Vision MH - Cornerstone 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

Overall summary

We carried out an unannounced focused inspection of this service following concerns identified to the Care Quality Commission.

We do not rate services that we inspect as part of a responsive inspection. We found that action was required by the provider because:

- Staff could not observe patients effectively in all parts of the ward. The service had installed mirrors to aid observation, but staff had not placed where needed. As a result, lines of sight were not clear.
- Staff did not seek appropriate levels of medical attention when patients harmed themselves.
- Managers undertook ligature risk assessments and staff had identified ligature points throughout the service, where patients might be able to harm themselves.. However,staff had taken no action to minimise the risks to patients.
- The ward did not comply with mixed-sex accommodation guidelines, as there were no separate day spaces for women.
- Staff were nursing one patient in long-term segregation to prevent the risk of harm to other patients and to themselves. Staff had not completed management plans or multidisciplinary reviews of this to ensure the patient was safeguarded in line with the Mental Health Act code of practice.
- Cleaning records showed that cleaning took place regularly; however, some areas of the service were not clean. Three bedrooms inspected were dirty and had an unpleasant odour. Ensuite facilities in two bedrooms had stained toilets and flooring.
- The emergency drugs held in the clinic room were out of date. Staff did not check medication regularly or effectively as this error was unnoticed.
- The service did not manage stock medication or controlled drugs in line with Nursing and Midwifery Council standards. We found errors in both the dispensing of, and recording of, controlled drugs. Staff did appropriately manage the recording of stock medication.
- Medication was stored in a fridge, which staff records showed, had temperatures that were higher than the accepted range. The fridge also contained solid ice. This could have changed the effectiveness of the medication. Staff had taken no action to address this.

Summary of findings

- The service used blanket restrictions, such as limiting patients' access to mobile phones and to the internet. This was not individually risk assessed.
- Staff knew how to report incidents and used an electronic system to do this. However, those report records reviewed were incomplete and lacked information about the incident and the lessons learned.

However,

- There were alarm call bells in patients' rooms, which meant they were able to call for help if they needed it.
- Staff completed risk assessments and updated them when the risk to patients changed.
- The hospital had enough staff on shifts to meet the needs of patients on the ward. Managers could adjust the staffing levels if required.
- Eighty-one percent of staff had completed mandatory training.
- Staff interacted with patients in a positive way and showed good understanding of individual needs.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults		We do not rate services that we inspect as part of a focused inspection.

Summary of findings

Contents

Vision MH - Cornerstone House

Services we looked at:

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

Summary of this inspection

Background to Vision MH - Cornerstone House

- Vision Mental Health Limited is registered to provide inpatient treatment for up to 26 people with a mental health diagnosis who may also be subject to detention under the Mental Health Act 1983.
- At the time of inspection there were 26 patients. Twenty-two patients were detained under the Mental Health Act and four patients were informal, meaning they were there voluntarily. The service provided care and treatment for males and females patients.
- The service offered assessment, and multidisciplinary care and treatment based on recovery philosophy.
- The last inspection took place in November 2013 and the service was compliant across all regulations inspected.
- The registered manager of the service was Matthew Angell and the controlled drugs accountable officer was Nicholas Cockburn.

Our inspection team

The team that inspected the service was made up of two CQC inspectors and a specialist professional advisor who had experience of managing mental health rehabilitation services..

Why we carried out this inspection

We carried out an unannounced focused inspection of this core service following concerns identified to the Care Quality Commission.

These concerns included:

- Errors made in medication management
- Risks to patients' physical health not addressed appropriately
- Premises were not fit for purpose
- Lack of observations during night shift
- Hygiene of the hospital.

How we carried out this inspection

During this focused inspection, we looked specifically at the safe and caring domains.

Before the inspection visit, we reviewed the information that we held about the location.

During the inspection visit, the inspection team:

- Looked at the quality of the ward environment and observed how staff were caring for patients
- Met with eight patients who were using the service
- Interviewed the clinical nurse lead and risk manager
- Spoke with four other staff members
- Reviewed nine care and treatment records of patients
- Carried out a specific check of the medication management in the hospital
- Examined a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

- Patients reported that the service repeated therapeutic activities so there was not much choice. One patient said they stopped engaging in activities, as these seemed pointless.
- Seven patients told us that staff were respectful, supportive and helpful. They could see a doctor in charge of their care each week in care review meetings and felt their views were listened to. However, patients told us that staff were often busy and did not have much time to spend with them and to engage in joint activities.

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 do not rate services during responsive inspections but found that action was required because:

- Staff could not observe patients effectively in all parts of the ward. The lines of sight were not clear. The service had mirrors to aid observation, but they were not placed where needed.
- Staff had identified ligature points throughout the service. Managers undertook ligature risk assessments, but staff had taken no action to minimise assessed risks to patients.
- Staff did not seek appropriate levels of medical attention when patients harmed themselves.
- The clinic room was well-equipped, but staff had not made sure that emergency medication was not out of date and did not keep the oxygen mask in sterile conditions.
- Staff were nursing one patient in long-term segregation to prevent the risk of harm to other patients and to themselves. Staff had not completed management plans or multidisciplinary reviews of this to ensure the patient was safeguarded in line with the Mental Health Act code of practice.
- Three bedrooms we inspected were dirty and had an unpleasant odour. The floors were stained and surfaces were marked.
- The service did not manage stock medication or controlled drugs in line with Nursing and Midwifery Council standards. We found errors in both the dispensing of, and recording of, controlled drugs.
- Medication had been stored in the fridge. Staff records showed the fridge temperatures were higher than the accepted range and the fridge contained solid ice. This could have changed the effectiveness of the medication. Staff had taken no action to assess this.
- The service used blanket restrictions such as limiting patients' access to mobile phones and to the internet. This was not individually risk assessed.
- Staff reported incidents on an electronic system. However, reports were incomplete and lacked information about the details of the incident and lesson learned.

However,

- There were alarm call bells in patient's rooms, which meant they could summon help if they needed it.

Summary of this inspection

- Staff completed risk assessments and updated them when the risk to patients changed.
- The hospital had enough staff on shifts to meet the needs of patients on the ward. Managers could adjust the staffing levels if required.
- Eighty-one percent of staff had completed mandatory training.
- Staff appropriately managed the recording of stock medication.

Are services caring?

We do not rate services during responsive inspections but found that:

- Staff interacted with patients in a caring and respectful manner.
- Staff demonstrated a good understanding of individual patient needs in a range of settings and activities. Staff supported patients to attend to their activities of daily living and therapeutic activities.
- Patients reported that the staff did not provide enough therapeutic activities and that these were often repeated. One patient said they stopped engaging in activities, as the activities seemed pointless.
- Seven out of 26 patients told us that staff were respectful, supportive and helpful. However, patients also told us that staff were often busy and didn't have much time to spend with them to and to engage in joint activities.
- Patients were actively involved in care planning. They attended regular review meetings where the doctor would discuss their care. They reported that their views were listened too.

Detailed findings from this inspection

Notes

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards were not reported on as this was a focussed inspection.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Caring	

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

Safe and clean environment

- Staff could not observe patients effectively in all parts of the ward. The lines of sight were not clear. The service had mirrors to aid observation, but these were not placed where needed and staff could not observe patients in all areas or ensure that they were safe.
- Staff had identified ligature points throughout the service. Managers undertook ligature risk assessments but staff and managers had taken no action to minimise assessed risks to patients.Staff working on the wards lacked awareness of the ligature risk assessments and the implications for their practice when asked.
- The clinic room was fully equipped. However, staff had not completed regular checks of the equipment. Staff had not identified that emergency medication had expired and that the oxygen mask was not kept in sterile conditions.
- Cleaning records showed that the hospital was regularly cleaned. Communal areas of the ward were clean, had good furnishings, and were well maintained. However, we inspected the majority of the bedrooms and found three bedrooms were dirty, with stained flooring and toilets. All had an unpleasant odour.
- One bedroom did not have an opening window because a staff office had been built directly adjacent to the outside wall. This also made the room dark as there was no source of natural light for the patient
- One bedroom was cluttered and dirty and could pose a fire and health and safety risk to the patient and staff.
- Staff carried personal alarms, which could summon help in an emergency.
- There were call systems in the patient's bedrooms. This meant they could call for help if needed. However, in one bedroom the alarm button was out of reach if the patient was in bed or resting as it was at the opposite end of the room to the bed and furniture.

Safe staffing

- The service's minimum safe staffing level was 11 whole time equivalent (WTE) qualified nurses and 21 support workers. At the time of inspection, there was one qualified nurse vacancy.
- Levels of staff during the day were two qualified nurses and five support workers. At night, there were two qualified nurses and two support workers.
- The clinical nurse lead told us that bank and agency staff were rarely used and if required they would choose staff from one agency. This enabled the service to set specific standards about agency staff they would employ.
- From 1 September to 14 October 2015, there were enough staff for all day shifts. There were examples of the number of staff rising above the required level. We were told this was to ensure patients could attend activities or appointments in the community. This included home visits. Two shifts were recorded as having one qualified nurse during the day. However, the clinical nurse lead and hospital director supported them at these times.
- The same data showed that determined levels of qualified staff were not always met for the night shift. There were eight examples of one qualified nurse on shift when the requirement was two.
- The manager was able to adjust staffing levels based on the risk assessment of the patients or individual patients' activity schedules.
- A qualified nurse was often in the communal areas of the service. Although a support worker is present in the communal areas at all times.
- Staff recorded in case records that patients had one-to-one time with staff. However, patient feedback suggested that patients would like more time than they were allocated.
- Staff told us that there were occasions when a patient's leave was cancelled based on an individual risk assessment. This included if a patient was unsettled or was unwell. Staff did not cancel leave based on staffing levels.
- Eighty-one percent of staff had completed mandatory training.

Assessing and managing risk to patients and staff

Long stay/rehabilitation mental health wards for working age adults

- Managers and staff told us that the use of restraint was a last resort and that de-escalation techniques were used to distract and engage patients as a first response. However, incident records did not always contain full information about when restraint was used. For example, the records did not always contain information on the staff involved, the type of restraint used and the length of time the patient was restrained for.
- Staff completed comprehensive risk assessments with patients on admission to the ward and records were updated when risk changed.
- Staff did not seek appropriate levels of medical attention when patients harmed themselves. We received information prior to the inspection and a patient informed us during the inspection that when they had hurt themselves nurses and healthcare assistant did attend and treat the patient. However, the initial treatment was not overseen or authorised by a doctor. The injury was not assessed or reviewed by a doctor.
- The service applied blanket restrictions to patients that included limiting the use of mobile phones and access to the internet. Staff did not individually risk assess the patients when applying these restrictions.
- There was no information on the wards displaying the rights of informal patients. However, informal patients had specific access cards that allowed them to leave the hospital should they wish to.
- Staff used closed circuit television (CCTV) to observe patients. This was alongside 30-minute nursing observations. However, staff told us that CCTV observations were used solely during night shifts and that nursing observations were not always completed. We made the senior manager on shift aware of these concerns during the inspection.
- When staff nursed patients in long-term segregation to prevent the risk of harm to other patients and to themselves. There were no management plans in place or multi-disciplinary reviews of this to ensure that the patient was safeguarded. The service did not follow their personalised care, treatment and support policy or the Mental Health Act Code of Practice.
- Eighty percent of staff had completed training in safeguarding vulnerable adults.
- Staff recorded the locked fridge temperatures but they had not taken the appropriate action when the temperatures exceeded the recommended level. This meant staff were not aware of the efficacy of medication stored in the fridge. We saw solid ice had formed internally on the rear panel. The fridge was unlocked when we entered the room, which meant that the medications were not secure.
- Staff stored controlled drugs in a specific cupboard and recorded their use in the controlled drugs register. Staff had not followed the correct procedure for recording the dispensing of controlled drugs as one member of staff had signed when two signatures are required. We found examples of this happening on 10 occasions when we completed a random check of the controlled drug book.
- Staff dispensing controlled drugs did not record the dispensing accurately. There were errors in the logging of the receipt and dispensing of controlled drugs. We found three examples of a 10 ml discrepancy for methadone medication. Staff could not provide an explanation for this discrepancy.

Reporting incidents and learning from when things go wrong

- The provider used an electronic reporting system. Staff knew how to use the electornic system how to report incidents.
- We looked at eight incident reports all of which were incomplete. Staff had not always recorded the description of the event and information about lessons learnt was missing.
- The service told us that they used weekly reflection sessions to review incidents but there were no records available to demonstrate this.

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

Kindness, dignity, respect and support

- Staff interacted with patients in a caring and respectful manner. We observed staff playing cards and talking to patients about the television programmes they were watching television in the lounge and escorting patients on leave. The interaction were positive and demonstrated staff knew individual patient needs and preferences.

Long stay/rehabilitation mental health wards for working age adults

- Staff supported patients to engage in activities in the communal areas with other patients. Staff supported patients to complete daily living activities and to engage in therapy sessions.
- Patients reported that the service did provide a wide choice of therapeutic activities available to patients. However, they were often repeated. One patient said they stopped engaging in activities as they seemed pointless.
- Patients told us that staff were respectful and supportive. Patients would have liked more time with staff and told us that, when staff were busy, they could not offer as much time with them to engage in joint activities.
- Patients were actively involved in care planning and this was recorded in case notes. Patients signed their care plans to show they agreed with the goals that were created. Staff encouraged patients to attend regular review meetings to formally review their treatment plans.
- Patients said they had been given information about their medication and they were aware of their treatment plan. Patients were able to describe their rights under section 132 of the Mental Health Act.
- Staff encouraged patients to provide feedback on the service. One patient was identified as the patient representative and attended meetings with senior managers to share feedback on behalf of other patients.

The involvement of people in the care they receive

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that policies and procedures are adhered to, to ensure the safe management of medication and controlled drugs.
- The provider mustmonitorthe level of cleanlinessand ensure that patient bedrooms are cleaned regularly and free from odours.
- The provider must ensure that patients' needs must be taken into account when premises are designed, built, maintained, renovated or adapted in line with national guidance.
- The provider must ensure that the approach to and use of restrictive practices is regularly monitored and reviewed for compliance with national guidelines.
- The provider must ensure that ligature risks are identified and mitigated to reduce the risk they pose to patients.
- The provider must ensure that the appropriate level of medical attention is provided when patients require this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the provider did not have effective cleaning schedules in place to maintain the cleanliness of bedrooms and ensuite bathrooms. This was in breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant. Providers should: use appropriate cleaning methods and agents, operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment and monitor the level of cleanliness. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 15 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment One patient's bedroom was not fit for purpose. The patient was unable to open windows to have access to fresh air. A staff office had been built adjacent to the room which blocked out sunlight. This was in breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises must be suitable for the purpose for which they are being used. Premises must be fit for purpose in line with statutory requirements and should take account of national best practice. People's needs must be taken into account when premises are designed, built, maintained, renovated or adapted.

This section is primarily information for the provider

Requirement notices

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 15 (1) (c)Regulation 15(1)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not manage the dispensing and Recording of controlled medications. Signatures were omitted and medications did not reconcile. This was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must ensure the proper and safe management of medicines. Policies and procedures should be in line with current legislation and guidance and address: • dispensing • administration • recording • storage The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Emergency medication that was held in stock had expired. Emergency equipment was not sterile. There were no policies and procedures in place to inform staff when a patient required medical attention outside of the hospital. Ligature points were identified throughout the

This section is primarily information for the provider

Requirement notices

hospital. The providers ligature assessment had been completed, but did not identify all ligature risk. This was in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Sufficient medication should be available in case of emergencies.

The provider must assess the risk and do all that is reasonably practicable to mitigate the risk by having a suitable policy in place for staff to follow in these circumstances. This meant that serious injuries to patients were not receiving the appropriate medical intervention.

The provider must do all that is reasonably practicable to mitigate any such risks

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 12 (2) (a)(b)(e)(g)