with timescales for work to be completed.
- Domestic staff completed daily and weekly cleaning schedules and checks, we reviewed these for the two months prior to our inspection and found them to be complete. All bedroom areas had a weekly deep clean by domestic staff however we noticed an odour of urine in the stairs area at Sedgley house and in four of the patient bedrooms, this was brought to the attention of the registered manager who acknowledged this and contacted the facilities department to have the flooring replaced, this work was completed and confirmation of this was provided to us following our inspection.
- The registered manager, senior staff and the maintenance department completed a comprehensive internal and external building risk assessment in June 2015. All identified risks had detailed plans in place to mitigate them and the risk assessment was reviewed annually. Safety testing stickers were in place on electrical items including the fridges in patients kitchens and were in date. Fire extinguishers were available for use and were checked regularly and in date.
- Staff adhered to infection control principles. Hand-washing spray and gel was available for all staff at entrances to the building and in communal and clinical areas and we saw staff using this regularly. Hand hygiene technique checking and audits were completed individually with all staff.
- All staff at Sedgley house had access to personal alarms with an electronic system in place that enabled staff to identify the location where the alarm had been activated. All staff we spoke to were aware of how this alarm system worked and describe how they would use them. Staff at Sedgley lodge raised concerns that there were occasions where there were insufficient personal alarms due to them being issued to visitors to the unit. The registered manager was aware of this at the time of our visit and extra alarms were being delivered the day following our inspection.

Safe Staffing:

- At the time of our inspection there were 11 whole time equivalent (WTE) qualified nurses employed by the provider and 32 WTE nursing assistants. There were three WTE qualified nurse vacancies which had been recruited to and were awaiting start dates. There were seven WTE nursing assistant vacancies, interviews were planned to recruit to these vacancies the day after our inspection.
- Staff sickness rates were low with an average of 4.6 % for the twelve month period prior to inspection. Staff turnover was high for the previous year, with 20 leavers of a total substantive team of 83 (24%). The registered manager attributed the high turnover to a variety of reasons, including staff that had started the job and not successfully progressed through their probation period and staff that had left the hospital to work at a nearby newly opened hospital by the provider.
- The registered manager used a staffing analysis and minimum staffing level tool developed by the provider to ensure all shifts had a suitable number of qualified and unqualified staff to ensure patient safety. The staffing level estimate for the service reflected current and historical risks of the patients using the service, staff training competencies and included the procedure to be followed if staffing levels needed to be increased to ensure patient safety.
- Day time staffing levels at Sedgley house were two qualified nurses and six nursing assistants, at night this was decreased to two qualified member of staff and four

nursing assistants. Day time staffing levels at Sedgley lodge were two qualified nurses and four nursing assistants, at night this was decreased to one qualified member of staff and three nursing assistants. Staffing rota's were reviewed daily as part of the morning MDT meeting and could be changed to meet the needs of the service. The registered manager was able to request increased staffing levels to take into account the case mix of patients. The daily safe staffing levels did not take into account the hospital manager; head of care, and core multi-disciplinary staff. This meant that there were always available staff to provide extra support for patients if required. We reviewed a request by the registered manager to the regional operations director to increase staffing temporarily to manage high level observations. The request was responded to positively within seven minutes, via e-mail.

- Agency staff were not used by the service. Bank staff usage for the six months prior to our inspection was 13%.The registered manager was able to access a bank staff co-ordinator employed by the provider, this meant that bank staff were often familiar with the service and the patients needs and had received a provider specific induction and training.
- A minimum of one senior nurse was on duty every shift and maintained a presence in the ward area. Senior nurses were supported during day shifts by a dedicated head of care for the house and the lodge, this was a senior staff member not included in the shift numbers and who provided an oversight and support function for the service.
- Patients told us that staffing levels ensured that they received planned face to face sessions with their named worker and that they could access staff support as and when required. Most staff Staff reported no concerns about staffing levels. Patients reported activities were sometimes cancelled due to staff shortages, but leave generally went ahead as planned. The hospital monitored the provision of activities and leave as part of their key performance indicators each week. The hospital aimed for 25 hours of meaningful activity each week and monitored how many patients were active by 10am each day. In the month prior to our inspection, Sedgley lodge had recorded 100% of patients having received 25 hours of meaningful activity, Sedgley house had recorded 75%.
- Medical cover was provided for Sedgley house and Sedgley lodge by a consultant psychiatrist and a specialty registrar grade doctor. Out of hours on call medical cover was provided by the consultant psychiatrist during weekdays. On call medical cover was provided at weekends through a regional on call rota with support from the consultant psychiatrist if required. Staff told us the system worked well and there had been no occasions where they had not been able to access medics when required.
- Staff had received and were up to date with mandatory training. This included the management of violence and aggression, responding to emergencies, information governance and infection control. The average training rate for all staff was 87%. Attendance at fire warden training was below 75% and 69% of staff had attended this. A training calendar was available for staff and the registered manager reviewed training as part of the supervision and appraisal process.

Assessing and managing the risk to patients and staff:

- There were no reported incidents of seclusion or segregation in the six months prior to our inspection. The service did not seclude patients and a policy was in place to inform staff of the definition of seclusion under the Mental Health Act (MHA) Code of Practice to ensure that de-facto seclusion did not occur.
- There were twelve incidents requiring the use of restraint in the six months prior to our inspection. Prone restraint was not used in this location. Where restraint was used, the staff detailed the type of restraint used in accordance with training they had received in the management of violence and aggression. We reviewed all the records relating to the use of restraint. Staff recorded the type of restraint used, the duration of the restraint and which staff had been involved, including who had been responsible for each body part of the patient. Patients were offered access to de-briefs following restraint being used.
- Staff completed the short term assessment of risk and treatability (START) risk assessment for each patient following their admission. This was an evidence-based tool that assessed future violent and risk behaviours in the short term and identified risk to self and others through structured professional judgements. Repeat assessments captured attitudes and behaviours over time to evaluate patient progress. The risk assessment

contained a summary sheet detailing identified risks for each patient, grading of whether the risk was identified as high or low and details of plans to manage the identified risk. Each patient had identified strengths and vulnerabilities and a risk formulation taking these factors into account. Staff undertook regular reviews of the START risk assessment as well as a daily risk assessment of each patient as part of the planned shift handovers.

- The daily risk assessment was a Cambian document that consisted of a checklist of key risk behaviours in areas of neglect, suicide, and violence. It had a brief risk management plan focussing on risk reduction and identifying leave status. Each patient had a coloured rating of red, amber or green depending on their presentation and behaviour over the previous twenty-four hours. Staff shared the risk status of each patient with the senior management team at each morning meeting. The consultant psychiatrist and the specialty registrar attended the daily morning meetings at the house and lodge individually and met following this to discuss any incidents that had occurred and to ensure information sharing and consistent approaches to patient treatment.
- Activities that were planned to take place had an activity risk assessment screening tool completed. This included whether the activity was a high or low risk and included all activities from horse riding to making drinks. Occupational therapists completed community risk assessments for patients including road safety.
- The registered manager told us that they were attempting to reduce the use of blanket restrictions with patients. The service previously had a contraband items list in place that applied to all patients. The manager had recently removed this restriction however some individual care plans still included lists of items forbidden in the hospital. These appeared generic and did not appear to be linked to risk assessments of individual patients. We brought this to the attention of staff at the time of our inspection. Patients were able to see visitors in their bed space following a risk assessment and staff gave us examples where this had happened.
- All detained patients at Sedgley house were subject to pat down searches on their return from leave. The providers current search policy was under review at the time of our inspection however, the previous version was still valid and in place and stated that " a search of any kind must only be exercised where there are reasonable grounds to believe that the search is necessary". The use of searches on all patients could constitute a blanket restriction under the MHA Code of Practice 2015. We brought this to the managers attention at the time of our visit who reviewed it with the regional operations director. An update was provided that the hospital would in future only be carrying out searches of patients on their return from leave where there was an indicated risk and this would be individually care planned with the multi-disciplinary team. Random room searches were not carried out, any room searches that did take place were responsive to individual risks identified by staff.
- A policy on the use of observation and engagement was in use and staff could access this via the providers intranet. There were also paper copies available for staff to review. Daily reviews of each patient were used to determine appropriate levels of observation to ensure patient safety and that levels of observation were decreased in a timely and responsive way. All qualified nursing staff were able to increase observation levels for patients in response to a change in their risk presentation. The consultant psychiatrist or specialty registrars authorisation was required to decrease observation levels following discussion with the MDT. All patients were subject to a minimum of hourly observations at night. During the night this necessitated staff opening some bedroom doors as they did not have observation panels. Some patients told us this disturbed their sleep and that some night staff banged doors. The registered manager informed us that patients were able to opt out of hourly night time observations in negotiation with the MDT and a review of their risks. However, we did not see evidence of this in practice.
- All staff and patients we spoke with told us that restraint was only used as a last resort to manage patient and staff safety. Most staff (84%) had been trained in the management of violence and aggression (MVA), including bank staff . Those staff that had not yet received MVA training were not able to be involved in restraining patients.
- There were five occasions where the service had used rapid tranquilisation with patients in the six months prior to our visit. A policy and procedure was in place to provide guidance for staff in the use of rapid tranquilisation and to ensure adherence to the National

Institute for Health and Care Excellence (NICE) guidance (NG10) for the short term management of violence and aggression in inpatient and community mental health settings. When staff had administered rapid tranquilisation they had completed physical health monitoring forms and had recorded the patient's pulse, respiration and consciousness. Staff also used the adapted modified early warning system (AMEWS) to detect early warning signs of physical deterioration for patients who had been administered rapid tranquilisation. The AMEWS was completed every five to ten minutes for the first hour and then half hourly until the patient was ambulatory. Staff had completed an incident reporting form following every use of rapid tranquilisation and this was used as part of the governance monitoring and key performance indicator system to measure the effectiveness of the service.

- Staff we spoke with had a good clinical knowledge of the process of making a safeguarding referral and 91% of staff had received training in the awareness of safeguarding issues for children and adults. The registered manager described a very good relationship with the local safeguarding team. There had been three safeguarding referrals made in the six months prior to our inspection, all of these had been closed at the time of our visit. An updated safeguarding adults policy was in place from November of 2015 and was due for review in 2017. All staff had access to this via the services intranet.
- A service level agreement was in place between the hospital and the local pharmacy for the provision of medication. Staff said that medication was ordered monthly for both Sedgley lodge and Sedgley house and medication reconciliation was carried out weekly by the heads of care and nursing staff. A robust plan was in place for the monitoring and management of controlled drug administration. Two staff were required to sign at the point of administration and this was audited daily. The registered manager was also in the process of completing an application for the controlled drugs accountable officer status at the time of our inspection.
- Staff completed monthly medication checklists and a full medication audit was completed of the hospital every four months. This contained a review of the clinic room, the medication administration records and storage arrangements. Actions required were allocated to individual staff and time frames were specified for completion. Most patients prescription charts had photographs attached for identification and consent was recorded in all cases where photographs had been used.
- A policy and procedure for visitation to patients was in place and contained special consideration concerning child visitors. Children that visited the hospital were able to use a side access door to a visitors room, this meant they did not have to pass through clinical areas. Staff told us that they would do all they could to facilitate and maintain patient contact with family and children where appropriate and could access social services for support to do so if required.

Track record on safety:

- There had been no reported serious incidents requiring investigation at Sedgely Hospital in the 12 months prior to our inspection.
- Minutes were reviewed from an internal clinical governance meeting held in September 2015. Staff had identified that a patient had not returned from unescorted leave in the community at the allotted time and this remained unnoticed for 30 minutes. A chart was introduced for patients to sign on their return from leave to prevent this happening again.

Reporting incidents and learning from when things go wrong:

- All staff were aware of the procedures for incident reporting and received annual training in the procedures for dealing with concerns at work, 91% of staff had attended this at the time of our inspection. Incident reporting forms could be submitted by staff of all grades and were submitted monthly to the provider's central quality intelligence group for analysis of trends and themes and feedback was provided to the registered manager.
- A regional clinical governance group was held on a three monthly basis and a local hospital governance group was held monthly with representatives from all staff groups. Lessons learned from incidents that had happened nationally and locally were discussed at these meetings and minutes were emailed to all staff. A reflective practice group for staff was also chaired by the psychologist for the service. This gave staff the opportunity to discuss incidents and the effectiveness of the interventions used.

Long stay/rehabilitation mental health wards for working age adults

Good

- We reviewed the minutes from the last three debriefs that had been held, these included incidents where patients had been aggressive towards staff and an occasion where staff had provided support to a patient's family when delivering news of a family bereavement. There was evidence that lessons had been learnt as a result of the incidents that had occurred. Consideration was given to changing the hospital environment to remove items that could be used as weapons. Support had been requested from community teams to attend best interests decision meetings for patients where the management of finances had been identified as a trigger for violence or aggression.

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 reviewed 20 care records during the inspection. All contained a comprehensive assessment of patient needs completed at admission by a nurse assessor. The admission assessment included a review of previous risks, family history, physical healthcare needs and medication regimes, current and historical. The multi disciplinary team (MDT) at the hospital reviewed all assessments and made the final decision on whether they thought they could safely meet the patients needs, and whether they were at a suitable stage in their mental health recovery for a rehabilitation setting. All patients were required to have a minimum of eight weeks of stability in their mental health needs to be considered for placement at the hospital.
- Most care records reviewed had evidence of personalised, holistic and recovery focussed care plans although some were written in a way which did not evidence collaborative working with patients and appeared prescriptive. Discharge planning took place from the point of admission. Staff had developed individualised strategies for patients to manage their own care where possible. One patient had been provided with a laminated flip card list of their medication, with the packet labels cut and displayed for him. This had been developed to help the patient remember and learn about the medication he was prescribed and showed an ability of staff to adapt their care to patient need. Patients told us they were offered copies of their care plan, although we did not always find that they had signed to evidence this.
- Assessments of patients physical healthcare needs were present in all care records we reviewed. Physical health assessments were carried out by the hospitals consultant psychiatrist and specialist registrar and included the monitoring of lithium levels, weight and body mass index, and electrocardiograms. Staff reported strong links with the local general practice surgery and that patients were able to attend regularly for physical health check ups and blood tests.
- Patient treatment records were paper based and were stored securely. Staff told us they were able to access records when required, to update progress notes or assessments that had been completed by members of the MDT. Cambian also maintained an electronic data management system which was used for the monitoring of key performance indicators for the hospital, including patient hours of meaningful activity, bed occupancy, care programme approach (CPA) reviews and the timeliness of care planning meetings.

Best practice in treatment and care:

- The consultant psychiatrist and specialty registrar for the hospital completed all medication prescribing, there were no nurse prescribers in post at the time of our inspection. A policy and procedure for the administration of medication was in place and nursing and medical staff were able to describe how they could access it if required for guidance. A medication monitoring form was in use for patients prescribed above the British National Formulary (BNF) prescribing guidelines. The form recorded whether a patient had a history of cardiac impairment, hepatic or renal impairment or obesity. Patients prescribed above BNF limits also had an increased frequency of physical health monitoring, including electrocardiograms every three months.
- A clinical psychologist and two psychology assistants were in post at the time of our inspection and provided patients with access to 1:1 psychological therapies. This was in line with National Institute of Health and Care

Excellence (NICE) guidance for the treatment of depression (CG90) and the treatment of schizophrenia (CG178). Standardised assessments and outcome measures were also used by the psychology team and formed part of the MDT treatment planning and CPA review process. Assessments in use included the Becks depression inventory (BDI), the Becks anxiety inventory (BAI) and the Wechsler adult intelligence scale (WAIS).

- Access to physical health monitoring and routine checks were available via the local general practice surgery and staff and patients reported that there were effective links with this service. Nursing staff and medical staff reported that the surgery shared information with them regarding patients physical health checks.
- Staff completed recognised rating scales to measure the effectiveness of the clinical treatments and interventions that were being offered to patients, this included the health of the nations outcomes scales (HoNOS) and the model of human occupation screening tool (MOHOST). Analysis of patient progression in their recovery was reviewed at the local clinical governance meeting using the daily living skills outcome scale (DLSOS) to provide a percentage figure of patients that had progressed, made no change, or had relapsed. The outcome data that was produced by the hospital was shared nationally within Cambian every quarter.
- Clinical staff completed audits as part of an agreed Cambian schedule. The heads of care for the lodge and the house had completed a range of audits for their services, including; information governance, prevention of suicide, ligature risks, infection control, hand hygiene and case tracking. Audits were allocated thoughout the year with a variety of frequencies to ensure all topics were covered on a regular basis. Full medication audits were completed on a four monthly basis.

Skilled staff to deliver care:

- The hospital had a full range of mental health disciplines that made up the MDT. There were registered mental health nurses and nursing assistants. The occupational therapy department consisted of two occupational therapists and two therapy assistants and psychology was provided by a clinical psychologist with support from two psychology assistants. Social workers did not form part of the MDT, but were available from the NHS home teams that provided care for the patients when they resided in the community. The hospital employed maintenance, domestic, catering and administrative staff and representatives from each role were expected to attend the monthly local clinical governance group and staff meetings.
- Three personnel files were reviewed as part of the inspection process. Details of former work experience of staff and references of their suitability for their roles were found in all files. Disclosure barring services (DBS) certificates or reference numbers were also present and in date. Staff that were required to completed revalidation with professional bodies, including the nursing and midwifery council, had copies of their certificates also included in their files. All staff had completed an induction and probationary period and evidence to support this was available for the inspection team to review. Qualified nurses had access to a preceptorship development programme. Support workers had access to a role specific induction and were given copies of the care certificates standard booklet, which they were required to complete parts of before being able to work independently.
- Staff were given graded inductions to their work in the service. The responsible clinician had commenced his role with support from his predecessor and had a period without a caseload to familiarise himself with the service and spoke positively about steps taken to induct him thoroughly to his new role.
- Minutes of staff supervisions and appraisals were kept within staff's personnel files. At the time of our inspection, 88% of staff at Sedgley house and 89% of staff at Sedgley lodge had received supervision. Psychology staff received profession specific supervision on a monthly basis and had access to clinical case supervision via telephone if required, they were also able to access monthly psychology team meetings.
- The appraisal rate across both the house and the lodge was 70%. The registered manager said that this was lower than hoped and there had been discrepancies with how appraisals had been completed and recorded prior to her time in post which she was in the process resolving. Team meetings took place monthly and staff could be paid to attend if the scheduled meeting took place outside of their working hours.
- Staff were supported by Cambian to undertake specialist training and further education. At the time of our inspection there were two students being seconded and funded to undertake their registered mental health nurse training. There were also a number of other staff

undertaking training opportunities including two accessing higher education and one staff member training to be a social worker. The heads of care for the lodge and the house had both been on training to provide supervision for junior staff.

- Poor staff performance was monitored and managed through formal disciplinary processes when required. We saw evidence that staff had received formal warnings when investigations into concerns about their competence or conduct had been upheld. Sickness monitoring and use of the hospitals absence management policy had also been used where there had been concerns over repeated staff absences.

Multi-disciplinary and inter-agency working:

- Staff completed handovers twice daily at shift changes. Handovers provided staff with an opportunity to review all patients progress for that day, any changes in risk presentation or observation levels and review and develop management plans for patients that were experiencing a deterioration in their mental health.
- An MDT meeting was held each morning for both Sedgley House and Sedgley lodge, these were attended by the consultant psychiatrist, specialty registrar, heads of care and representatives of each discipline of staff.
- The MDT reviewed each patient monthly. We attended a care review as part of the inspection process. We found that staff worked collaboratively with patients and took time to understand their views and wishes. The care plan was developed using the patients words and staff negotiated safe treatment goals with the patient, taking into account their previous medication regime and risk history.
- Feedback from stakeholders and other organisations wereas sought prior to the inspection, including the local independent mental health advocacy (IMHA) service. Responses we received from all external sources were very positive. Community teams and commissioners described the hospital as having a flexible and committed approach to patient care. One stakeholder described the service offered by the MDT at Cambian as outstanding. All community teams said that they felt fully involved in all patient care decisions and were regularly invited to clinical meetings and reviews. Feedback from the mental health advocacy service that provided input to the hospital was that patients were happy with the day to day care provided. The IMHA service also reported patients had good access to ward rounds, managers hearings and tribunals.

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

- We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings as a determiner in reaching an overall judgement about the provider. At the time of our inspection, Sedgley hospital had 30 patients detained under the MHA and two patients that held informal status. A MHA reviewer visited the hospital as part of this inspection and completed a MHA monitoring visit and reviewed the detention documentation for four of the detained patients at Sedgely lodge. A MHA monitoring visit for Sedgley house was completed in September 2015.
- At the time of our inspection 74% of staff had received training in the updated 2015 MHA Code of Practice. Most staff were able to discuss with the inspection team what the guiding principles of the MHA were and how this impacted on patient care. Some staff we spoke to said they were awaiting training in the MHA, we fed this back to the registered manager who told us future training dates were being made available.
- There was evidence patients had been given information in accordance with Section 132 on admission. This included information about their right to an IMHA. Patients told us they had been given information about their rights. According to a note on one file this information was supposed to be revisited every three months but we did not find evidence this always happened, one informal patient had also been offered information when he was re- admitted but had refused. There was no evidence this had been revisited.
- Copies of detention papers were available on patient files andwere in order. However, we did not find copies of Approved Mental Health Practitioner (AMHP) reports on the file of one patient detained under Section 3 of the MHA.
- There was evidence managers' hearings had been held when detention for patients subject to the MHA was renewed. Patients told us they were aware of their right to appeal to a tribunal and an informal patient that we spoke with had been previously discharged via this process.

Long stay/rehabilitation mental health wards for working age adults

Good

- All detained patients had medication authorised on either a form T2 or T3. Detained patients being administered medication for longer than three months must have a T2 or T3 form in place. A T2 form is used when a patient who has capacity agrees to take medication after three months detention. A T3 is provided by a second opinion appointed doctor (SOAD) when a person who lacks the capacity to consent to medication remains on medication after the first three months detention, or the patient has capacity but does not agree to taken their medication.
- All patients had been granted Section 17 leave which was authorised by the Responsible Clinician (RC) on standardised forms. The forms specified the length and frequency of leave and also the number of escorts required for those granted escorted leave. The forms stated the nurse in charge could withhold any episode of leave. Although leave was reviewed at monthly ward rounds we did not find evidence that episodes of leave were routinely reviewed with one patient. The leave forms of patients subject to restriction orders did not refer to Ministry of Justice approval although we found the appropriate letter authorising the RC to grant leave on the patient's file.
- On some files we did not find a clear assessment of capacity or record of discussion around consent. We noted that the T2 forms used required the RC to confirm they had made an entry in the medical records. On most files of patients reported to be consenting to treatment we were unable to find evidence they had been given the information required for them to give informed consent.
- Some patients were being treated above British national Formulary (BNF) maximum doses. Four of these had their treatment reviewed by a second opinion approved doctor (SOAD). One of these had last been reviewed by a SOAD in July 2013.
- We found no assessment of capacity or record of discussion about consent on the file of one patient who was no longer subject to detention.
- A MHA administrator was employed by the hospital and worked on a full time basis, they worked with staff to monitor completeness of the MHA paperwork and to carry our regular audits. Case tracking audits were completed three times a year. These reviewed MHA paperwork completeness, details of whether patients consent to treatment was contained within notes and whether section 132 rights had been read to patients on a regular basis and the most recent copy was in date.
- There was evidence that patients had access to the local IMHA and staff reported good links with the service. We spoke to an IMHA that worked with the hospital and they reported they visited fairly regularly, patients were informed about their rights and had access to the complaints process if they had concerns, which they had seen in action and which worked well.

Good practice in applying the Mental Capacity Act:

- At the time of our inspection 74% of staff had received training in the Mental Capacity Act (MCA).Most staff were able to discuss with the inspection team what the guiding principles of the MCA were and how they used these principles in their clinical work. Training in the MCA was completed as part of the induction process and annual refresher training sessions were mandatory.
- There had been no deprivation of liberty safeguards (DoLS) applications made by the hospital in the twelve months prior to our inspection and no patients were subject to DoLS at the time of our inspection. The provider had a DoLs policy in place and this was available via the intranet for staff to access for guidance.

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

Good

Kindness, dignity, respect and support:

- We observed patient and staff interactions during scheduled groups, ward reviews and in communal areas. During the ward review we observed collaborative care planning between the members of the multi-disciplinary team (MDT) and the patient involved
- We observed good staff interaction with patients. They were respectful and displayed a good knowledge of each patient. There were high levels of engagement during the period of our visit from staff of all disciplines

and in clinical and non clinical roles. Staff were able to speak at length about the likes and dislikes of individual patients and could discuss individual care plans and the decision making that underpinned their development

- Most patients spoke very highly of staff and stated that they were treated well and liked the staff that worked with them. We did however receive two statements from patients stating that they felt that the night staff did not interact with them. They both stated that they had raised concerns about this with the head of care for investigation. In both cases the patients in question were complimentary of the day staff.
- We saw a member of staff making every effort to maintain confidentiality. Staff were discussing a patient in the nursing office. We observed a member of staff asking a patient to move away from the office window in order that their conversation could not be overheard.

The involvement of people in the care they receive:

- Most care records and risk assessments that we reviewed showed evidence of patient participation in the care planning and risk assessment process. Care plans were holistic and there was evidence patients' wishes and feelings had been considered in some areas. However some were written in a way which did not evidence collaborative working and appeared prescriptive. Patients told us they had been offered copies of their care plans. Staff had developed individual patient files due to care plans being left in communal areas once patients had been given a copy. The files contained copies of the latest care programme approach paperwork, information on patient rights, and information on the rights for informal patients. These could be stored by patients either in their bedrooms, or in a locked cupboard in the nursing office.
- Access to advocacy services were available for patients and were commissioned by the local authority in adherence to guidance from the Mental Health Act (MHA) Code of Practice 2015. Feedback was sought from the advocacy service prior to our inspection taking place and was positive, stating that patients seemed happy with day to day care, had access to regular reviews and were able to use the complaints process if they needed to.
- Families and carers that we spoke with told us that the service was excellent, One carer said that staff were very professional and very caring and they couldn't fault them in any way, another said that they felt the care provided by the hospital was better than any they had previously received. All carers that we spoke with said they felt fully involved with the care planning process and their views and wishes were listened to and respected. All carers told us they were invited to clinical meetings and kept informed of any changes in the wellbeing of the person the hospital cared for. One carer said they felt the visitors room at Sedgley house was too small. They had raised this with staff while visiting and been given access to the hospitals board room for as long as required and supplied with refreshments for the duration of the visit.
- Staff held weekly community meetings for patients each friday. We reviewed minutes of these for the previous six weeks for Sedgley house and Sedgley lodge as part of our inspection. The community meetings were chaired by patients and covered a variety of topics including a wellbeing check of how patients were feeling and a review of the food provided. Patients used the community meeting to plan activities for the coming weekend and this was included in the minutes with records of when they had been achieved.
- A patient survey report was commissioned by the hospital annually. Areas that were covered included the environment and living conditions, staff attitudes, confidentiality and complaints and activities offered. Responses that were received were positive in most areas although patients at Sedgley house requested further information regarding the complaints process if they needed to use it.

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

Good

Access and discharge

- Sedgley hospital had 34 beds and at the time of our visit there were 32 patients. In the 12 months prior to our inspection the average bed occupancy was 98%. There had been 14 admissions to the hospital and 18 patients had been discharged.

Long stay/rehabilitation mental health wards for working age adults

Good

- The hospital monitored their yearly discharges as a key performance indicator of the clinical effectiveness of the care being provided, discharges were also categorised as either positive or negative. A positive discharge was a patient whose care needs and levels of risk had decreased and had moved to a less acute service. A negative discharge was categorised as a patient that required transfer to a more secure setting. In the year prior to our visit there had been 16 positive discharges, and two negative discharges.
- An established care pathway was in place and helped patients to identify goals to work towards in their recovery. Admissions were usually to Sedgley house and were patients that had more acute needs and needed increased care. This was reflected by a higher ratio of staff to patients. As a patient progressed through their recovery, they were able to move to Sedgley lodge and this was reflected by the majority of patients self medicating at the lodge, having more frequent periods of leave to engage in activities in the community and a lower ratio of staff to patients. Patients also had the option of a further step down unit attached to the hospital to aid their transition to more independent living.
- At the time of our inspection we spoke to one patient at Sedgley lodge who had informal status under the MHA and was awaiting the identification of a suitable community placement by their community mental health team (CMHT). The patient described that they felt they were being held at Sedgley lodge against their wishes due to a lack of community placement. We discussed this with the registered manager who acknowledged that a suitable placement had not been found, this was the responsibility of the CMHT, but that the patient was informal and spent time in the community on a daily basis without restriction. The service had also taken steps to ensure the patient's rights and their solicitor regularly attended ward rounds to support them.
- Medical and nursing staff said they were able to access psychiatric intensive care units (PICU's) if one was required. At the time of our inspection one patient had been transferred to a PICU recently, and a referral for another patient was being completed following a multi disciplinary team (MDT) review.

The facilities promote recovery, comfort, dignity and confidentiality:

- There was a range of rooms and equipment in the hospital to support patient treatment and care. There were clinic rooms and one had an examination couch available for use if required. Patients had access to their own kitchen for the use of making snacks and drinks, there was also a therapy kitchen available for patients to practice their activity of daily living skills and carry out occupational therapy assessments. A large lounge area was available at both Sedgely house and Sedgley lodge and the furniture was clean and in good condition. A laundry room was available for patients to do their own laundry under staff supervision. There were some restrictions on the availability of space for activities at Sedgley house which could not be altered as it was classed as a listed building. Staff said they made the best use of the space available to them and most activities were community based in keeping with the rehabilitation remit of the service. Patients were able to access their bedrooms and were offered a room key on admission. All bedrooms were single occupancy with en-suite toilet, shower and washbasin. Lockable bedrooms provided secure storage for possessions and patients were able to personalise their bedrooms if they chose to.
- The visitors room at Sedgley house was small and staff, carers and the local independent mental health advocate raised this as an issue. Carers that we spoke with told us that staff gave them access to larger meeting rooms and they were appreciative of this. Patients had access to patio space between the hours of 8am and midnight although if access was required outside of this time it could be facilitated. Staff were nominated to be on patio duty on a daily basis for half hour increments to provide support for patients in outside areas. A payphone was available for patient use and all patients could have their own mobile phone for use following a risk assessment.
- Catering staff cooked food on site at both Sedgley lodge and Sedgley house. Wolverhampton city council had last visited the hospital in 2012 and awarded Sedgley house a maximum rating of very good. Sedgely lodge had not been visited and we raised this with the registered manager who was planning to follow this up. A patient survey completed in May 2015 showed that 70% of patients felt they were offered a choice of food

Long stay/rehabilitation mental health wards for working age adults

Good

and 77% of patients stated they liked the meals that were offered. The daily menus were available for patients in communal areas. Patient feedback on the food provided was a standing item on the agenda of the weekly community meetings.

- There was access to activities, including at weekends and patients had the option to choose weekend activities on a weekly basis. A programme of therapeutic activities was in place and facilitated by the occupational therapy department with support from nursing staff and activity co-ordinators. The therapy timetable included social and leisure groups, skill acquisition groups including a breakfast group and access to community facilities. The dining area at Sedgley House had an activity board with quizzes posted on it and prizes of gift vouchers. Cambian also offered patients the option to undertake therapeutic paid activities that contributed to the running of the service. A notice board was available advertising job roles and 11 of 13 had been recruited into with two still vacant.

Meeting the needs of all people who used the service:

- There was access and provision for people requiring disabled access and facilities. These were limited due to the age and nature of the building, which meant that upstairs corridors and doorways were narrow. Alternative Cambian Hospitals were available within the region with increased provision for patients with physical disabilities.
- There was provision of accessible information for patients, this was included in the admission welcome pack and in the reception and communal areas. Information provided related to advocacy services, local solicitors, whistleblowing and a range of services providing translators and interpreters. Some information was available for patients in different languages although not all leaflets were. However, staff said they could arrange this if required. Patients we spoke with were able to give examples of when interpreting services had been made available for family members to participate in clinical meetings.
- Patients we spoke with told us that there was a range of dietary options available for them, All meat provided by the hospital was halal approved. Patients were also able to prepare their own meals in the therapy kitchen as part of their therapeutic activity plan.
- Patients were able to attend local places of worship. Religious items including prayer mats were available in the hospitals multi-faith room for patient use.

Listening to and learning from complaints and compliments:

- Five complaints were received by the hospital in the 12 months prior to our visit. A review of these complaints with the registered manager found that they had been recorded and investigated in accordance with the hospitals complaints procedure. One complaint was upheld and one was partially upheld. None of the complaints received were referred to the independent sector complaints adjudication process or ombudsman service. When complaints had been upheld, duty of candour was evident and the registered manager had written to the complainant acknowledging that errors had been made. The registered manager gave the senior management team feedback from the outcomes of complaints as part of the monthly clinical governance group. Minutes of this were forwarded via email to all staff.
- Patients reported that they knew how to complain and were able to do so either directly through the hospital service or using the independent mental health advocacy service. Feedback that we received from the advocacy service was the complaints procedure seemed to work well and that they were aware of patients using it successfully to get issues resolved. Staff we spoke with said that they tried to provide patients with the opportunity to raise any concerns with them or through the patient community meetings if they felt happy to do so. All staff received training on dealing with complaints as part of their mandatory induction programme.

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

Good

Visions and Values:

- The Cambian group had a list of four beliefs that would correspond to a list of corporate values; everyone has a

personal best; everyone can find something to aim for; everyone can achieve something special and everyone should have the opportunity to strive for it. Staff we spoke to were aware of these values and the information booklet provided to patients at the time of their admission listed the provider's beliefs.

- Staff knew who the senior managers were in the organisation and reported good links with them. We saw that the regional operations director responded quickly and positively to the registered managers requests for increased staff when required, and we were able to meet with the regional operations director on the day of our visit.

Good governance:

- Mandatory training levels were high and the average training compliance rate for staff was 87%. Staff were able to access online and face to face training on a regular basis and this was managed by senior staff and the registered manager. Most staff received supervision on a regular basis and 89% of staff had attended supervision recently at the time of our inspection. Appraisal attendance was lower at 70% of non medical staff having received an appraisal in the previous 12 months. The registered manager was aware of this and was scheduling in dates for those staff without an appraisal.
- The registered manager and senior staff attended regional clinical governance meetings with the managers of other local Cambian hospitals. We reviewed the minutes of these meetings as part of our inspection process. The meetings provided an opportunity for the hospital to measure its performance against other Cambian Hospitals, review the outcome from audits and learn lessons from incidents that had occurred within the organisation. Actions that arose from the governance meetings were documented with staff responsible and timescales for achieving them. These were reviewed at subsequent meetings. Eighteen audits had been completed by the hospital in the six months of data provided prior to inspection. These included mental health act audits, suicide prevention audits, service user involvement and an audit of personnel files. All personnel files we reviewed as part of the inspection process contained suitable references for staff, up to date disclosure barring service (DBS) checks, and evidence of performance management where it had been required.
- The hospital used key performance indicators (KPI's) to measure the clinical effectiveness of the service it provided. The registered manager submitted KPI data on admission and discharge rates, incident reporting, the use of restraint and rapid tranquilisation and patient engagement in hours of meaningful activity. Reviews of all patients took place using standardised outcome measures including the daily living scores outcome scale and the global assessment of progress as part of the clinical governance group.
- The registered manager felt that they were well supported in their role by the provider and by staff at the hospital, they said they had sufficient administrative support locally and were given the autonomy by senior managers in the organisation to make decisions about how the service should run. The manager had access to the organisations risk register and felt able to submit items relating to the hospital if required. There were no items submitted to the risk register relating to Sedgleys hospital at the time of our inspection.

Leadership, morale and staff engagement:

- Sickness rates were low at the time of our inspection and were recorded as 4.6%.There were no reported incidents of bullying or harassment being investigated and staff did not raise concerns relating to these issues.
- Staff turnover in the previous year had been high at 20%. The registered manager attributed this to new staff who had not successfully completed their probation and some staff had left to join a new hospital opened locally by the provider. One member of staff had been promoted in their role and this had counted towards the staff turnover although they still worked at the hospital. Some staff reported that the staffing vacancies had impacted upon their ability to do role specific work as they could be required to provide support by undertaking generic tasks. At the time of our inspection, most qualified nurse vacancies had been recruited to and the registered manager was holding support worker interviews within the following week
- Staff reported that the manager was flexible in their approach and the morale within the multi-disciplinary team was very good. Most of the senior management team for the hospital were relatively new in post and had worked at the hospital for a year or less. Staff reported that the team was developing well, there were high levels of mutual support and they enjoyed a good

degree of job satisfaction. All staff felt able to raise concerns without fear of victimisation and were aware of the organisations whistleblowing process if they had concerns.

- Staff were able to attend regular meetings to provide feedback on the services and contribute to its development. Results from the recent annual staff climate survey were very positive. Eight areas were covered including flexibility of job role, motivation and self worth, most were rated as either good or excellent by over 80% of staff.

Commitment to quality improvement and innovation:

- At the time of our inspection, the responsible clinician and the assistant psychologists were undertaking a research study into the validity of the Global Assessment of Progress (GAP) tool used by the service. The GAP tool is an internationally validated tool to rate the social, occupational and psychological functioning of adults in view of their mental illness symptoms. It is part of the Diagnosis and Statistical Manual of Mental Disorders, (DSM IV).

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the provider MUST take to improve

Action the provider SHOULD take to improve

- The provider should ensure that all staff receive an annual appraisal.
- The provider should ensure that care plans demonstrate evidence of collaborative working between clinical staff and patients.
- The provider should ensure there are sufficient personal alarms available for all staff to use.
- The provider should ensure that information on their complaints process is available for all patients.
- The provider should ensure that allied health professional staff have sufficient time to carry our role specific assessments and interventions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

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.