Maryfield Court

Quality Report

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Date of inspection visit: 5th and 6th February 2019
Date of publication: 03/04/2019

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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated Maryfield Court as requires improvement because:

- We found that full physical health screening that included the taking of full histories, on admission, was not completed by staff. Only three patients had had a full history taken and physical examination take place.
- Agency staff when making entries into the electronic care recording system generated the same identification number. Staff should have an individual security pass which identifies their usage of computer systems.
- Information about patients was recorded in different places. New users of the systems would be unclear were to access current information or assessments.
- Staff told us they were unaware that audits of care records were formerly recorded so it was difficult to establish how staff became aware of quality assurance issues.

However:

- The service provided safe care and the ward environment was well maintained, furnished and clean. There were enough staff with the right skills to meet the needs of the patients.
- Patients using the service told us that they were treated with dignity and respect and described the staff as caring and helpful. We observed that staff took time to communicate with patients in a respectful and compassionate manner.
- Regular multidisciplinary meetings were held and attendance by outside agencies was encouraged. Families and carers were involved in this process where appropriate. Advocacy services were accessible and available to support patients.
- The ward environments were effectively managed and risks mitigated with the use of observation. Staff conducted regular environmental quality checks and patients could discuss and resolve environmental issues in community meetings.
- The wards had enough staff on shifts. Patients were supported by a skilled multidisciplinary team of staff which included nursing, psychiatric, psychological and occupational therapy support.
- Staff received supervision and appraisal and worked together as a multidisciplinary team.
- The service maintained good links with other external agencies that formed part of the patient's care pathway.
- Medicines were appropriately stored, administered and reconciled on all wards. All medicine was in date and labelled.
- Staff were trained in the Mental Health Act and Mental Capacity Act. Staff followed local procedures and support was available from a Mental Health Act administrator. Patients were given information and support to ensure appropriate representation and aid understanding of their rights.
- Staff we spoke with were positive about their roles and were positive about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	

Summary of findings

Contents

Requires improvement

Maryfield Court

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units;

Summary of this inspection

Background to Maryfield Court

Maryfield Court is an independent hospital owned and operated by ASC Healthcare. It is a former care home which has been converted into a hospital. It provides a total of 27 placements for people who may be liable for detention under the Mental Health Act 1983. The service is divided into four distinct living areas known as apartments, each apartment accommodates six to eight patients. Currently apartments one and two are open providing accommodation for 13 patients.

Maryfield Court is registered for accommodation for individuals detained under the Mental Health Act and for the treatment of disease, disorder or injury. At the time of this inspection, six patients were detained under the Mental Health Act.

All the patients at Maryfield Court are placed there by a local NHS trust who have an exclusive contract. Under this arrangement patients who are transferred to Maryfield Court do so after being assessed against a strict criteria for their care and treatment. Patients are admitted for short-term continual assessment before they are discharged either back into the care of the NHS Trust or into community based services. The average length of stay at Maryfield Court is 14 days.

There is a registered manager in place, currently they are the registered manager for another service as well.

Maryfield Court opened in August 2018 and has not been inspected before.

Our inspection team

The team that inspected the service comprised two CQC inspectors, one CQC assistant inspector and two specialist advisors. One had a variety of experience of working in acute mental health wards and the other was a qualified pharmacist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all open wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service and two carers
- spoke with the registered manager and two heads of care
- spoke with nine other staff members; including doctors, nurses, occupational therapist, health care assistants and a mental health act administrator

Summary of this inspection

- attended and observed a multi-disciplinary meeting
- looked at five care and treatment records of patients
- carried out a specific check of the medication management on two wards, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients from the two open wards were positive about their experiences at the hospital. Patients reported feeling safe and felt that the staff took a genuine interest in their care and wellbeing. One patient who had become homeless gave an example where staff had supported him in retrieving property from a previous address.

Patients felt supported through their treatment and understood this was a short-term placement. Patients understood where they were on their recovery pathway. Patients told us that the wards were clean, the quality of the food was good and that staff were always available.

We received feedback from families and carers of patients that spoke highly of the service and the treatment their relatives were receiving. Carers were invited into meetings with patients to review their treatment and staff were good at responding to their questions or concerns. The service encouraged patients to maintain relationships with families.

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:

- The ward environments were safe and clean. The wards had enough staff on shifts and whilst there was a reliance on agency staff when the hospital had first opened this had been reduced. Regular bank staff ensured consistency and familiarity with the hospital.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour and participated in the provider's restrictive interventions reduction programme.
- There was an open and transparent culture to reporting incidents and learning from incidents. Lessons learnt from incidents were shared across teams.
- All staff we spoke with understood the duty of candour at a level appropriate to their role; staff could give an example where they had written to a patient to apologise.
- Staff had received appropriate mandatory training and managers monitored staff compliance with training.
- There was good medicines management practice on the wards.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We found that full physical health screening that included the taking of full histories, on admission, was not completed by staff. Only three patients had had a full history taken and physical examination take place.

However:

- There were weekly multidisciplinary ward rounds and regular care programme approach reviews for patients. Patients could access a range of treatments to support their recovery within a multi-disciplinary team approach.
- Staff were appropriately skilled for their role. Staff told us they received regular appraisal and clinical supervision both individual and group supervision.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Staff treated patients with compassion and kindness, respected their privacy and dignity and understood the individual needs of patients. Patients considered staff caring, compassionate and interested in their wellbeing. Carers told us they were actively involved in decisions about care.
- Patients were orientated to the ward on their admission with welcome packs to help new patients settle into the ward environment. Patients were given verbal and written information about ward facilities and routines.
- Staff listened to patients' views and responded to patient concerns. Patients and carers could give feedback on the quality of the service they received.
- Patients were supported in multidisciplinary meetings and could access advocacy services.

Are services responsive?

Good

We rated responsive as good because:

- There was a robust admittance and discharge criteria, which ensured only patients whose needs matched the type of care available at the hospital were treated there.
- The wards provided a range of activities and facilities to meet patients' needs. Facilities were available to and cultural and religious needs were met.
- All staff and patients were aware of the complaints process and felt that their complaints were taken seriously and responded to in a timely manner. Themes from complaints received by the hospital were discussed and actions to address concerns were recorded.
- There was clear evidence that service understood patients different cultural and language needs.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Agency staff entering information in the electronic care recording system generated the same identification number. Staff should have an individual security pass which identifies their usage of computer systems.
- Staff told us they were unaware that audits of care records were formerly recorded so it was difficult to establish how staff became aware of quality assurance issues.

However:

Summary of this inspection

- There was a weekly governance meeting with the local NHS trust at which the hospital management team were held to account for the standard of care and performance of the hospital.
- There was a clear statement of visions and values. Staff knew and understood the hospitals vision, values and strategic goals.
- Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments. Staff could give feedback on the service and input into service development.
- There was a hospital risk register in place. Ward managers could escalate risks through the governance structure to be included on the risk register. The risk register was reviewed regularly.

Detailed findings from this inspection

Mental Health Act responsibilities

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

The mandatory training module included Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of the inspection staff training was above the hospitals target of 85%.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The hospital had a dedicated Mental Health Act administrator.

The provider had relevant policies and procedures that reflected the most recent guidance and staff had easy access to these on the intranet.

Patients had easy access to information about independent mental health advocacy. However, there was no evidence within care plans that patients had been sign posted towards this service.

Staff explained to patients their rights under the Mental Health Act as required by section 132 in a way that they understood. This was done at the time of admission and policy dictated every 30 days.

Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this had been granted. Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) so they were available to all staff that needed access to them. However, there were no Approved Mental Health Professional reports within the records. This meant that information about the patients' circumstances on entering the mental health service was not available.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards training was part of the mandatory training programme all staff had to complete. Training compliance was above the hospital's target of 85%.

The provider had a policy on the Mental Capacity Act, including Deprivation of Liberty Safeguards. Staff were aware of the policy, had access to it and knew where to get advice from.

Staff showed an awareness of the Act and were able to give examples of when best interest assessments were required. Staff knew if they had any queries or needed further clarification they could consult the Mental Health Act administrator or members of the multidisciplinary team for further information.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Good

Safe and clean environment

Maryfield Court was a former residential care home which had been converted. It consisted of four wards, two on the ground floor and two on the first floor. There was a secure entrance to the building supervised by reception staff. The wards that were open at the time of inspection, Apartment One and Two, were situated on the ground floor. Each ward was self-contained and consisted of a communal space the middle with all other rooms facing onto the ward from either side.

The wards were for male patients only. There were nurse call points in each patients' bedroom, and these were fitted with anti-ligature furniture. Audits and assessments of the environment were comprehensive and up to date. Ligature risks were places to which patient's intent on self-harm might tie something to strangle themselves.

All areas of the ward were clean, comfortable and well-maintained. The wards had only recently opened and contained all new furniture. We saw cleaning rotas that demonstrated regular cleaning from the services housekeeping team.

The service did not have a seclusion room and patients were not secluded in any other room in the hospital. There was a seclusion and segregation policy in place and an agreement with the commissioning NHS trust that any patient who became inappropriately placed would be discharged back into their care. There was an observation policy and we observed staff following this policy. Observations are a routine part of clinical practice, the purpose of

which is to ensure the safety of patients during their stay within an inpatient ward as well as promoting therapeutic engagement with patients.

Clinic rooms across the wards were fully equipped and had available emergency resuscitation equipment and emergency medicine. There was evidence that these were checked weekly and all equipment was calibrated and portable appliance tested. However, an electrocardiogram machine was broken and had been sent for repair. Arrangements were in place to use one located at a sister service or access one through the local hospital. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally.

Safe staffing

The service operated both wards with the same staffing mix of one nurse and two health care assistants. The wards operated a two-shift system, a day and night shift. Managers could adjust staffing levels daily in response to ward activity patient mix or clinical need. Managers could access bank and agency staff to provide cover or increase staffing numbers when required.

Within the structure there was a registered manager and two heads of care. These individuals were expected to cover for short term unexpected absences.

The staffing establishment and vacancy levels for the hospital were:

- Total establishment levels qualified nurses (whole time equivalent): 8

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- Total establishment levels healthcare assistants (whole time equivalent): 17
- Number of vacancies for qualified nurses (whole time equivalent): None
- Number of vacancies for healthcare assistants (whole time equivalent): 2
- Total number of substantive staff: 25
- Total number of staff leavers since August 2018: 1
- Total percentage of vacancies overall: 0.5%
- Total percentage of permanent staff sickness overall 0.6%

The service had been reliant on bank and agency staff from opening on 6 August 2018 until 14 November 2018.

- Number of shifts filled by bank staff to cover staff sickness, absence or vacancies: 18
- Number of shifts filled by agency staff to cover staff sickness, absence or vacancies: 398
- Number of shifts not filled to cover sickness, absence or vacancies: 69

However, these rates had declined and in January 2019 they were:

- Number of shifts filled by bank staff to cover staff sickness, absence or vacancies: 54
- Number of shifts filled by agency staff to cover staff sickness, absence or vacancies: 22

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward.

The hospital provided a mandatory training programme for all staff. Mandatory training covered a range of different areas including fire safety, first aid, health and safety. Mandatory training

compliance for staff was above the services target of 85% for all courses. Training included creative intervention training in response to untoward situations(CITRUS), which the service used for least restrictive approach to managing violence and aggression.

The hospital employed a consultant psychiatrist (whole time equivalent of 4 days a week). A speciality doctor (whole time equivalent of 5 days a week) was available to address patients' physical health needs. On call support was provided by the consultant psychiatrist or a locum when they were not available. Out of hours support for physical health care needs would be accessed through normal NHS services.

Psychological interventions were delivered by a psychologist (whole time equivalent of 2 days a week employed via an agency) with a full time occupational therapist delivering the therapeutic weekly activity programme.

Patients had one to one time with the nurse that was allocated to their care. In between these times, all other staff were available for patients to talk to if they so wished. Staffing was sufficient to be able to take patients out on leave from the wards.

Assessing and managing risk to patients and staff

We reviewed five care records. All patients had a risk assessment completed by the hospital staff on admission to the hospital. Continuing assessment of risks were not formally reviewed as new risk assessments but as continuing assessments within the original risk assessment. Client risks were reviewed at each handover using a recognised risk assessment tool, with changes documented within care plans and observation levels. If patients presented other risks a new risk assessment was completed.

Staff could talk about individual patients and describe how they used the hospital observation policy to mitigate against any identified risks. We found that during our inspection this policy was being adhered to.

Patients had free access to bedrooms. The site was smoke free with detained patients being offered a smoking cessation programme. Informal patients could leave at will and knew that.

The hospital did not have any seclusion facilities available and there were no episodes of seclusion or long-term segregation within this service. Since the service opened in August 2018, there were three episodes of restraint within the service. Staff understood the Mental Capacity Act definition of restraint and where appropriate worked within that definition. No episodes of restraint resulted in prone restraints being used or any rapid tranquilisation. Should a patient become violent there was an agreed protocol in place for the discharge of that patient back into the care of the NHS trust.

There was a weekly governance group meeting with the commissioning NHS trust. At this meeting restrictive practices and incidents involving restraint were monitored

and discussed. There was a restrictive practices policy within the governance structure of the hospital and patients discussed hospital practices during weekly communal meetings.

Safeguarding

There had been no safeguarding referrals. All staff had received safeguarding training. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

The hospital had identified a safeguarding lead and had safeguarding procedures in place to provide guidance for staff. These outlined their responsibilities for the safety and wellbeing of patients who were less able to protect themselves from harm, neglect or abuse.

Staff we spoke with had a good knowledge of safeguarding and displayed a clear understanding of what would constitute a safeguarding concern. Staff knew how to report a safeguarding concern, and how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff access to essential information

There was a combination of electronic and paper records at Maryfield Court. The electronic recording system was developed by the hospitals owners ASC Healthcare and contained daily records, one to one sessions and doctor's notes. Care plans and assessments were recorded elsewhere as were physical health checks and occupational therapy plans. This had already been identified by the hospital senior management team who had requested an updated electronic record keeping system to incorporate all documents. However, staff could show inspectors where these records were and how to access them. They had access to the electronic systems in place.

Information governance procedures guided staff to enable compliance against the law and assess whether information was handled correctly and protected from unauthorised access, loss, damage and destruction.

However, agency staff used the same access code when entering the electronic care record system. This meant that all agency staff had the same identification code automatically generated against each entry making it difficult to identify who had made what entry if they had not included their name at the end of the entry.

Medicines management

There was good medicines management practice at the hospital. Medicines were stored appropriately. There were procedures for the ordering and disposing of medicines and a policy for controlled drugs. Staff undertook regular checks on medicines including stock levels. Alerts and safety information were shared with ward teams.

There was a service line agreement in place with a pharmacy service to provide comprehensive pharmacy support. A pharmacist visited the service twice a week to dispense named-patient medicine, provide stock medicine and review the medicine management charts to undertake regular audits.

We reviewed all medicine charts and they were all accurate and without any errors, including 'as and when' medicines.

There had been one medication error where a patient had been given a higher dose of medication than was prescribed. This dose was still within safe limits for the medicine concerned. The service completed a root cause analysis and shared findings from the investigation with staff.

Maryfield Court did not subscribe to POMH-UK (The Prescribing Observatory for Mental Health), a national audit and quality improvement programme. However, internal medication audits and medicine management meetings did take place monthly at Maryfield that followed the same principles of POMH-UK.

Track record on safety

There were no serious incidents reported by the hospital. However, there were robust process in place should a serious incident occur.

Reporting incidents and learning from when things go wrong

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Maryfield Court had an electronic incident recording system. Staff submitted an incident report which was reviewed by the senior nurse in charge. These were then shared with the senior management team who reviewed all incidents.

A total of 117 incidents had been recorded by hospital staff. These were catalogued under different headings as damage, harm to others (both physical and nonphysical), absent without leave and accident. Staff understood what incidents needed reporting and we saw evidence that a range of incidents had been submitted onto the system and appropriately investigated.

The service had a duty of candour policy in place that staff were aware of. The service was open and transparent with patients, family members and carers if things went wrong. As part of the investigation process and incident reporting system at the service, duty of candour was included and monitored by senior leaders.

There was a critical incident debriefing system in place at the hospital. Staff and patients received debriefing to identify and address any physical/emotional harm to patients or staff after serious incidents. Feedback and lessons learnt from investigations following incidents were disseminated to staff and staff could describe these communications and lessons learnt from incidents. Support was available to staff through peer supervision which included reflective practice and discussion.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Maryfield Court only accepted patients from one NHS trust and had an agreed admission policy. They would not admit any patients who for example had a violent history, where alcohol or drug detox was the primary treatment concern or if the patient was currently displaying levels of aggression or violence.

Therefore, the referring trust did a pre-admission assessment to ensure the patient met the criteria before making the referral. Patients typically had low acuity and had accessed the mental health system in crisis for a short period before transferring to Maryfield Court.

The hospital had a specialist doctor for the physical wellbeing of patients. While we found evidence of vital signs such as temperature, blood pressure and pulse being taken on admission, we could only be shown three complete physical health screening assessments including the taking of full histories from patients on the day of admission. The monitoring of medication side effects was within the multi-discipline team using a nationally recognised monitoring tool.

At the start of the inspection there was no nationally recognised model in use to risk assess physiological measurements to identify risks to patient health. When we interviewed the speciality doctor they informed us that they were planning to implement such a model and during the inspection they did so.

Care plans were personalised, holistic and recovery-oriented. Staff updated care plans when necessary. Care plans met the patients' needs but we did see a variance of quality where staff attempts to describe actions as though they were by the patient were written in a more medical way, such as. "To comply with my medication in order to prevent deterioration of my mental health". There was no evidence in the care plans of outcome tools being used to assess the progress of patients.

Best practice in treatment and care

The service provided a range of care and treatment interventions through psychological intervention and occupational therapy. In line with their policy when patients were admitted their occupational activity was matched to a completed interest checklist. Recently admitted patients did not have an individual occupational therapy plan or a completed occupational therapy screening assessment. Patients undertook a full occupational therapy assessment when they had been identified within the multi-discipline team meeting as continuing treatment beyond two weeks.

The hospital had audit plans in place which included a ligature audit, infection control, Mental Health Act, clinical

supervision, risk assessment, and Mental Capacity Act. Action planning for audit activity was evident and issues raised from audit activity were reviewed in senior team meetings and discussed with ward teams.

Staff supported patients to live healthier lives for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, screening for cancer, and dealing with issues relating to substance misuse. The specialist doctor at the hospital was available for all physical health care needs.

Patients were encouraged to maintain links with their own general practitioner to assist with the transition back into community mental health care settings.

Skilled staff to deliver care

A range of professionals supported patient care. These included nurses, healthcare assistants, an occupational therapist, psychologist and consultant psychiatrist. An external pharmacist visited the hospital twice a week. Staff were appropriately skilled for their role. The provider had a corporate induction, which new staff attended. Agency staff also received an induction to the hospital.

Managers ensured that staff had access to regular team meetings. Both wards had supervision structures in place. The heath care assistants also had a supervision structure within their discipline. Staff received clinical supervision, and at the time of the inspection compliance with supervision across the service was 89.47% and appraisal rates were at 100%.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Staff told us they attended external courses leading to further qualifications.

Staff we spoke with told us they received regular supervision and that they found it meaningful.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

A multidisciplinary team meeting to discuss recommended treatment options and decisions relating to the care of individual patients took place twice a week. The multidisciplinary meetings were attended by the patient, nurses, consultant psychiatrist, specialist doctor and occupational therapist. The meeting we observed was also attended by a community care coordinator. Other professionals would attend if required and carers described attending these meeting to discuss treatment options.

There was also a weekly meeting with the commissioning NHS trust during which patients' progress and potential discharge dates were discussed.

There was evidence of good communication with local authorities, community mental health teams and social services. Links with external agencies were encouraged and supported by the multidisciplinary teams.

The ward teams had effective working relationships. Staff shared information about patients at handover meetings.

Adherence to the MHA and the MHA Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and knew the key principles of the Act and the accompanying Code of Practice. All clinical staff had received training in the Mental Health Act which was mandatory and refreshed on an annual basis. ASC Healthcare ensured all relevant policies and procedures reflected the most recent national guidance and was available to all staff.

A Mental Health Act administrator was in post who had a lead role in maintaining processes and systems to support compliance with the Mental Health Act and the associated Code of Practice. The Mental Health Act documents appeared to be correct and valid. Mental Health Act section expiry dates were within statutory timeframes. Regular audits were undertaken.

Staff we spoke with understood the Mental Health Act and associated Code of Practice. Mental Health Act training was a mandatory requirement and above the hospital target of 85% of staff.

There was a system in place to ensure that patients were given information about their legal status and rights under section 132 on admission to the ward and reminded of this information at monthly intervals. Patients confirmed that staff spoke to them about their rights and all knew what section they were detained under and how to appeal. They were aware of the advocacy service and information about it was displayed on each ward.

A notice was displayed on the ward to tell informal patients that they could leave the ward freely.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Staff ensured patients could take section 17 leave when this had been granted and completed pre and post leave assessments to assess and manage any risks associated with patients taking leave.

Informal patients were identified to staff within records and on a display board within the nurse's station. However, we found evidence of poor record keeping where staff referred to the same patients as both detained and voluntary indicating that staff were not aware of each patient's status.

Good practice in applying the MCA

Staff received training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards and at the time of the inspection the percentage of eligible staff trained was above the hospital target of 85%. Staff were aware of where to get advice about the Mental Capacity Act.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from it.

While no current patients had capacity issues, staff could give examples of other patients whose capacity had been questioned and best interest decisions taken to help and support those patients.

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

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

We observed staff treating patients with respect and dignity on both wards. Staff supported patients to understand and manage their care, treatment or condition. Patients told us staff were caring in their approach and provided help and support when they needed it. Examples included supporting one patient who had become homeless before entering the hospital. Staff had liaised with local housing and had even returned to the patient's previous address to recover personal documentation.

All clinicians demonstrated a real understanding of the patients on the wards and were knowledgeable of patient risks and treatment plans. During our observations we saw staff giving detailed histories of patients' backgrounds, current treatment options and what the patient had identified as treatment goals.

Staff understood the personal needs and preferences of patients, including their cultural and religious beliefs. A range of food options were available including vegetarian and Halal. Patients could also personalise their bedrooms and the ward environment.

Patients we spoke to said staff maintained their privacy and confidentiality and processes were in place to support this. Staff said they could raise any concerns of negative attitudes or abusive behaviours towards patients if needed.

Staff collected patient feedback using different methods. Satisfaction surveys were completed and patients said they could raise any concerns or ideas about the service with staff openly. There was also a discharge survey for patients to complete. The results were shared at management meetings and had influenced change within the hospital.

Involvement in care

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.

On admission all patients were orientated to the ward by staff and patients were given information about their care and treatment. Patients were also given a comprehensive welcome pack and staff explained the processes and timings on the ward.

Patients were allocated key workers and were kept informed of who would be supporting them. The wards also had staff pictures on ward boards with names of staff members to help patients' understanding of staff roles.

There were weekly community meetings that patients could attend. These meetings gave a space for patients to raise issues with staff, give compliments, feedback and have a choice of the structured activities offered on the wards. There were examples where staff had acted upon issues raised by patients. Patients could also attend multi-disciplinary team (MDT) meetings to discuss their treatment.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Patients had copies of their care plans and were fully aware of their treatment pathway. All patients we spoke to understood if they were detained or voluntary and all understood what was required for them to be discharged. All patients had access to advocacy.

Family members and carers told us they were updated and involved in patients' care when consent had been given by the patient. Family members and carers were invited to attend multidisciplinary meetings or phone into the meetings where this was not possible. Families and friends gave feedback through surveys.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

The hospital was solely commissioned by a local NHS trust. Referrals could be made at any time of day. There was a manager's triage system in place during office hours with the senior nurse in charge accepting the referral out of hours. There was agreed admission criteria between the trust and the hospital to ensure only patients suitable for the hospital were referred. Should a patient's placement become unsuitable the agreement ensured they were repatriated within the NHS trust.

The average length of stay was 14 days. Patients either returned to NHS trust care or to community mental health services within a short period of entering the hospital. The bed occupancy for the previous six-month period was 100%. Beds were not reallocated until a patient had been discharged so patients could always return to their own room after leave.

There was evidence that discharge planning was discussed with the patient at every level. It was discussed at every first multi-disciplinary meeting and all staff and patients we spoke with could provide information about discharge plans.

Discharge planning was planned and some patients we spoke to had discharge dates back into community mental health services that week. There had been no delayed discharges.

Staff supported patients during referrals and transfers between services for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. Patients were admitted onto the ward at all times and the hospital had a clear policy on admission procedures out of hours. Discharges were during the day.

The facilities promote recovery, comfort, dignity and confidentiality

The physical environment although not spacious was comfortable and promoted safety, privacy and dignity.

All bedrooms were en suite and single occupancy with secure storage. Bedrooms were personalised with patients' belongings and decorations. Both wards had a separate clinic room for physical examination and care.

There were quiet areas on the ward and a bespoke meeting room for visitors. Patients could make a phone calls in private.

Each ward had a secure outside space. Access to this outdoor space was monitored due to a ligature risk immediately next to the entrance, access was allowed by staff opening the door when requested by patients.

The hospital operated as a non-smoking facility so those patients who smoked had to go outside the hospital. On several occasions we saw a group of patients and staff outside the entrance to the hospital car park. There had also been a complaint from a local resident about this practice. Patients were offered support with smoking cessation. Patients had access to hot drinks and snacks at all hours on the ward.

Patients' engagement with the wider community

Patients were encouraged to maintain contact with their social networks and keep in contact with family and friends. Patients were also supported to utilise leave to go out into the wider community and visit relatives.

The hospital had also engaged with a community sports club offering a wide range of sporting opportunities. Patients could use the facilities and join club activities.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Meeting the needs of all people who use the service

Maryfield Court is a newly refurbished building and as such the hospital met all the required disability access standards with bedrooms adapted for wheelchair use and assisted bathrooms.

Information for patients was posted on notice boards to ensure patients could obtain information such as how to make a complaint, advocacy, local services etc. Information would be adapted for those requiring this in different languages or in accessible format. There was access to interpreters or sign language specialists if identified as a need. We saw evidence of the regular use of an interpreter to support patients.

A range of food was available to patients to meet their dietary requirements and cultural needs. Patient feedback was sought on the range and quality of the food provided. Patients had access to spiritual support and one patient told us they had been supplied with a copy of the Koran and could pray whenever they needed to.

Listening to and learning from concerns and complaints

Staff knew the complaints process and policy. Complaints were discussed in team meetings and staff could demonstrate learning from complaints. Complaints were seen by staff as an opportunity for patients to provide feedback about their care.

There had been seven complaints received by the hospital since it had opened. All complaints had been investigated. Complaints received from patients and carers were continuously reviewed and acted upon to improve quality of care. There was no pattern to the complaints.

The service had responded to a complaint from a local resident about the number of people stood smoking outside the hospital grounds and agreed to reduce the number especially in the evening.

Concerns could also be raised and discussed in community meetings. There was evidence of open and honest discussion and encouragement for patients to speak up and add to the discussions. All meetings were recorded and actions discussed.

There were 12 compliments recorded mainly from carers and patients.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Requires improvement

Leadership

We spoke with the service managers. The management staff had managerial and operational responsibility for each ward and all aspects of ward performance.

Managers informed us that they had effective day-to-day support to manage the hospital. However, some staff told us the recent introduction of a new shift coordinator at a corporate level had reduced their ability to act quickly to provide cover for vacant shifts.

Managers had a weekly governance meeting with the commissioning NHS trust to discuss the day to day running of wards and clinical governance.

Leaders were visible on the wards and around the hospital with senior leaders having open door policies. Staff told us that senior leaders were approachable and supportive to their needs and concerns.

Staff told us they had development opportunities available to them and could access good supervision and support for their roles. The hospital had a senior health care assistant role, who supervised the other health care assistants, this role offered developmental opportunities to health care assistants. Other staff told us they were being supported to take management and leadership qualifications.

Vision and strategy

ASC Healthcare, the provider, promoted its vision:

ASC Healthcare through a unique approach in their delivery of a social and clinical partnership model, will actively support individuals to develop a range of life skills and functional strategies that will allow individuals to live the life they want to live now and in the future.

They had also developed a framework of behaviours and values:

• Pride – showing pride by being the best in everything we do

• Respect – showing regard for the feeling, rights and views of others

• Patients first and always – placing the patient at the heart of everything we do

• Compassion – showing understanding, concern and contributing to providing a safe, secure and caring environment for everyone

• Standards – Setting the highest standards of care in all that we do

The hospital management team promoted the service's values and behaviours. Posters were

displayed across the hospital site.

Staff were educated about the values during induction and reminded about them at staff meetings. Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff reported feeling respected, supported and valued as part of their teams. Most staff felt positive about the service and proud to work there. Staff described good working relationships within the multi-disciplinary teams where all staff input was considered in a respectful and professional manner which led to constructive decision making. Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

Staff felt able to raise issues and escalate concerns without fear of retribution. Staff were aware of the whistleblowing process and would be happy to follow it if required.

There were no performance issues at the time of our inspection but ward managers reported that they knew the process to take and would receive sufficient support if they did encounter issues. The service's staff sickness and absence were similar to the provider target.

Staff appraisals included discussions about career development and the opportunities and training available to staff members.

Recruitment procedures included identity checks, employment history, professional registration and qualifications, right to work in the UK, health assessment, checks from the disclosure and barring service and reference checks.

Governance

There was an established governance structure with a defined hierarchy of reporting and decision making. There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

Monitoring was in place and regular systems audits took place. The was an audit schedule for ligature and infection control and senior members of the team conducted regular environmental 'walk rounds' where quality checks were made. Managers reviewed all care plans, physical health checks and occupational therapy plans. However, staff told us they were unaware of these audits; therefore it was difficult to determine how quality was improved.

There were systems to ensure that staff complied with mandatory training and attended clinical supervision and annual appraisals. Systems were in place to monitor complaints and incidents across the service and these were investigated where appropriate.

The hospital had a risk register in place, risk mitigation and action planning was reviewed monthly at the senior management team meetings. Staff were able to submit items for the local risk register.

Management of risk, issues and performance

There was a system in place to identify, monitor and address risks at the hospital. The risk registers were populated through the hospital's risk assessment and evaluation processes. This enabled risks to be quantified and ranked. Manager had systems in place that recorded the actions taken against these risks.

The hospital held a risk register locally. The assessment of risk took place at the hospital and any risks that were assessed as high were escalated onto the ASC Healthcare risk register which was discussed at every board meeting.

The hospital had protocols in place for major incidents and business continuity in the event of emergencies.

Information management

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. The service had systems in place that could collect data for the quality assurance team automatically, so not burdening frontline staff with analytical data collection tasks. There were also staff available to interpret and analyse that data.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Staff made notifications to external bodies as needed.

Staff had access to sufficient equipment and information technology to do their work. The secure record keeping system was easily available to staff to update patient care records and review during ward rounds and other team meetings.

However, bank and agency staff were using the same log in to record information onto the electronic care record system. Staff should have an individual security pass which identifies their usage of computer systems. This meant an audit trail of who was making what entry was not possible when a staff name was not added at the end of the entry.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. They had access to the intranet, bulletins, and newsletters.

The staff views were gathered from a range of sources such as engagement events, appraisal and staff surveys. When asked, 92% of staff said they thought their line managers were approachable and felt comfortable approaching their line managers for help.

Patients had opportunities to offer feedback on the service they received both during an admission period or after. We saw feedback from patients was recorded and considered. All patients were given an exit questionnaire on discharge to review the service they had received. This feedback was discussed at a weekly governance meeting with the commissioning NHS trust.

The hospital recognised its role within the local community and engaged with community leaders before opening to explain what sort of care would be delivered there.

Learning, continuous improvement and innovation

Maryfield Court is a new hospital, having opened in August 2018. A weekly governance group had been established to look at improving the care and treatment of patients.

Managers told us they had been solving teething problems expected with a new start up and had developed a building maintenance plan to develop better facilities and an improvement plan to create better systems to ensure better control.

There were plans to develop occupational therapy provision with a new kitchen and hospital management were in discussion with other health commissioners to open the other two wards.

As a new hospital they had not yet registered with any national accreditation scheme.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure that full physical health screening including the taking of full histories was completed by staff on admission
- The service must ensure that staff have separate log in security codes which identifies which member of staff is making an entry when documenting notes within patients' electronic record.

Action the provider SHOULD take to improve

- The service should review its electronic record keeping system to incorporate all patient records.
- The service should review its audit processes to ensure all members of staff are aware of the audits and that the results of those audits improve quality.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Patients were not subject to a full physical health check on admission. This was a breach of regulation 12 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Staff did not identify themselves as the author when they put entries on to the electronic care recording system. This was a breach of regulation 17 (2) (c)