Uplands Independent Hospital

Quality Report

Uplands Independent Hospital
61 Park Lane
Fareham
Hampshire
PO16 7HH
Tel: 01329 221817
Website: www.uplandsindependenthospital.co.uk

Date of inspection visit: 24 and 25 November 2015 and 20 May 2016
Date of publication: 29/06/2016

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?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
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.

Summary of findings

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

We undertook a planned comprehensive inspection in November 2015 and found a number of serious concerns. We visited the provider again in May 2016 and found that the provider had made a number of significant changes and improvements. Both inspections are described within this report.

When we undertook the inspection in November 2015:

- During our inspection visit in November 2015, we identified a number of serious concerns in relation to the governance and operation of the service. We took separate enforcement action by serving a warning notice in order to ensure the provider took immediate action to address the concerns identified.
- The provider had not taken appropriate steps to address serious risks associated with the physical environment. For example, the hospital was in an old building with numerous blind spots. The hospital did not have any procedural management of ligature risks and individuals who presented specific risks did not have any individual ligature risk management care plans. The building ligature point assessment, (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation), did not identify all ligature risks present within the building and assessed all risks from a general perspective such as architecture features, which included door hinges, architrave, fireplaces and window frames. There was no identified learning following a serious ligature incident in 2014, which resulted in a patient's death. There was no hospital risk register. There was no senior oversight of risk; minutes from the provider's governance meetings did not provide sufficient information about what those attending the meetings discussed or any quality or safety factors relating to Uplands Independent Hospital. The provider recognised that the current incident reporting system did not provide appropriate insight, although there was no clear plan to address this.
- We identified serious concerns in relation to the provider's systems for reporting incidents and learning from when things go wrong. There had been no training for the staff team at Uplands Independent Hospital on completing incident forms. We were concerned that inconsistent recording and reporting of incidents, lack of senior and organisational oversight, meant that the provider could not be assured that incident data was accurate and reflected the actual number or detail of incidents, or the current risks within the service. It also meant that potential trends or near misses might not be identified to learn from and prevent future incidents. The service's incident reviews were not detailed enough to identify developing trends, or any learning that might improve services.
- The recording of physical interventions, any form of physical contact and application of force to guide, restrict or prevent movement, did not meet the standards of the new Mental Health Act Code of Practice, as they did not identify the people involved, whether staff gave medication and, if so, by which route, and what the outcome was. Incident records reflected that seclusion, (the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving), might have been used but not recognised by staff.
- The hospital did not have access to a full range of professionals to ensure patients received appropriate care and treatment. Care plans were not personalised and 'pen pictures 'used to allow new staff to gain a

Summary of findings

quick understanding of patients did not include all current risks. There was limited patient involvement in care planning and some patients had not been given copies of their care plan.

- There were safeguarding threshold care plans in place (care plans used to stop unnecessary referrals to the local authority safeguarding team) but there was no monitoring in place to ensure they remained appropriate and effective. The hospital relied on risk assessments from previous placements for patients and did not consider the impact of a new environment on the patient.
- Staff had not received training in the new Mental Health Act Code of Practice, and scrutiny of Mental Health Act paperwork was ineffective. There had been no consideration of mental capacity for informal patients.
- The provider was starting to admit more patients from medium and low secure services. However, there had been no effective engagement with service commissioners, such as local Care Commissioning Groups, about the development of the service. There was no comprehensive plan for the proposed changes to the service or building alterations, there was a draft plan in place which lacked detail and was awaiting approval.

However, we also found:

- The hospital was clean and maintained to a good state of repair. The hospital had accessible bathrooms. Female patients did not need to go through male areas to use bathrooms, and their bedrooms were behind a locked door.
- We observed that staff treated patients with kindness and respect. Staff interacted respectfully with patients, sitting down to eat with them at meal times, and knocking on doors before entering bedrooms. Patients could visit the hospital before admission to familiarise themselves with the hospital, talk with patients and staff at meal times, and choose from any available bedrooms. There was a good range of activities and staff reviewed them with the patients monthly.
- There were regular patient meetings and the hospital manager made themselves available to meet with the patients. Patients could personalise their bedroom.
- The hospital manager was able to alter staffing levels to meet any changing clinical need.
- Supervision records showed that staff received appropriate support from managers and that supervision happened regularly. Handover reports included information about risk and patient behaviour. Staff reported feeling supported by the hospital manager and were able to raise concerns. Some staff felt that they had been involved in some aspects of service development.

Following our visit in May 2016:

The provider produced an action plan to address our concerns and they then sent us an updated plan to identify the progress made. The lead commissioner, for the service, supported them in meeting the plan. We re-visited Uplands Independent Hospital on 20 May 2016. We were following up on the concerns identified in relation to the warning notice. We found that effective actions had been taken and we lifted the warning notice. We found that the team at Uplands had clearly worked very hard and made significant progress in a number of key areas of concern, most notably:

- The ligature audit had been re-formatted and undertaken much more comprehensively with a clear risk rating, depending on a number of clearly identified factors. This in turn had been linked to the potential individual patient risks. All individual risk assessments and care records had been reviewed and updated. Risk assessments were well organised and detailed. There was a schedule of anti-ligature works available for us to review. The provider had taken a number of immediate actions to reduce the level of risk posed by the ward environment. For example, they had installed mirrors to increase the line of sight, and removed door openers and blocked in bannister spindles that might have been used as ligature anchor points. The management and staff team demonstrated a much better understanding of assessing and managing risks in the environment and relating this to individual and patient groups.
- An improved governance structure has been put in place within the hospital and this had been linked to the new, wider provider governance meetings. Whilst it was still being established, with this new structure, there was potential for there to be much better senior oversight of a range of quality and safety issues. This

made it more likely that any increased risks would be identified in a timely manner and the team should get the support they need from the provider to address them.

- The provider had amended the incident reporting system. Investment in the incident reporting tool had enabled the staff team to enter a much more detailed report, this had the potential to record more accurately incidents allowing for clear review for trends and monitoring restraint activity.
- The provider had updated Mental Health Act policies to take account of the revised code of Practice and made available the details of hospital managers. It had amended the incident reporting system to allow staff to record the appropriate detail in relation to restraints. The provider had updated the support plans for the management of violence and aggression for each patient. The hospital administrator had accessed specific training and an additional administrator had been employed to allow protected time to focus on the Mental Health Act administrator role.
- Staff morale was good and staff reported that the additional investment and senior oversight was a positive for the development of the hospital, as well as day to day patient care and staff safety – whilst it was recognised there was still work to do, everyone felt more confident and supported to continue with the development of the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	Start here...

Summary of findings

Contents

Requires improvement

Uplands Independent Hospital

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

Summary of this inspection

Background to Uplands Independent Hospital

Uplands Independent Hospital provides care and treatment to people aged over 18 who may be informal patients or detained under the Mental Health Act 1983. It offers assessment, treatment and continuing care for up to 30 people. At the time of the November 2015 site visit, there were 22 inpatients; 16 were detained under the Mental Health Act and six were informal. The hospital provides treatment for patients who require long stay and rehabilitation services. The Hospital was a single ward with a separate area for the female patients' beds. At the time of our visit in November 2015, there were 17 male and five female patients admitted.

Uplands Independent Hospital is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.

Uplands Independent Hospital is located in an old manor house on the outskirts of Fareham and is set within its own grounds. When originally established, the services was set up to provide for patients who had long term mental health issues and was seen as a placement for life for patients. The inspection team were told that the service intended to provide a more rehabilitation focused model of care; this was because the provider believed this was more in line with current mental health provision. To provide this they would redevelop the site. The provider had also identified patient groups, including patients in secure mental health services, as admission sources. At the time of the inspection, the provider's management board had not approved the plans or the required funding.

Our inspection team

Team leader: Gavin Tulk, Inspector

The team that inspected this service comprised an inspection manager, two inspectors, a specialist mental health nurse and a Mental Health Act reviewer (MHAR).

Why we carried out this inspection

We inspected this core 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 these services, and asked a range of other organisations such as local safeguarding teams and clinical commissioning groups for information.

During the November 2015 inspection visit, the inspection team:

- visited the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients

Summary of this inspection

- spoke with three patients using the service that wanted to speak to us
- spoke with the hospital manager
- spoke with nine other staff members, including doctors, nurses and recovery support workers
- interviewed the director for adult services and the national manager
- attended and observed a staff meeting
- collected feedback from 21 patients and staff using comment cards
- looked at three treatment records and records related to the detention of the 16 detained patients looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with three patients and received 13 completed comments cards from people currently inpatients at the hospital. Patients' views about the services were divided:

- some felt they were treated with dignity, respect and were listened to, while others felt they were not listened to
- some felt their needs were met, while others commented they did not get enough tea or coffee
- some felt the hospital was clean and safe, while others disagreed and felt the decoration needed updating

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?

Requires improvement 

When we undertook the inspection in November 2015, we found:

- The hospital did not have clear lines of sight and the provider had done nothing to reduce the risk from blind spots.
- The service did not assess the risks posed to individual patients by potential ligature anchor points, or consider them in patient risk assessments; there was no ligature risk management procedure and no learning from a 2014 serious incident.
- Recording of physical interventions did not meet the standards identified in the Mental Health Act Code of Practice; review of physical interventions did not include trend analysis, identify learning, or reflect the provider's policy for incident analysis.
- Our review of incidents identified that staff sometimes used seclusion without formally recognising that this was the case and without undertaking the appropriate reviews.
- The hospital did not comply with guidance on the provision of same-sex accommodation because there was no separate day room area for female patients; we raised this after our inspection and the hospital addressed this immediately. The hospital did ensure that female patients did not need to go through areas that included male bedrooms to use bath and toilet facilities.
- Pen pictures, brief summaries about the needs of a patient, did not cover all known risks.
- Staff did not monitor safeguarding threshold care plans (care plans used to prevent unnecessary referrals to the local authority safeguarding team) to confirm that they remained appropriate.

However:

- The environment was clean and well maintained.
- There was an effective system for checking medication.
- The hospital manager was able to adjust staffing levels to meet clinical needs.

During a follow up inspection in May 2016, we found:

- The ligature audit had been re-formatted and undertaken much more comprehensively with a clear risk rating, depending

Summary of this inspection

on a number of clearly identified factors. This in turn had been linked to the potential individual patient risks. All individual risk assessments and care records had been reviewed and updated. Risk assessments were well organised and detailed.

- There was a schedule of anti-ligature works available for us to review, and we could see a number of immediate actions had been taken where possible to reduce the high risks in the environment, for example, mirrors to increase the line of sight, removing door openers and blocking in bannister spindles. The management and staff team demonstrated a much better understanding of assessing and managing risks in the environment and relating this to individual and patient groups.
- Regular quality and governance meetings had been re-established with the lead commissioner to review a range of quality and safety areas of patient care and treatment, including safeguarding threshold plans and managing risks.

Are services effective?

Requires improvement

When we undertook the inspection in November 2015:

- At the time of the November 2015 inspection, the hospital did not follow a model of care that was consistent with a rehabilitation ward; that is, a model whose purpose was to enable people to reacquire the skills to live in a setting of lower dependency.
- The care plans were not sufficiently personalised or recovery focused for a ward whose purpose is rehabilitation.
- The multidisciplinary team at the hospital did not include a psychologist, which meant patients did not have access to psychological therapies.
- There had been no training around the new Mental Health Act Code of Practice and new policies did not reflect this key change in legislation.
- The managers of the hospital did not scrutinise the Mental Health Act paperwork effectively.
- Staff had not considered the mental capacity of informal patients
- None of the staff had received an annual appraisal.

However:

- Staff assessed the physical health needs of patients on admission and monitored their physical health regularly.
- Handover records passed on appropriate information about patients' behaviour.

Summary of this inspection

- A good medicines management process was in place and there were active plans to reduce medication that was above the levels identified in the British National Formulary, a pharmaceutical reference book that contains information and advice on prescribing and pharmacology.
- Records showed that staff received effective support from managers and that supervision took place.

During a follow up inspection in May 2016, we found:

- Mental Health Act policies, Code of Practice and hospital manager details were updated and available; incident reporting system had been amended to allow for the appropriate detail in relation to restraints. Support plans for the management of violence and aggression had been updated for each patient. The hospital administrator had accessed specific training and an additional administrator had been employed to allow protected time to focus on the Mental Health Act administrator role.
- Care plans had been reviewed and updated, they were well organised and detailed – we saw that care plans included comments and contributions from patients. It was clear from the staff team that there was enthusiasm and support for moving forward with the recovery model.

Are services caring?

Good

When we undertook the inspection in November 2015:

- We observed that staff treated patients with kindness and respect.
- Patients could visit the hospital before admission to familiarise themselves with the hospital, talk with patients and staff at meal times, and choose from any available bedrooms.
- There were regular patient meetings and the hospital manager made themselves available to meet with the patients.

However:

- Patients were not involved in planning their own care and not always given a copy of their care plan.

During a follow up inspection in May 2016, we found:

- Care plans had been shared with patients and we saw that where people were able to make comments and contribute to the care plans, they had done so.

Are services responsive?

Requires improvement

When we undertook the inspection in November 2015:

Summary of this inspection

- The hospital was not always able to discharge patients who needed a higher level of security within a reasonable timescale; this was because commissioners were unable to find suitable alternatives.
- The service did not provide information in accessible formats to meet the different communication needs of patients.
- Staff were unable to identify any learning from complaints.

However:

- Patients were offered a wide range of leisure activities.
- Patients were able to personalise their bedrooms.
- The hospital provided accessible bathrooms and disabled access.
- There was a good range of activities and staff reviewed them with the patient monthly.

Are services well-led?

Requires improvement

When we undertook the inspection in November 2015:

- At the time of the November 2015 inspection, the hospital was operating as if it was a 'home-for-life' for its residents as opposed to one focused on rehabilitation and recovery. The inspection team were told that the service intended to provide a more rehabilitation focused model of care although this had not been established at the time of the inspection, the registered manager had started implementing aspects of the recovery model.
- The organisation did not have a good overview of current risks to staff and patients, and did not manage such risks appropriately.
- The provider did not have effective systems to regularly assess and monitor the quality and safety of the services provided.
- The minutes from the provider's governance meetings did not give enough detail of discussions relating to Uplands Independent Hospital.
- Staff had not been given training in relation to completing incident forms.
- Incident form reports did not give the provider effective oversight of incidents. Although the provider recognised this, at the time of the inspection it had not addressed the matter sufficiently.
- There was no clear, strategy for the proposed changes to the service. Whilst the provider had a draft development plan, this was awaiting funding and lacked detail until this had been finalised. The provider advised that once funding was agreed by the board, they would seek consultation from key stakeholders.

However:

Summary of this inspection

- Staff felt well supported by the hospital manager and reported that morale had improved.
- Staff felt confident the manager would listen to them if they raised a concern.

During a follow up inspection in May 2016, we found:

- An improved governance structure was in place within the hospital that was included within new overarching provider governance meetings. Whilst it was still being established with this new structure there was potential for there to be much better senior oversight of a range of quality and safety issues, meaning that any increased risks would be identified in a timely manner and the team should get the support they need from the provider to address them.
- The incident reporting system had been updated. Investment in the incident reporting tool has enabled the staff team to enter a much more detailed report, this has the potential to record more accurately incidents allowing for clear review for trends and monitoring restraint activity.
- Regular quality and governance meetings have been re-established with the lead commissioner to review a range of quality and safety areas of patient care and treatment.

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. We reviewed adherence to the Mental Health Act (MHA) during our inspection in November 2015 and found the following:

- staff had not received training in the new MHA code of practice
- the hospital was still using the old MHA code of practice and therefore had not introduced policies, procedures and guidance included in the new code of practice
- there was no effective scrutiny of mental health paperwork on admission
- we identified some errors on Mental Health Act detention renewal paper work where it had not been signed by or on behalf of the hospital managers
- people had access to independent mental health advocacy (IMHA) support
- detained patients' capacity to consent was assessed on admission and recorded in the notes
- staff did not recognise when they were using seclusion, the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving

However, when we re-visited on 20 May 2016 we found that the provider had taken significant steps to address a number of issues in relation to adherence to the Mental Health Act (MHA) that we identified in November 2015.

- A training programme had been prepared and delivered to staff by the MHA lead in a neighbouring NHS trust. This course covered legislation, the guiding principles of the code of practice, seclusion, and scrutiny of documents, restraint and Deprivation of Liberty safeguards. The revised MHA code of practice was available for staff. Mental Capacity Act training was being arranged for staff.
- The existing hospital administrator now had three days per week of her time allotted to MHA administration. She was due to attend a specialist-training course. A new part time assistant had been recruited to backfill her general administration responsibilities. A specialist well regarded MHA law firm was now available to the hospital for consultation on MHA matters.
- A MHA scrutiny panel had been established with external representatives and there was a MHA quarterly report. Section 17 leave and section 132 rights were now audited monthly.
- The registered manager had gone through Annex B of the revised Code of Practice and drafted updated policies to meet these requirements.
- The provider had followed up the nearest relative issue for the two patients where this was identified as an issue at the last inspection. One had a solicitor as nearest relative and a nearest relative was in the process of being appointed by the local authority for the other.
- The provider talked to us of their understanding of de-facto seclusion and they had updated patients' time out care plans and support plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Eighty five percent of staff had received training in the Mental Capacity Act.
- Patients' ability to consent to treatment had not been considered for the six informal patients. Plans were made to address this while we were on site.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

Uplands Independent Hospital is a grade two listed building set within its own grounds. There are two floors, with long corridors and a number of communal areas. At the time of our November 2015 inspection, there were 30 individual bedrooms although only 22 were occupied. Due to the design of the building, it did not have good lines of sight. The hospital had not reduced the risk from the large number of blind spots (corners in the corridors, alcoves and areas under staircases), for example, by the use of mirrors. There were no observation panels (windows in doors that can be opened to allow observation or shut to allow privacy) in any of the doors to mitigate individual patient risk. The environment was clean and tidy and the furnishings were generally in a good state of repair, however some of the carpets were old and worn.

We reviewed the hospital's ligature assessment. The ligature assessment was general in nature; it had grouped rooms in to categories, for example all 30 bedrooms. It had not identified all ligature risks that were present in each room, for example door hinges and architrave. It did not identify risks that were individual to each room, such as ornate fireplaces. The ligature assessment identified all such risks as "architecture features". The provider advised us that ligature risks were managed by an individual risk assessment. Two patient records we reviewed, that identified suicide as a historic risk, did not include ligature management in their risk plan.

However, when we re-visited the hospital on 20 May 2016, we found that the ligature audit had been re-formatted. It was much more comprehensive with clear risk rating, depending on a number of clearly identified factors. This in turn had been linked to the potential individual patient risks. All individual risk assessments and care records had been reviewed and updated, they were well organised and detailed. There was a schedule of anti-ligature works available for us to review, and we could see a number of immediate actions had been taken where possible to reduce the high risks in the environment, for example, mirrors to increase the line of sight, removing door openers and blocking in bannister spindles. The management and staff team demonstrated a much better understanding of assessing and managing risks in the environment and relating this to individual and patient groups.

The hospital only had a few rooms with en-suite bathrooms and there was not a separate day room for female patients, we discussed this issue with the hospital manager after the inspection and they ensured that a female only lounge was immediately provided. Patients did not have to pass the bedrooms of the opposite sex to access bathrooms. Female bedrooms were separate to males' rooms and secure behind a door with keypad entry. A female patient told us they felt safe.

The clinic room was clean and well organised; it had appropriate equipment such as an emergency bag, defibrillator, blood pressure machine and refrigerator for medication. We did not see any checks in place for medical devices other than the defibrillator. The defibrillator and

emergency bag checks were carried out weekly and were complete. However, there was no list of what equipment should be in the emergency bag; therefore, the hospital could not be sure all necessary equipment was in place. There was an appropriate system in place for the management of clinical waste. The pharmacist carried out emergency drugs checks and rotation of stock. There was a system in place for the checking of medication stock levels and expiry dates. The pharmacist advised that the service never ran out of medication and never over stocked.

We saw evidence that infection control audits were completed every six months. Staff used the alcohol gel dispensers at the entrances to the hospital.

Safe staffing

The staffing establishment was:

- Two qualified nursing staff and four unqualified nursing staff on a day shift (07:00 – 14:30 and 14:00 – 21:30)
- One qualified nursing staff and two unqualified nursing staff on a night shift (21:00 – 07:15)

We were advised that there were not always two qualified staff on a day shift, but on these occasions, the hospital manager and the deputy manager covered the shift. The hospital had introduced senior recovery support workers (unqualified). In the three months between June and August 2015 119 shifts were not filled on the hospital rota. Staff were able to work additional hours to cover 42 shifts and agency were used on 48 occasions. Therefore, 29 shifts were left uncovered. The manager advised that the service tended to use agency staff who had worked at the hospital before and that they had agreed longer term contracts with agency staff who knew the service to offer them fixed hours for the next three months. The hospital was currently recruiting to address the need to use agency staff and to cover their current vacancies. There were three and a half full-time qualified nursing vacancies; one person was currently going through the recruitment process. There were three and a half vacancies for unqualified nursing staff.

When additional support was required for patients, staffing numbers were increased. The manager was able to increase staffing numbers and to apply for additional funding for staff, from the commissioners, if needed. We were given an example of when staffing was increased when a patient was admitted to hospital and required more support than originally assessed to ensure planned activities could go ahead.

It was reported by staff that patients' leave could be cancelled due to staff having to support patients to health appointments. One out of ten staff we spoke to felt that patients were not able to access their leave regularly enough and in one out of four patient records we reviewed staff had recorded that a patient was unable to access leave due to staff shortages.

The wider multidisciplinary team consisted of a consultant psychiatrist and occupational therapist. There was only one psychiatrist employed by the hospital and they provided all the out of hours support. There were plans to increase the number of psychiatrists providing out of hours support. There were arrangements in place to cover sickness and annual leave. With only one psychiatrist in place, they were responsible for ensuring all the day to day medical input reviewing medication, monitoring side effects and physical health.

We were concerned about the lack of clarity in relation to the current purpose of the service and patient group. The service was taking more referrals from low and medium secure services, although there was no clear referral pathway or assessment process. The service did not have an appropriate multidisciplinary team in place to provide the appropriate care and treatment.

Staff told us that they were not always able to give patients one to one time, however we were given the assurance that the service was about to introduce protected time for two staff members to work one to one with patients on each shift.

The provider reported that 93% of staff had completed the mandatory training, which included training such as first aid, fire and health and safety. First aid training included cardiopulmonary resuscitation (CPR).

Assessing and managing risk to patients and staff

Risk assessments were completed on admission. However, these did not contain a clear summary of risk and relied upon information from risk assessments completed by the previous placement. The risk assessments did not reflect any increased risk associated with the individual being in a new environment, or specific risks from the hospital

environment. Staff were unable to advise of any risk tools used within the service. Risk management plans did include information on known risks, when the risk was likely to occur and plans to help manage the risk. We noted that identified risks were viewed in a static way, for example, when a risk occurred in the hospital, risk management plans were not up dated to reflect how this might affect community leave. However, when we re-visited the hospital on May 20 2016, all individual risk assessments and care records had been reviewed and updated. They were well organised and detailed, containing comprehensive detail about current and historic risks.

Staff carried personal alarms and there were nurse call points in the bedrooms and therapy areas.

Staff reported having good links with local social service teams. The hospital had safeguarding threshold care plans (plans to identify when issues become safeguarding concerns due to frequency or severity) in place for some patients. Since the monitoring meetings with the local safeguarding team had stopped early in 2015, there had been no monitoring or review of these plans to identify if they remained appropriate and effective. Following the inspection it has been agreed to restart these meetings.

Staff had used physical restraint to control patient behaviour on 76 occasions between March and August 2015. None were in the prone position and none required rapid tranquilisation. We identified that the record of these interventions did not meet the standards of the latest Mental Health Act code of practice guidance, because they did not explain the reasons why a physical intervention was used, how it was implemented and the patient's reaction to it. Staff could explain how they would deescalate patients to avoid restraints. In the records we reviewed, we saw care plans that included early warning signs and plans to prevent the escalation of behaviours. The plans we reviewed were not personalised and did not involve the patient.

Incident records reflected that seclusion, the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, might have been used but not recognised by staff. We identified that patients were being asked to leave communal areas and to remain in their bedrooms following incidents. Staff stated that they would remain with them and they were free to leave if they wanted to do so. However, care plans did not make this clear and some incident forms indicated that staff prevented patients from leaving their bedrooms.

There were good medicines management practices in place. The hospital had a contract with a local pharmacy to provide pharmacy support and they conducted a weekly audit of prescription cards and medication stock. Staff recorded any concerns on the incident recording system. We spoke with the pharmacist, and they did not report any concerns with the service. On some prescription cards, reviewed, out of date prescriptions were not clearly crossed out.

Track record on safety

There had been a serious ligature incident in 2014. However, nine out of the ten members of staff we spoke with were unable to identify any learning that had occurred because of this. One member of staff advised that the service would no longer admit patients who presented a risk of suicide. However, there were still patients admitted with history of using ligatures to harm themselves. Staff did not tell us anything they or the provider could do to improve assess and reduce risks. There were no procedures in place to reduce the risk presented by ligature points.

Reporting incidents and learning from when things go wrong

Incidents involving patients were recorded on the service's electronic incident reporting system. This system was monitored by an external organisation, which provided analyses of incidents to the hospital and the board. A meeting to review reported incidents was scheduled to take place monthly. However, the meeting had not taken place in the absence of the registered manager, or involved wider members of the team, for example, the psychiatrist. It was not clear that this review meeting was an effective forum within which trends analysis, identifying learning or monitoring identified actions from incidents happened. There was not always sufficient detail on incident forms to provide a clear picture of what actually happened, for example, how many restraints took place, for how long, what medication was given and by what means, the outcome of the incident and who was informed.

The hospital was not following its policy, when analysing physical restraints. The hospital was also not following the Mental health Act code of practice, which requires them to

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

record the reason for the restraint and the patient's response to it. There had been no training provided for staff in relation to completing incident reports. The provider informed us that they were looking at an alternative recording and reporting system, although no specific action had taken place in relation to this at the time of inspection.

Staff completed a behaviour-monitoring index for each patient following an incident, which recorded what occurred before, during and after each incident. This information was not used in the incident monitoring meetings which meant any patterns or concerns could not be identified in line with their behaviour management plan.

When we re-visited the hospital on 20 May 2016, we found that the incident reporting system had been amended. Investment in the incident reporting tool has enabled the staff team to enter a much more detailed report, this has the potential to more accurately record incidents allowing for clear review for trends and also monitoring restraint activity. They had also introduced weekly risk management meetings to review incidents in detail.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed four patient records, during our inspection in November 2015, and saw that there was timely assessment of physical and mental health needs on admission by the consultant psychiatrist. The hospital used a paper recording system there were currently no plans to transfer to an electronic system. Care records were kept securely in the office and were well organised. Staff we spoke with advised that they had access to the information they needed in the files, however they did not always have time to spend looking at information. We saw evidence that the authors audited their own care plans. Care plans were also peer reviewed. However, care plans were not recovery focused or personalised. The manager recognised that care plans were not always updated in a timely fashion. However, when we re-visited the hospital on May 20 2016, all individual risk assessments and care records had been reviewed and updated. We also saw that patients had made comments about their care plans where they had capacity to contribute.

We saw evidence in care records of ongoing monitoring of patients' physical health.

There were 'pen pictures' available to new staff so that they could quickly learn about patients' needs and how best to work with them, however these did not cover all risks identified for the patients.

Handover records showed that they passed on appropriate information about patients' behaviour and health. One member of staff told us that because domestic staff did not attend the handover, which they had done in the past, valuable information might be missed

Best practice in treatment and care

The service was in the process of introducing a model of care more focused on rehabilitation and was using the recovery star, a tool for optimising individual recovery and gaining the information to create a recovery-focused care plan, and the service had staff familiar with using this tool. The senior team recognised that this tool was not suitable for all patients and for the older patients the service needed to focus on the quality of patients' lives.

Each patient had an individual activity programme. This included social type activities in the evenings and weekends. Staff also took patients into the community to help them develop life skills and do daily tasks independently if they were able.

Skilled staff to deliver care

Many of the staff team had been in post for several years and had a good understanding of the patients.

No staff were being managed under the provider's staff performance policy.

The service did not employ a psychologist, speech and language therapist or social worker, which meant that patients did not have access to psychological therapies or other treatments. The service did not have staff experienced at working with patients from a forensic background or with a good understanding of the risks they might present. The services already had admitted patients with forensic histories and had identified this patient group as one that could provide future admissions.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

External trainers had delivered additional training in relation to schizophrenia, psychosis and safeguarding vulnerable adults. Staff were able to complete on line training and it was reported that if they did this in their own time they were paid for it.

Qualified nursing staff were supposed to receive supervision on a monthly basis with the manager and unqualified staff every two months. Five of the six members of staff we spoke with about this reported receiving supervision in line with the supervision policy, but one member of staff reported that they had not had supervision within this timeframe. We reviewed ten supervision records and they contained appropriate topics and detail of discussions for example, training, operational issues, support and development. Nine of the staff records viewed indicated that supervision had occurred within the hospitals timeframe and one was just outside this period. Staff who reported not receiving regular supervision did report that the manager was approachable and supportive of staff.

No staff had received an annual appraisal during 2015; the hospital manager confirmed this during our inspection.

Multi-disciplinary and inter-agency team work

The service had weekly clinical review meetings and each patient was reviewed on a monthly basis. The consultant psychiatrist, qualified nurses and the occupational therapist attended these meetings. The service followed the care programme approach, the statutory framework within which mental health services organise care for patients with mental health problems. The hospital held meetings to discuss this every six to eight months, with hospital managers and care co-ordinators invited to attend. The hospital manager told us that care co-ordinators attended relevant meetings and visited on an ad hoc basis.

Adherence to the MHA and the MHA Code of Practice

We were advised that staff had not received training in the new Mental Health Act code of practice. The service was planning to arrange this although no dates had been set at the time of our visit in November 2015. Patients had their capacity to consent assessed on admission, which was then recorded in the patients' notes. We could also see in patient records that patients' capacity was considered regularly. However, we identified that one patient still had a T2 form in place, despite it now being superseded by a T3 form. T2 forms are the forms used when a patient has capacity to agree to their treatment and they have agreed to the treatment. T3 forms are used to identify when a patient lacks capacity or does not consent to their treatment but a second opinion appointed doctor (SOAD) has agreed with the treatment and therefore the treatment can go ahead.

The hospital did not have a Mental Health Act administrator on site or access to one. Mental Health Act detention paperwork was checked by the manager and then re-checked by the hospital administrator. We were advised that the administrator did not have any particular training in the Mental Health Act. We identified some errors on Mental Health Act detention renewal paper work where it had not been signed by or on behalf of the hospital managers.

We identified that policies, procedures and guidance that the new Mental Health Act code of practice states should be in place were not; this included a policy on searching patients and their belongings and visitors. We identified that the hospital was still using the old code of practice when drawing up new policies. Given the concern relating to the Mental health Act we have taken the necessary enforcement actions to ensure the provider addresses these issues.

People had access to an independent Mental Health Act advocate (IMHA) who visits every three weeks and when requested. We spoke to the IMHA during our visit; they did not express any concerns regarding the hospital. A new IMHA provider had been visiting the service since October 2015, they reported that staff were helpful. They also told us that no concerns had been passed on when the service was handed over to them from the previous IMHA provider.

Good practice in applying the MCA

- The provider reported that 85% of staff had received training in the Mental Capacity Act via an on-line electronic learning package.
- We were told that capacity to consent was reviewed regularly and recorded in the patient notes and discussed as part of the clinical review meeting. The patient records we reviewed supported this. If a best interest decision, needed to be made this would also be discussed at the clinical review meeting and the outcome recorded in patient notes. There were six informal patients, we asked about the mental capacity of these patients and the staff were unsure. We were

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

later advised that two of the patients lacked mental capacity to consent to their treatment and that an arrangement had been made for the patients to be reviewed by the responsible clinician.

At our follow up inspection in May 2016, we found:

- There was much more focus on the recovery of patients and care plans set out a clear aim, developed with each patient, about where they wanted to move to or live following discharge from the Uplands. Care plans clearly documented rehabilitation plans using the recovery star. The service manager described how the service had developed a clear pathway and was using one of the providers step down unit (in the same area) to support patients to move into the community or move elsewhere as appropriate. The lead commissioner told us that it felt Uplands had made considerable progress in identifying what its core business was and in moving towards that model. However, the provider and lead commissioner recognised there was still work to do to embed a number of these changes.
- The service had secured the services of a psychologist who had overseen the introduction of a range of psychological therapies. In addition, more training had been provided to staff to enable them to deliver psychological therapies.
- More recovery support workers had been recruited specifically to work with patients to support their rehabilitation. Three of the recovery support workers that we spoke with said they had been able to access specialist training to prepare them for their role.
- Three recovery support workers and two registered nurses confirmed that they received supervision on a regular basis and that a system of appraisal had been introduced.
- At the last inspection in November 2015, there were a number of issues in relation to adherence to the Mental Health Act (MHA). The provider had taken significant steps to address these.
- A training programme was prepared and delivered to staff by the MHA lead in a neighbouring NHS trust. This course covered legislation, the guiding principles of the code of practice, seclusion, and scrutiny of documents, restraint and Deprivation of Liberty safeguards. The revised MHA code of practice is now available for staff. Mental Capacity Act training is being arranged for staff.
- The existing hospital administrator now had three days per week of her time allotted to MHA administration. She was due to attend a specialist training course. A new part time assistant had been recruited to backfill her general administration responsibilities. A specialist well regarded MHA law firm was available to the hospital for consultation on MHA matters.
- A MHA scrutiny panel had been established with external representatives and there is a MHA quarterly report. Section 17 leave and section 132 rights were audited monthly.
- The registered manager had gone through Annex B of the revised Code of Practice and drafted updated policies to meet these requirements.
- The provider had followed up the Nearest Relative issue for the two patients where this was identified as an issue at the last inspection. One had a solicitor as nearest relative and a nearest relative was in the process of being appointed by the local authority for the other.
- The provider now demonstrated a clear understanding of de-facto seclusion and had updated patients' time out care plans and support plans.

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

Good

Kindness, dignity, respect and support

We saw that staff acted in a respectful manner towards patients. Two members of staff advised us of the need to treat the patients with dignity and respect. We observed staff sitting down to eat with patients at meal times and knocking on patients doors before entering the bedrooms. Two members of staff told us that, other staff, did not always maintained patients' personal hygiene to an appropriate standard.

The involvement of people in the care they receive

Patients received an induction leaflet on admission and were shown around the hospital. As part of the admission process, patients could visit the hospital for meals and choose from the available suitable bedrooms.

We were told that patients did not routinely get involved in developing their own care plans. They were given the opportunity to read their care plan, make comments and

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

then sign. The patient did not always receive a copy of their care plan and care plans were not available in accessible formats to meet the communication needs of all the patients.

Staff reviewed all activities a patient had engaged in on a monthly basis with the patient, this information helped develop future activity plans. All patients had a care plan linked to the recovery star and there was a recovery tree in one of the lounge areas (a tree painted on a wall which patients and staff were encouraged to add their own definitions of and recovery goals to).

Staff told us that they were not always able to give patients one to one time. The manager and members of the staff team shared plans to introduce protected time for one to one work with patients.

The hospital had residents meetings, usually attended by about six patients, where patients could raise concerns, the hospital manager was working to involve more patients in these meetings. Patients were helped to use the hospitals internal complaints process. The manager had also introduced a quarterly meeting between herself and the patients.

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

Requires improvement

Access and discharge

The manager told us that admissions and discharges were planned for a suitable time. The service only had one patient placed from outside the county at the time of inspection in November 2015. The service was unable to give us any information relating to assessment, admission and delayed discharges. Previously the hospital was considered a placement for life. In the 12 months prior to our inspection there had been two discharges; one of the patient had been resident at the hospital for sixteen years and the other for eight years.

One patient had been on one to one observation for several months, and it had been agreed they should not remain at the hospital. However it had taken several months to identify a suitable placement to discharge them to, and a date had not been set, on the day of our inspection in November 2015, for the patient to be discharged. The delay was caused by the length of time it has taken for commissioners to identify and agree the funding for a new placement.

The facilities promote recovery, comfort and dignity and confidentiality

The hospital had a large occupational therapy and activities room, two lounges and a large dining room. The furniture was comfortable and appropriate for the patients. The hospital was set within large well-maintained gardens and there was a large covered smoking area for patients.

There was an activities board in place, which listed the activities for the coming week. Included in the range of activities available were outings to the community to play pool and bowls and to have coastal walks. Staff reported that activities were more limited at the weekends than during the week as the occupational therapist was not present and they organised most activities. However, the activities co-ordinator did work at weekends.

Patients were encouraged to personalise their bedrooms and to have a kettle in their bedrooms for making hot drinks. The rooms we saw had been personalised by the patients. Patients were allowed to use mobile phones in their bedrooms. Patients were able to lock their rooms for safe storage.

Meeting the needs of all people who use the service

The provider had provided access for people using a wheel chair or walking frame via the back entrance to the building. There were bedrooms available on the ground floor and ramps installed for people to move around easily. The hospital had accessible bathrooms, which include a step in bath.

The service did not currently offer information in an accessible format or in other languages; however, staff advised us that they could access this information from their head office if required.

The service had a kitchen on site that was able to cater for different dietary needs and preferences and patients were offered a choice of meals at each serving.

Historically the hospital has been a placement for life for many of the patients; the service was planning to provide a

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

more recovery focus to its care and treatment. The hospital manager recognised that this was not suitable for all the current patients. They are planning to develop care plans that focus on recovery and a recovery tree (a tree painted on a wall which patients and staff were encouraged to add their own definitions of and recovery goals on) has been painted onto the wall of the main lounge. However, these plans are in the early stages and the required agreement and investment that had not yet been agreed by the provider.

Listening to and learning from concerns and complaints

We asked five staff about patients making complaints and they all felt that patients knew how to complain. We saw that there were leaflets available and displayed in the main entrance during our visit. Staff advised us that they would assist a patient to make a complaint if they wanted them to.

In the past 12 months there had been four formal complaints received from patients. All had been reported as being resolved to the satisfaction of the complainant and none were referred to the Parliamentary and Health Service Ombudsmen.

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

Requires improvement

Vision and values

We were told about the plans for Uplands, which included a major redevelopment of the hospital with 11 admission beds, nine rehabilitation beds and four transition studios. Within the new structure there were to be two deputy managers, only one of whom was in post at the time of the November 2015 inspection.

The hospital advised us that they were in the process of reviewing the service provided at Uplands Hospital, including a refurbishment plan. However, there was no clear strategy in place, finances were not yet confirmed. While planning permission has been granted in relation to the proposed development, the specific detailed discussion with the planning and conservation officers regarding the details of each room design and specification had not been undertaken and agreed.

Good governance

Through the inspection process, we identified a number of serious concerns in relation to the governance and operation of the service. This has resulted in our taking separate enforcement action in order to ensure the provider takes immediate actions to address the concerns identified.

There was a lack of suitable governance arrangements in place to ensure that the organisation had a good overview of current risks to the staff or patients, and that these were appropriately managed. At the time of our visit in November 2015, the hospital was addressing risk through a service improvement plan, which included actions from the previous Care Quality Commission inspection. The provider did not have effective systems in place to regularly assess and monitor the quality and safety of the services provided. There were limited processes for monitoring and reviewing incidents and limited evidence of learning from incidents.

We found that the hospital did not have suitable arrangements in place to ensure that the organisation had a good overview of current risks to the staff or patients, and that these were being appropriately managed. We were concerned about the safety and suitability of the layout of the property, fixtures and fittings. The provider did not demonstrate that learning had occurred and been passed on to the staff team following a serious incident at the property. These risks were not highlighted in the service's own improvement plan. The hospital did not have any procedural management of ligature risks and the ligature assessment lacked detail and did not contain all the ligature risks.

The provider did not demonstrate that they had a good understanding of the risk present within the environment and had not taken appropriate steps to identify and mitigate these risks. The hospital did not have a risk register. The provider's senior management team advised us that there were no specific risks, in relation to the hospital, identified or recorded on the corporate risk register. We were concerned that this reflected a lack of senior oversight and understanding of the risks within the service.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We were advised that the external company that monitored the service's incident reporting system produced a report for the board. This was discussed at the board's quarterly care governance and safeguarding committee meetings. We reviewed minutes provided for September 2014, 6 January 2015 and 24 April 2015. We found these gave very little detail about what was discussed in the meeting and did not reflect that the provider discussed the hospital, quality or risks. For example, there was no specific section for discussion of incidents or individual locations. The minutes contained no outcomes or clear sense of deadlines, and there was no thematic analysis. Further, no clear reflection on incidents or subsequent learning was recorded. The provider had identified, in senior management interviews with the inspection team, that the current incident recording and reporting system did not allow for the level of detail or oversight required to assure the provider they were fully aware of the nature of incidents and could identify potential trends, or monitor action plans. Additionally, there had been no training provided for staff in relation to completing incident reports. The provider informed us that they were looking at an alternative recording and reporting system, although no specific action had taken place in relation to this at the time of the November 2015 inspection.

There had been no training around the revised Mental Health Act (MHA) code of practice for staff and the policies, procedures and guidance that providers are required to put into place, had not been. The associate managers had not received copies of the revised MHA code of practice and had not received any training on the revised code or other aspects of the Mental Health Act. We concluded that there was no effective governance arrangement to monitor and review the way that functions under the Act were undertaken.

We were concerned about the lack of clarity in relation to the current purpose of the service and patient group, and the culture of risk within the service. The service was taking more referrals from secure mental health services, although there was no clear referral pathway or assessment process. There was little evidence of detailed internal audits, clear plan or monitoring strategies to inform service development and management of risk. There had been little engagement with external stakeholders in relation these plans, although the service told us that they had had informal discussions with some care managers and were waiting for confirmation of funding before moving forward with these plans. We were unable to confirm the detail of informal discussions, or how effectively these had been used in the planning and development process. There were no contract monitoring meetings in place with the lead commissioner to monitor progress against plans to improve the quality and safety of services. The provider and lead commissioner made plans to meet after our inspection and have we confirmed that they now meet every two months.

A follow up inspection in May 2016 showed:

At the follow up visit on 20 May 2016, we found that the ligature audit had been re-formatted and was much more comprehensive. There was a schedule of anti-ligature works available for us to review, and we could see a number of immediate actions have been taken where possible to reduce the high risks in the environment. The management and staff team demonstrated a much better understanding of assessing and managing risks in the environment and relating this to individual and patient groups.

An improved governance structure had been put in place both within the hospital and this is then included within new provider governance meetings. Whilst it was still being established with this new structure there was potential for there to be much better senior oversight of a range of quality and safety issues, meaning that any increased risks would be identified in a timely manner and the team should get the support they need from the provider to address them.

Information tools to provide oversight of patient and hospital quality and safety issues had been improved, such as the handover tool – this was now clearly detailing a range of activity over the shift to enable more effective cross-referencing with incident reports and notes. There was a patient risk register in place which identified a range of individual patient risks and then this gave a clear overview of the overall risks of the patient profile of Uplands.

Leadership, morale and staff engagement

The hospital manager had been in post since March 2015, following the retirement of the previous hospital manager. The service had identified the need to have additional managerial oversight and had developed two additional posts of deputy hospital manager. One post was still vacant

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

at the time of inspection in November 2015, but has been recruited to since our inspection. The hospital manager reported to the national operations manager who provided support.

Uplands independent hospital had not conducted a staff survey but the staff had been able to take part in a wider Care Tech (the parent company) survey of staff. The manger advised us they were in the process of engaging staff and gaining their opinions relating to:

- what they liked and did not like about working at Uplands
- what the hospital did well
- what the hospital did not do well
- what the hospital needed to improve at

This information would inform the hospital improvement plan and inform staff appraisals. We saw evidence in a staff meeting room of this information being gathered.

Staff reported feeling supported by the hospital manager. Staff felt they would be listened to if they raised a concern. Staff reported that morale was low but had been improving since the new manager came into post. The hospital manager had established qualified nurse meetings, but these had not taken place during, a planned six week absence. The manager had made plans for a senior manager to chair the meetings.

All staff we spoke with knew how to raise an issue and gave example of the sort of incidents they would raise with senior staff, such as not following care plans or attitude towards patients. Staff felt confident they would be listened to if they raised a concern.

A follow up inspection in May 2016 showed:

The hospital management team and the senior management team responded pro-actively to the feedback from the inspection and the concerns identified in the warning notice. It was clear that the Uplands team had worked hard to address some of the immediate concerns, and were committed to continuing to work towards some of the longer term development plans and embed improved oversight of quality and safety.

Commitment to quality improvement and innovation

The hospital was not involved in any quality improvement schemes such as the College Centre for Quality Improvement (CCQI) for rehabilitation.

The hospital was not using the Green Light Tool Kit, an audit to that helps to improve mental health services for people with learning disabilities and/or autism.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure effective suitable governance arrangements are in place to ensure that the organisation has a good overview of current risks to the staff or patients, and that these are being appropriately managed.
- The provider must take appropriate steps to ensure risks associated with ligature points are mitigated.
- The provider must ensure each patient admitted to the hospital has a comprehensive risk assessment that reflects changes in the patient's circumstance.
- The provider must ensure that a robust system is in place to analyse and learn from incidents.
- The provider must ensure that all policies and procedures are reviewed in line. with new Mental Health Act Code of Practice and that staff receive appropriate training.
- The provider must ensure that they follow the new Mental Health Act Code of Practice and provide training to staff.
- The provider must ensure the new admission process reflects the new Mental Health Act Code of Practice.
- The provider must ensure there is appropriate scrutiny of Mental Health Act paperwork.
- The provider must ensure all staff are aware of what defines seclusion and ensure it only occurs as identified within the Mental Health Act.
- The provider must record restraint in a way that enables pattern and concerns to be identified and complies with the Mental Health Act Code of Practice.
- The provider must ensure all safeguarding threshold care plans are reviewed regularly and by an appropriate external authority.
- The provider must provide training for staff in the systems and processes for the recording of incidents, to ensure accuracy and consistency of data captured and support effective oversight of service provision.
- The provider must ensure there are suitable day rooms designated for the use of females.

Action the provider SHOULD take to improve

- The provider should ensure there are enough staff on duty to prevent leave being cancelled.
- The provider should ensure that informal patients' capacity to consent to treatments is assessed.
- The provider should take the necessary steps to ensure patients are involved in the development of their care plans.
- The provider should discuss development plans with their service commissioners.
- The provider should ensure that there is an admission pathway for referred patients that includes an admission criteria.
- The provider should regularly review all patient documentation to ensure it provides accurate and up-to-date information.
- The provider should ensure that information is provided to patients in an accessible format.
- The provider should ensure any learning from complaints is shared with the team.
- The provider should ensure that all medical devices are maintained in working order and a record is kept of this.
- The provider should ensure a list of what is required in the emergency bag is place and appropriate for the patients.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Following observations of the premises, we were concerned about the safety and suitability of the layout of the property, fixtures and fittings. The hospital did not have any procedural management of ligature risks and the ligature assessment lacked detail and did not contain all the ligature risks. This is a breach of regulation 15(1)(c)(e)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risk assessments we reviewed did not consider the dynamic nature of risk. Risk behaviours within the unit were not considered when the patients were accessing s17 leave. Safeguarding threshold monitoring plans were not reviewed. This is a breach of regulation 12(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was a lack of suitable governance arrangements in place to ensure that the organisation had a good overview of current risks to the staff or patients, and that these were being appropriately managed. The provider did not demonstrate that they had a good understanding of the risk present within the environment and had not taken appropriate steps to identify and mitigate these risks. The provider did not demonstrate that learning had occurred and been passed on to the staff team following a serious incident. There was no effective scrutiny of Mental Health Act paperwork. The new code of practice for the Mental Health Act had not been introduced and therefore policies, procedures and guidance had not been reviewed to reflect this. Recording around the use of physical intervention did not meet the standards required under the new Mental Health Act code of practice. There was no effective analysis of incidents and physical interventions. This is a breach of regulation 17(1)(2)(b)