The Cardinal Clinic

Quality Report

Oakley Green
Windsor
Berkshire
SL4 5UL
Tel: 01753 869755
Website: www.cardinalclinic.co.uk

Date of inspection visit: 1-2 May 2019
Date of publication: 13/06/2019

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated The Cardinal Clinic as good because:

- A strong ethos of person-centred care was visible throughout the clinic and patients were actively involved in their care. We observed staff treating patients with kindness, dignity and respect at all times during the inspection. Staff at all levels went above and beyond to ensure that they met the needs of patients and feedback we received from patients, relatives and stakeholders was unanimously positive.
- Staff involved patients and their relatives as active partners in their care. Patients and relatives felt involved in their care and treatment and staff provided ample opportunities for them to offer feedback.
- Staff ensured that patients remained in contact with people who mattered to them. Friends and family were encouraged to visit patients and invited to join them for meals on weekends. Staff offered support to relatives via a weekly support group or on an individual basis. A relative told us they found this support invaluable.
- The clinic was well staffed with a multidisciplinary team who worked together to best meet the needs of patients. Staff were well supported by managers who ensured that appraisals, supervision and reflective practice were in place.
- Managers provided a strong and visible presence within the service. Staff and patients had faith in the leadership at the clinic. They told us managers were always approachable and willing to listen to any comments or suggestions they had. Morale within the staff team was high.
- The clinic environment was tranquil and relaxing. The buildings and grounds were well maintained and clean throughout. All of the patients we spoke with praised the environment and felt it had helped to aid their recovery.
- Patients had access to psychological therapies in both a group and one to one setting. There was also a varied programme of activities available seven days a week. Patients told us their time was always occupied.
- Staff knew how to report incidents and had a good understanding of lessons that had been learned following incidents. Managers were open and honest with patients when any incidents occurred. A no blame culture was observed, with staff keen to learn from incidents to prevent them from happening again.
- Staff worked hard to develop relationships with other organisations locally, for example a general practitioner and mutual aid organisations. Staff ran events to raise awareness of mental health and wellbeing in the local community. They also delivered monthly continuing professional development sessions for other local professionals.
- Robust governance structures were in place with clear lines of accountability. An audit programme was in place and we saw evidence that audit results were reviewed by the relevant governance committees. There were clear processes in place for any actions identified from audits to be passed on to staff and mechanisms in place to monitor these.

Summary of findings

Contents

Good

The Cardinal Clinic

Services we looked at

Acute wards for adults of working age

Summary of this inspection

Background to The Cardinal Clinic

The Cardinal Clinic is an independent hospital providing acute inpatient care for working age adults experiencing mental health problems. The clinic has 23 individual bedrooms for men and women. At the time of our inspection there were 14 patients receiving treatment at the service. The clinic provides general mental healthcare as well as an eating disorder programme, drug and alcohol detoxification programmes and treatment for post-traumatic stress disorder. A day patient service is provided for patients who require access to a treatment programme but do not require admission, or for clients to step down to following an admission. Consultants and therapists also offer outpatient appointments for a variety of patient groups including children and adolescents.

Clients at The Cardinal Clinic either self-fund their treatment or it is funded by health insurance. In 2018, the clinic delivered 307 inpatient admissions, 1500 day patient sessions and 20000 outpatient appointments.

For the purpose of the inspection we have inspected this under the core service framework 'acute wards for adults of working age'.

The Cardinal Clinic is registered to provide accommodation for persons who require treatment for substance misuse; treatment of disease, disorder or injury and assessment or medical treatment for persons detained under the Mental Health Act (1983).

At the time of our inspection none of the patients receiving treatment at the clinic were detained under the Mental Health Act.

There was a registered manager in post.

The clinic had previously been inspected in March 2014 and November 2016 when the clinic was rated good. No breaches in regulation were identified.

Our inspection team

The team that inspected the service comprised two CQC inspectors and two specialist advisors; one of whom was a nurse with experience working in adult acute settings and the other a consultant psychiatrist experienced in community child and adolescent mental health services (CAMHS).

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:

Summary of this inspection

- looked at the quality of the environment in the inpatient building, day patient service and outpatient building
- spoke with four patients who were using the service and an ex-patient who sat on the patient and carer committee
- received feedback from a relative
- spoke with the registered manager, medical director, head of nursing and quality manager
- spoke with 27 other staff members; including doctors, nurses, psychologist, music therapist, healthcare assistants, kitchen staff, housekeeping staff, finance staff, maintenance staff and administrative staff
- spoke with external partners including a visiting general practitioner
- attended and observed a handover meeting, senior management team meeting and a healthy living group
- looked at 12 care and treatment records of patients, including six medication records
- looked at three staff files
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection, we spoke with five patients and a relative. All were universally positive about their experiences of the clinic and were full of praise for the staff and the clinic environment.

Patients and relatives said that staff consistently treated them with kindness, dignity and respect and that they frequently exceeded their expectations in ensuring they received the best level of care possible.

Patients appreciated that staff involved them in decisions about their care and gave them the opportunity to provide feedback about the provision of care at the clinic.

Patients told us that the food at the clinic was fantastic and that kitchen staff were always willing to make adaptations to ensure any specific dietary needs were met.

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 provider had strict admission criteria in place and did not admit high risk patients for whom the environment would be unsuitable.
- Managers completed ligature audits at least annually and had documented plans in place to mitigate any identified risks.
- The housekeeping and maintenance teams worked incredibly hard to ensure that the buildings and fixtures were safe, clean and well maintained throughout.
- The clinic had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The clinic did not have any vacancies for nurses or healthcare assistants. Agency staff were rarely used.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- Patients remained under the care of the same consultant psychiatrist whether they were an inpatient, day patient or outpatient. This ensured good continuity of care.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team via meetings and monthly bulletins. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as good because:

- Patients had access to a good range of psychological therapies which were available in both group and one to one settings.
- Staff assessed the physical and mental health of all patients on admission. Patients received a comprehensive physical health assessment on admission and a GP visited the service three times a week to monitor ongoing health concerns.

Summary of this inspection

- Staff developed individual care plans, which they reviewed regularly and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.
- The team included or had access to the full range of specialists required to meet the needs of patients. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Although the clinic rarely treated patients who were detained under the Mental Health Act, staff had a good understanding of their roles and responsibilities under the Act.
- Staff held monthly training sessions for other professionals in the local area to attend and offered to visit GP surgeries to deliver lunchtime training sessions.
- The provider ran an annual event to raise awareness of mental health in the local community. This was often delivered in conjunction with other local organisations, for example, schools.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- A strong, well-established culture of person-centred care was in place throughout the clinic, with staff placing patient needs at the heart of their work. Staff had excellent knowledge of individuals needs and preferences and ensured these were accommodated.
- Feedback from patients, their families and other stakeholders was universally positive about the way staff treated people. Patients and relatives told us that staff consistently exceeded their expectations and went above and beyond to ensure their needs were met.
- Staff consistently treated patients with kindness, dignity and respect. Relatives told us they were impressed with the warmth, patience and professionalism demonstrated by staff.
- People who used the service were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered people who used the service to have a voice and to realise their potential.

Summary of this inspection

- Staff encouraged patients to look around the clinic prior to admission. Admissions were tailored to individual need and took place at a time which was convenient for patients.
- Staff encouraged patients to maintain contact with people who mattered to them. Friends and family members were welcome to join patients for mealtimes on Saturday evenings and Sunday lunchtimes.
- Nursing staff facilitated a weekly support group for relatives and also offered one to one support to them. Relatives told us that nursing staff were always available when they needed them.
- Staff made patients feel as though they were important and that they mattered. Patients who had been admitted to the clinic multiple times appreciated that staff remembered them when they returned.
- The clinic received a large number of compliments from patients and relatives stating how grateful they were for the care and treatment provided at the clinic.

Are services responsive?

Good

We rated responsive as good because:

- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- A varied programme of activities was available seven days a week.
- Patients told us that the food provided at the clinic was of very good quality. Kitchen staff ensured that any specialist dietary requirements were accommodated. Patients could make hot and cold drinks at any time.
- The service met the needs of all patients who used it – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team. Managers identified themes in complaints and shared these with the board.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the service they managed, and were visible in the service and approachable for patients and staff.
- Our findings from the other key questions demonstrated that governance processes operated effectively within the clinic and that performance and risk were managed well.
- Staff had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff told us they felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Staff felt that managers were receptive to any feedback or suggestions. Staff morale was high and staff felt involved in decisions about the service.

Detailed findings from this inspection

Mental Health Act responsibilities

No patients were detained under the Mental Health Act at the time of our inspection. Managers told us that there was an average of five or six detained patients who received treatment at the clinic per year.

At the time of the inspection 11 out of 15 permanent staff and all bank staff were up to date with mandatory training in the Mental Health Act. The medical director ran training sessions twice a year and the staff whose training had expired were booked to attend the next session in June 2019. Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Information about advocacy services was displayed in communal areas such as the lounge and dining area. Information was also included in the patient information pack given to all new patients.

A Mental Health Act administrator was in post who monitored compliance with the Act. Annual MHA audits were completed. The 2018 audit showed 100% compliance for the six patients who had been detained at the clinic that year.

Mental Capacity Act and Deprivation of Liberty Safeguards

Most of the staff we spoke with had a good understanding of the Mental Capacity Act and could describe how they would ensure decisions were made in a patient's best interests if they were found to be lacking capacity. Some staff told us they would seek advice from senior colleagues if they had any concerns about a patient's mental capacity. Doctors we spoke with told us that nurses were forthcoming in raising capacity concerns with them.

At the time of the inspection 11 out of 15 permanent staff and all bank staff were up to date with mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The medical director ran training sessions twice a year and the staff whose training had expired were booked to attend the next session in June 2019.

All of the care records we reviewed included a capacity to consent to treatment form. There were no Deprivation of Liberty Safeguards applications pending at the time of the inspection.

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	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

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

Good

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

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

Good

Safe and clean environment

The Cardinal Clinic consisted of three buildings – the main building where inpatients stayed, a day patient building and an outpatient building. Each building had a reception desk that was staffed where patients and visitors were required to sign in.

The inpatient building was an Elizabethan house made up of many different rooms which meant that clear lines of observation were not in place. However, staff mitigated this by placing any patients at risk of self-harm on an enhanced level of observation. The provider had strict admission criteria. Patients were individually risk assessed prior to admission and any patients at high risk of self-harm were not admitted. If risk levels increased following admission patients were nursed on a one-to-one level of observation until a more suitable placement was found for them.

We reviewed ligature risk assessments which were completed at least annually, the most recent of which had been carried out in February 2019. Any identified risks were rated as high, medium or low and had documented plans in place to mitigate the risks. All bedrooms had collapsible curtain and wardrobe rails and there were three bedrooms available on the ground floor of the building which had further modifications made to reduce the number of ligature points. High risk patients were accommodated in these rooms with extra levels of observation from nursing staff. Ligature cutters were available in the clinic room and nursing office and staff regularly checked these.

The clinic complied with guidance on eliminating mixed sex accommodation. They had a male corridor and a female corridor which were accessed via separate staircases. There were three bedrooms on the ground floor which could be allocated to either males or females. All of the bedrooms were ensuite. A female only lounge was available on the female bedroom corridor. Only the bedrooms on the ground floor were lockable; the bedrooms on the upper floors were not. All patients had a safe in their room to store valuable items. We discussed this with managers who informed us that the options of having locks on the doors was frequently discussed with patients in community meetings and that they preferred not having them as it meant less disturbance when staff entered their rooms to carry out safety checks during the night.

All of the bedrooms and bathrooms were fitted with call alarm buttons that patients could use to summon assistance from nursing staff when needed. None of the consultation rooms in any of the buildings were fitted with alarms and staff did not carry individual alarms. Staff told us that if assistance was needed they would call reception. However, staff had raised this with managers who were in the process of sourcing a suitable alarm system that could be used throughout the site.

All of the buildings were well maintained and clean throughout. When staff identified issues that needed fixing these were added to a maintenance book and addressed promptly by the on-site maintenance team. Up to date cleaning records were available.

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

Good

Staff adhered to infection control principles, including handwashing. We observed signs on display in the clinic room and staff bathrooms promoting good handwashing techniques. Staff carried out annual infection control and handwashing audits and all staff were up to date with their mandatory infection control training.

Staff had access to emergency resuscitation equipment including a defibrillator, oxygen and suction machine. Staff checked the equipment to ensure it was intact and suitable for use. All permanent staff and 86% of bank staff were up to date with their mandatory cardiopulmonary resuscitation and defibrillation training.

Closed circuit television (CCTV) was installed in some areas of the clinic including the entrances and car parks, landings, communal areas and admin offices. There were posters up around the building notifying patients and visitors that CCTV was in use and leaflets were also available explaining why it was in place and what footage would be used for.

The fire alarm in the building was tested weekly and fire evacuation drills took place twice a year. Fire awareness training was mandatory for all staff. At the time of the inspection 90% of staff had completed this.

Safe staffing

The clinic was well staffed with 95 substantive staff members. The inpatient unit was staffed using registered mental health nurses (RMNs), registered general nurses (RGNs) and healthcare assistants (HCAs). Shifts were broken down to mornings, afternoons and nights. Four nurses and an HCA worked the morning and afternoon shifts. Two nurses worked the night shift with an additional nurse until 11pm and an additional HCA until midnight. Between October and December 2018 five shifts had been filled by bank staff. Bank staff were required to complete the same mandatory training as permanent staff and agency staff were only used if patients required a one-to-one level of observation due to their level of risk. All bank and agency staff used were familiar with the clinic. No shifts had been left unfilled.

The clinic did not have any staffing vacancies for nurses or HCAs. There was an 11.5% vacancy rate for other disciplines. The clinic had a low sickness rate and in the last year 18 members of staff had left.

All patients were allocated a named nurse. Patients we spoke with told us that their named nurse frequently spent time with them. Patients told us that other nurses also checked on them frequently throughout the day.

Each patient had a consultant psychiatrist who was responsible for their care. Patients stayed under the care of the same consultant psychiatrist whether they were an inpatient, day patient or outpatient which ensured good continuity of care. It stated in their practicing privileges that consultants were required to be contactable at any time if staff required advice. Cover arrangements were in place for when consultants were on leave. We observed staff discussing consultant cover arrangements in a handover meeting, to ensure that everyone was aware who to contact should they need advice. Nursing staff told us that advice from consultants was prompt when requested.

It was rare that activities were cancelled due to lack of staff. Where this happened, it was because a therapist or external partner had cancelled, and cover could not be arranged at short notice. Patients told us that if activities were cancelled staff always arranged for something else to take place at the scheduled time.

Staff were required to complete various mandatory training courses and at the time of the inspection 88% of staff had completed mandatory training overall. Very few staff were up to date with risk training. However, nurses we spoke with had a good knowledge of risk assessment and risk management and the careful way risk was managed within the clinic. Managers told us that the training figures appeared low because different modules of the training were delivered at different times and it didn't show as complete until staff had completed the whole package. Managers had changed the way this training would be delivered going forward so that it would all be delivered in one day. We saw that all staff who had not completed the full package were due to complete this in June 2019. The HR training administrator monitored compliance with mandatory training and managers had good oversight of this.

Assessing and managing risk to patients and staff

We reviewed 12 care records across inpatients, day patients and outpatients. We found that detailed, comprehensive risk assessments had been completed for the inpatients and day patients and that a brief risk assessment had been completed for outpatients. Where any risks had been

identified a management plan had been put in place. In three of the outpatient records we reviewed there was no documentary evidence that risk had been reviewed. We discussed this with managers who told us that the clinic was planning to move from paper records to electronic records in summer 2019 and that this would help ensure consistency with patient records and prompt staff to record that changes to risk had been considered. A new director of IT/communications had recently been appointed to take the lead on this work.

Informal patients could leave the clinic but were required to notify staff that they were leaving, where they were going and when they expected to return. Staff completed a risk log when patients requested to leave the clinic grounds and risk mitigation plans were developed collaboratively with patients.

Nurses completed conflict resolution and physical interventions training. Staff gave examples of how they had managed verbal aggression on the ward, for example putting a patient on a behavioural contract or speaking to them about their motivation for being at the clinic.

There was a list of items which patients were banned from bringing into the clinic such as drugs, weapons, alcohol and energy drinks. Other than this, patients were individually risk assessed as to whether or not they could bring certain items to the clinic. Patients were allowed their mobile phones but were asked not to use them in communal areas such as the dining room.

Inpatients had access to fitness equipment and a swimming pool, both of which they were risk assessed prior to using. There were clear policies and procedures in place for the use of these facilities. The swimming pool could only be used by a limited number of patients at one time under staff supervision. The area was kept locked at all other times.

Safeguarding

Staff we spoke with had a good understanding of safeguarding processes and could describe what actions they would take if they had any safeguarding concerns. Most staff were aware who the safeguarding lead was. At the time of the inspection 86% of staff were up to date with safeguarding adults training and 93% of staff were up to date with safeguarding children training.

People under the age of 18 were seen as outpatients but were not admitted to the clinic. They were seen in the separate outpatient building. If children were visiting relatives at the clinic this was individually risk assessed to ensure it was in their best interests and staff allocated a specific consulting room for visits to take place. Children were not permitted in communal areas of the clinic unless passing through.

The provider completed an annual safeguarding audit.

Staff access to essential information

Staff used paper records which were stored in locked filing cabinets within locked staff offices.

The provider had plans to move onto an electronic records system and was in the process of developing this with a software company to ensure it met the needs of the clinic.

Medicines management

We checked the process for managing medicines at the clinic and reviewed six medication records. We found errors on two of these. On one chart a staff member had prescribed “as required” medicine on an ongoing basis rather than stating a date for this to be reviewed. Managers ensured this was rectified during the inspection and that feedback was given to the prescriber. On another chart a prescription had been taken over the telephone however it was unclear who this had come from. Managers told us that if medicines were prescribed remotely the chart would be signed the next time the prescriber was in the clinic. Following a remote prescription, the prescriber would send an email confirming the prescription which would be attached to the medicines chart in the meantime. In this instance the email had not been attached to the file however we were shown evidence that it had been sent.

An audit of medication charts in 2018 showed that a high percentage of charts contained at least one error. Common errors included a lack of block capitals being used, illegibility and the ‘valid date’ box not being completed appropriately. These errors were sent out to all consultants highlighting collective errors and individual errors. The audit was repeated weekly for three months which led to a significant reduction in errors. Managers told us that the audit would be repeated quarterly to ensure continued

improvement. We reviewed minutes from Medical Advisory Committee meetings which showed that audit results had been discussed and consultants had been reminded about requirements for completing medication charts.

Where patients had consented, medication charts had a photograph of patients on the front to help ensure that medicines were issued to the correct patient.

All medicines were stored securely in a well organised clinic room. Staff checked the room and fridge temperatures daily to ensure that the medicines were stored at the correct temperature. Staff also checked the use by dates on medicines to ensure they were all in date.

A pharmacist visited the clinic weekly to review inpatient medication charts and if any errors were identified informed the consultants. If any complex prescribing was undertaken this was scrutinised by the pharmacist, rationale documented and reviewed with the patient.

Naloxone was kept in stock for use in emergency situations. Naloxone is a medicine which is used to rapidly reverse the effects of an opioid overdose. This was a recommendation from the previous CQC inspection in 2016 which had been addressed.

Patients told us that doctors provided clear explanation as to why medicines were prescribed and informed them about potential side effects. They told us they felt involved in decisions about their medicines. Staff also gave patients written information about any medicines they were prescribed.

Medicines management training was mandatory for all nursing staff. All permanent staff and 86% of bank staff were up to date with this.

Track record on safety

The provider reported two serious incidents in 2018, both of which were unexpected deaths of outpatients. Senior managers had carried out investigations into the deaths and there were clear processes in place for learning to be shared with the team.

Reporting incidents and learning from when things go wrong

All staff we spoke with knew what incidents to report and how to report them. All incidents were reported using paper forms. There were different forms to use depending on whether the incident was a patient/visitor incident or a staff incident. Managers logged all incidents on a spreadsheet and ensured they were appropriately graded. Monthly newsletters were sent out to staff advising of any lessons learned from incidents. Learning from incidents was also discussed in monthly heads of department meetings and then cascaded to individual staff groups via team meetings. Annual updates on incidents also formed part of a general mandatory training update which all staff were required to complete. Ninety percent of staff had completed this.

All staff we spoke with were able to give examples of recent incidents and describe how processes had been changed as a result. For example, following an incident where incorrect medication had been documented in a discharge letter staff were aware that the process had been changed so that letters had to be checked against discharge documents and drug charts and then checked by another nurse prior to sending. Managers identified themes in incidents twice a year and these were reported to the board. The most common themes identified in incidents were self-harm, slips/trips/falls and confidentiality breaches. Staff told us that they felt well supported from managers and colleagues following any incidents.

The provider had an adverse events policy which detailed steps which should be taken following an incident. This included details of how staff should ensure they met their obligations under the statutory duty of candour. This means ensuring that they are open and transparent in informing patients when things have gone wrong. The serious incident form had a prompt for staff to state whether duty of candour was applicable and if so to detail how this obligation had been met. The hospital director had oversight of all incidents and ensured that duty of candour was met. Staff received training in the duty of candour as part of their annual general mandatory training update.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

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

Good

Staff assessed the physical and mental health of all patients on admission. Staffed worked with inpatients to create a care plan on admission. This was then reviewed after 48 hours and weekly thereafter or more frequently if necessary. Inpatient care plans reflected the assessed needs, were personalised, holistic and recovery-oriented. Outpatient care plans were less detailed however all patients had a documented management plan in place.

All of the inpatient care plans we reviewed had been developed collaboratively with patients. Patients had care plans for both their physical and mental health needs. Patients were asked to write their views and reflections in their own words and then asked to sign the care plan. There was also clear evidence that patients had been offered a copy of their care plan.

All patients were given a comprehensive physical assessment from a nurse on admission including blood tests and an electrocardiogram (ECG). An ECG is used to check the rhythm of the heart and electrical activity. Patients were then seen by a GP who visited the service three days a week. We observed a nursing handover meeting where staff discussed a patient who had been seen by the GP and passed on advice given around managing the condition to their peers.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Staff delivered treatment and therapies recommended by and in line with NICE guidance. Patients had good access to a range of psychological therapies which were available in either a group or one to one setting. Therapies available included cognitive behavioural therapy, dialectical behaviour therapy and eye movement desensitization and reprocessing therapy.

Staff ensured that patients had good access to physical healthcare and supported patients to live healthier lives. Staff encouraged patients to stop smoking and promoted smoking cessation to them. If patients did wish to smoke there was a designated smoking hut in the grounds. Patients were offered a healthy diet during their stay at the clinic and the dietician ran a weekly healthy living group.

Staff used recognised rating scales to assess and record severity and outcomes. We saw evidence in care records that the Health of the Nation Outcome Scale (HoNoS) and Patient Reported Outcome Measures (PROMS) were used to measure patients' responses to interventions.

The provider had a clinical audit programme in place to assure the effectiveness of services provided. Audits included consent; five day follow up; HoNoS and PROMS. Managers maintained a clinical audit action plan to monitor progress made against recommendations generated from audits. The audit programme was overseen by the clinical audit and effectiveness committee, who were a sub-committee of the board. Committee members reviewed all audit findings and provided feedback to clinicians.

Skilled staff to deliver care

The clinic team included or had access to the full range of specialists required to meet the needs of patients. This included nurses, psychologists, psychiatrists, a dietician, a music therapist, an art therapist and family therapists. Managers told us that if input was needed from other professionals, such as a speech and language therapist or occupational therapist, these would be sourced externally.

Managers supported staff with appraisals, supervision and opportunities to update and further develop their skills. Ninety-seven percent of staff had received an appraisal in the last 12 months and all doctors had been revalidated. Staff told us that they received supervision at least once every two months but that managers had an 'open door' policy so they could seek advice and support at any time. Staff also attended monthly reflective practice which was facilitated by a psychologist. Additional sessions were arranged to support staff following any challenging incidents. We saw evidence that managers supported staff to further develop their skills and encouraged them to pursue educational opportunities.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together to benefit patients. They supported each other to make sure patients had no gaps in their care. Patients were reviewed by their consultant psychiatrist at least three times a week and feedback was then given to the nursing team. We observed a handover session and found that the nursing staff were very knowledgeable about interventions patients were receiving from the wider multi-disciplinary team.

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

Good

The clinic had effective working relationships with other professionals outside the organisation, such as a local GP, mutual aid organisations, mental health trusts and local charities. We spoke with representatives from some of these external organisations who told us that staff went to a lot of effort to arrange community awareness events to help promote the importance of mental health and wellbeing within the local community. The provider held an annual mental health awareness day focusing on a specific theme. The focus for the 2018 event was mental health in schools and the focus for the 2019 event was suicide.

Professionals from other agencies were invited to attend governance meetings where relevant, for example the visiting GP had attended the Medical Advisory Committee and infection control meetings. External partners told us that clinic staff were extremely receptive to feedback and happy to consider suggestions. They were able to give examples of improvements made following feedback provided to staff.

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

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

We observed a strong, visible, person-centred culture at the clinic. Staff at all levels within the organisation were able to describe individual needs of patients and how they accommodated them. We observed a handover session and found that staff spoke about patients in a respectful way and that they knew their needs and preferences really well.

Throughout the inspection we observed numerous interactions between staff and patients and found that staff consistently treated patients with kindness, compassion, dignity and respect. We saw that staff greeted patients using their preferred name and that they were always positive in their approach and willing to help.

Patients and relatives that we spoke with unanimously agreed that staff were "fantastic", that they were always available and that they consistently exceeded their expectations in ensuring that their needs were met. They told us that "nothing was too much trouble" for the staff and that they were "exceptional". We were given examples of how staff had come in on their days off to ensure scheduled activities went ahead for patients and a member of kitchen staff going to the supermarket in their own time to ensure they could meet a patient's specific dietary needs. A relative told us they were impressed by how nursing staff were exceptionally warm, patient and professional at all times.

Patients praised the consistency and continuity of the staff team at the clinic. Patients who had been treated multiple times at the clinic appreciated that the staff were familiar and remembered them when they returned. This made patients feel important and as though staff genuinely cared about them.

Patients and relatives told us they always received a warm welcome at the clinic – from staff of all disciplines. They said staff always went out of their way to greet them and check how they were.

The provider received 85 compliments in 2018 and we reviewed a sample of these. There were lots of compliments about individual doctors, therapists and nurses, praising their professionalism, caring attitude and hard work. There were also lots of thank you cards from patients and their families stating how much they appreciated the care provided at the clinic.

Staff we spoke with appeared genuinely interested in the wellbeing of their patients and told us that seeing patients get better gave them a great deal of job satisfaction. Staff at all levels made their best efforts to ensure that patients had a positive experience at the clinic. For example, if patients had a birthday during their stay the kitchen staff baked them a cake to celebrate.

Involvement in care

Staff were fully committed to working in partnership with patients and those close to them. Patients were actively involved in their care planning and staff empowered them to make decisions about their care. Patients were asked to write their views in their own words within their care plan which was reviewed with nursing staff at least weekly. All of the patients we spoke with told us they felt involved in their care and this was evident in the care plans we reviewed. There was also clear evidence that patients had been offered copies of their care plan.

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

Good

Patients were encouraged to visit the clinic to look around prior to their admission. Patients were admitted to the clinic at a time which was convenient for them. On admission they were given a full orientation from nursing staff and introduced to the other patients. Staff spent time with patients until they felt comfortable. Patients were also given an information pack on their admission to the clinic. This included information about advocacy, compliments and complaints, finance, meals, medical records and data protection, the provider's mission statement, how to give feedback, different staffing departments, therapies and groups and useful numbers.

Patients were invited to attend weekly community meetings which were attended by staff including members of the senior management team. This provided an opportunity for patients to feed back to staff about what was working well within the clinic and what could be improved. Staff kept a log of feedback from patients and documented what had been done in response to any feedback they had given. We saw evidence that suggestions made by patients had been discussed with the wider team, for example patients had recently suggested that there could be photos of staff on the board in reception showing who was on duty which was being discussed with the nursing team to get their views. We also observed the senior management team discussing suggestions from the most recent community meeting within their weekly meeting.

Patients felt that staff were incredibly responsive to any feedback given. They told us that staff at all levels genuinely listened to them and that they always received feedback regarding any suggestions made. One patient gave an example of raising a concern with nursing staff who then arranged for them to meet with the medical director the following day. They were very impressed with the prompt and caring response received from staff.

Patients had created a journal that they could use to write messages in to give hope to newly admitted patients. There were lots of messages in the journal praising the staff and experience at the clinic.

Relatives were invited to attend a weekly support group at the clinic which was run by one of the nursing team. Relatives who had attended told us that this was extremely well facilitated and that they really appreciated the opportunity to share with others and learn about their experiences. Staff also offered to meet with relatives on an individual basis. Relatives we spoke with told us that nursing staff were always available.

Staff encouraged friends and family to visit patients at the clinic. Usual visiting times were during evenings and weekends however requests for visits outside these times could also be accommodated. Friends and family members could also join patients for mealtimes on Saturday evenings and Sunday lunchtimes.

The provider ran monthly educational sessions for other professionals which patient representatives were invited to attend to give their views. There were also patient representatives on the patient and carer governance sub-committee who gave input on a variety of matters including recruitment of new staff and developing training for staff.

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 average bed occupancy between July and December 2018 was 57%. Patients were referred to the clinic via their GP or one of the consultants working for the clinic. The average length of stay in 2018 was 18 days.

In November 2018 the average waiting time for an adult outpatient appointment was eight days; for a child and adolescent outpatient appointment the average waiting time was 39 days. Staff told us they did not have a target time to see patients within, instead their target was to meet each patients' individual needs and so appointment times would be offered depending on urgency and individual need.

Inpatients were admitted to the clinic on a date and time that suited them. Beds always remained available for patients while they were on leave.

Between July and December 2018 there were no delayed discharges and the readmission rate was five percent.

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

Good

Patients who were discharged from the inpatient service already had an outpatient appointment booked. Patients who did not live locally were offered outpatient appointments via skype. All patients received a follow up call five days after discharge.

The clinic provided a 24-hour crisis support line for all current and discharged patients to use so they could access support from a nurse at any time. Patients we spoke with who had used the crisis number told us that help had always been very prompt.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the clinic supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom which they could access throughout the day. All patients had a safe in their room so they could keep their personal belongings safe.

There were quiet areas for privacy including a female only lounge on the female corridor. There were a variety of individual consulting rooms as well as group activity rooms available.

Patients were permitted to use their mobile phones within the clinic and WiFi was available in the main communal areas, bedrooms and consulting rooms.

Patients had access to extensive grounds which included a large lawn with a seating area and equipment so that they could play games. Patients told us that they really enjoyed having access to the outside space and felt this helped aid their recovery.

There was a varied programme of activities available seven days a week. This included gardening, nature walks, garden games, art and crafts, yoga, mindfulness, assertion skills, music therapy, self-esteem group, flower arranging, reflective group, understanding anxiety, healthy living, therapeutic writing, understanding anger, understanding depression, drama and alcohol awareness. Patients were asked to complete feedback forms at the end of any groups they attended to ensure these were continually improved.

Patients unanimously told us that the food at the clinic was of a very high quality. The kitchen at the clinic had been awarded a five-star food safety award from the Food Standards Agency in 2018. Patients were given breakfast, a three-course lunch and a three- course dinner and were given a variety of options to choose from for each. Fruit was available between meal times. Patients could make their own hot and cold drinks at any time.

Patients' engagement with the wider community

Staff supported patients to maintain contact with their friends and family where they wished to do so. All patients we spoke with told us that their relatives had been welcome to visit them whilst they were at the clinic. Friends and family could also join patients for meals on Saturday evenings or Sunday lunchtimes.

Meeting the needs of all people who use the service

The clinic had one bedroom which was accessible for disabled patients which was located by the reception area on the ground floor of the main building. The outpatient building had accessible consultation rooms and there was a stair lift in the day patient building.

Staff told us that interpreters would be booked if needed and that information in other languages could also be provided.

Staff ensured that patients' dietary needs were met and provided specialist foods where needed, for example for patients who had a vegan or gluten free diet. Chefs discussed any menu changes with the dietician to ensure they met patients' nutritional needs. The kitchen staff met with patients to discuss their dietary needs and preferences. They gave us several examples of changes they had made to menus to accommodate individual dietary needs.

Staff ensured that patients had access to spiritual support. They informed patients where local places of worship were and offered to accompany them to attend.

Listening to and learning from concerns and complaints

The provider had a complaints policy in place. The hospital director responded to all complaints. An acknowledgement letter was sent out within two days of receipt and a full response was sent within 20 days.

The clinic received 16 complaints in 2018. Of these, six were upheld, two were partially upheld and eight were not upheld. Where complaints were upheld apologies had been issued and the provider had taken steps to rectify any errors.

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

Good

Details of the provider's complaints process were included within the information pack given to all patients on admission. Patients told us that they would feel comfortable complaining to staff if they needed to.

The hospital director analysed all complaints to identify any key themes. Themes highlighted from complaints received in 2018 were consultant care and communication on discharge. Lessons learned from complaints were shared with the rest of the team to prevent re-occurrence.

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

Good

Leadership

The clinic was managed by an experienced leadership team. The hospital director had worked at the clinic for over 20 years and the medical director six years. Leaders had the skills, knowledge and experience required to perform their roles, had a good understanding of the service they managed and were visible in the service and approachable for patients and staff.

The senior management team were involved in the day to day running of the unit, for example the head of nursing worked shifts with the nursing team as well as fulfilling her managerial responsibilities. Staff and patients told us that the leaders at the service had an open-door policy and were always available to speak with them. They told us that managers were extremely receptive to feedback and that they felt their suggestions were always listened to. They told us that they always received feedback regarding any suggestions made and that managers were willing to compromise where possible.

Vision and strategy

The provider's mission statement was 'better mental health for a brighter future'. There were five values embedded within the organisation to help deliver this. These were quality, patient choice, transparency, education and development and caring. These were displayed around the building and discussed in team meetings. Staff we spoke with could name some of the values but not all of them, however we observed staff living the values throughout the way they interacted with patients and one another.

Culture

We observed a well-established positive culture within the clinic with patient care at the heart. Staff told us they felt respected, supported and valued; many of them having worked at the clinic for years and some decades. They reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.

Staff at all levels told us that communication was good and that they were consulted about the development or alteration to policies and procedures and felt their contributions were valued. For example, staff felt well informed about the change from paper to electronic notes and had been encouraged to contribute to discussions. They told us that they worked together as one team to provide the best care possible for their patients. There was also a suggestions box in the staff dining area for staff to post comments.

Staff felt able to raise concerns without fear of retribution and that were confident their concerns would be dealt with fairly. Where conflict had arisen, this had been dealt with appropriately. There were no instances of bullying or harassment within the team.

The provider had a number of initiatives in place to ensure staff welfare and boost morale, for example profit shares, free staff lunches, health insurance, financially supporting staff to aid career progression and organising social events. Away days had also taken place.

Governance

The provider had a well understood governance structure with clear reporting lines throughout the clinic and up to the board.

Quarterly meetings were held for each of the different disciplines to attend. There was a Nursing Advisory Committee (NAC), Psychological Therapists Advisory Committee (PAC) and Medical Advisory Committee (MAC). Consultants and therapists were required to attend two out of the four meetings each year as a requirement for maintaining their practicing privileges at the clinic.

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

Good

In addition to this senior clinic staff chaired clinical governance sub-committees. These were audit and clinical effectiveness; education, training and continuing professional development; information management; human resources; risk management; patients and carers; infection control and health and safety. Feedback from these committees was provided to the board which members of the senior management team were also a part of.

Actions from sub-committee meetings were taken to the relevant professionals committee meeting. The hospital director kept a log to ensure that actions were discussed where this had been agreed.

The provider had a clinical audit programme in place to assure the effectiveness of services provided. We reviewed minutes from the professionals committees and sub-committees and saw that results from any relevant audits were discussed.

Head of departments meetings took place monthly. We reviewed minutes from the last three meetings which showed that the meetings opened with staff sharing examples of how people in their department had demonstrated excellence within the last month.

Management of risk, issues and performance

The provider had a robust risk register in place. All risks were rated as red, amber or green and included target dates for completion. A named person was allocated as having responsibility for the risk and documented mitigation plans were in place. We saw evidence that risks were regularly reviewed by the senior management team. Staff were able to escalate risks to be included and we saw that risks from a variety of departments had been included.

There were processes in place to deal with poor staff performance, however no staff were suspended or under supervised practice at the time of the inspection.

Information management

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. All patient records were paper based and were stored in locked filing cabinets within locked offices. When records were removed from the filing cabinets and taken to consulting rooms staff ensured they locked the doors if left unattended.

Managers had access to data and information they needed to effectively carry out their management roles.

Engagement

Managers sent out a monthly newsletter to staff recognising achievements, promoting events and detailing lessons learned from incidents.

Patients were encouraged to provide feedback about their experiences of being cared for by the clinic using an external website. Staff could view the feedback online. Patients and visitors could also place feedback in a suggestions box in the reception area.

The provider offered monthly educational sessions for local professionals focusing on a different topic each month. These were sometimes delivered by external speakers and patients had also been involved in delivering them to give their views. They also provided practice-based tutorials for GPs where GPs could request a consultant or therapist from the clinic to deliver a one hour tutorial about a specific mental health topic to staff at their practice.

Learning, continuous improvement and innovation

Staff participated in clinical audits to evaluate the effectiveness of the interventions they provided. Action plans were generated from audits to ensure that improvements were made.

The clinic did not participate in the Accreditation for Inpatient Mental Health Services quality improvement programme managed by the Royal College of Psychiatrists.