The Copse

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

We rated The Copse as requires improvement because:

- Staff did not always carry out or document that they had carried out physical health checks for patients. They had not checked a patient for signs of over sedation, after administering rapid tranquilisation medicine to reduce their aggression; over sedation can lead to breathing complications and potentially suffocation. We found mistakes had been made with the administration of clozapine (a medicine with potentially serious cardiac effects. Despite clear documentation to tell staff not to administer a full dose of clozapine (national guidance is to build up to the full dose) staff had administered the full dose straight off. Staff had not recognised that this should have been reported as an incident. Once we highlighted this to staff, they reported it as an incident. Patients on this medicine were not checked regularly for any signs of side effects.
- The systems in place did not ensure that allegations of abuse were raised in a timely manner to the appropriate bodies. Staff had received training on how to identify and raise concerns, but they left this task to a single member of staff. There were poor cover procedures or protocols for when this staff member was on leave or sick. We saw that this meant two alerts had not been made to the local authority, and staff had not notified CQC of the allegations of abuse as is required. We raised this and staff made the alerts retrospectively. Delays in raising safeguarding alerts potentially puts patients at risk of further abuse.
- Processes to ensure that learning from incidents was recorded did not always work. Staff discussed changes in patients' risks, and incidents that took place, but did not always document this appropriately or update risk assessments following incidents.
- The process that staff followed when assessing a patient's capacity to make decisions about their care did not ensure these assessments were always completed or available to relevant staff. We saw incidents where staff had acted against patients' wishes without assessing their capacity to make that decision. When staff did carry out best interest assessments they stored this on a staff member's individual computer drive, rather than in the care records. This meant that staff could not always access the documentation they needed.

However:

- Staff had started to implement a new recovery model based on the Recovery Star to help guide patients through their recovery and reach their individual goals.
- Patients said they felt staff were caring and supportive and involved them in their care planning and care decisions.
- A new hospital director had taken up post six months before this inspection, which staff saw as a positive. They felt the new director was approachable, supportive and willing to listen and act on any concerns their concerns. This had helped develop a culture of respect and pride in working at the hospital.
- The admission and discharge process at the hospital allowed patients to be discharged when they were ready (if there was an appropriate placement for them to go to).
- There were facilities to ensure that people with disabilities could receive care at the hospital, and the service could provide meals to meet patients dietary, cultural and spiritual needs.

Summary of findings

Contents

Requires improvement

The Copse

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

Summary of this inspection

Background to The Copse

The Copse is a long stay, high dependency rehabilitation unit that takes patients with enduring mental health issues from acute inpatient services, to help them transition to living better lives in the community or in supported community placements.

The hospital has 24 beds and is split into four, six bedded wards, two for men and two for women. At the time of this inspection, one of the male wards was closed for refurbishment. There were 15 patients at the hospital at this inspection, all were detained under the Mental Health Act.

The hospital is registered to provide the following regulated activities:

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

This is the first inspection since the hospital was acquired by Elysium Healthcare Limited. It had been previously run by Partnerships in Care Limited. Previously, the hospital was inspected in July 2016 where it was rated as good overall and in all five domains.

Our inspection team

The team that inspected the service comprised three CQC inspectors and a specialist nurse advisor with experience in long stay rehabilitation care.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three open wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the hospital director
- spoke with nine other staff members; including a doctor, nurses, an occupational therapist and a social worker
- spoke with an independent advocate
- attended and observed two multi-disciplinary meetings
- looked at five care and treatment records of patients
- reviewed eight staff appraisals and five supervision records
- carried out a specific check of the medicines management on two wards
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

Patients felt that staff were supportive and respectful in caring for them. They felt that they could raise concerns with staff and these would be dealt with fairly. They said staff treated them with dignity and they felt safe at the hospital.

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

We rated safe as requires improvement because:

- Staff had administered rapid tranquilisation medicine to a patient (to reduce their aggression), but did not complete health checks to check for over sedation. This could have put the patient at risk of suffocation as the medicine can supress patients' breathing. Although the use of rapid tranquilisation was infrequent, staff were not following the policies in place.
- Six patients were receiving clozapine. Clozapine is a medicine that can have serious physical side effect including putting patients at risk of cardiac issues. Staff were not completing health checks on these patients in line with national guidance.
- Staff did not always recognise when to report incidents. In one case, staff had documented in the clients notes that they should not administer a full dose of clozapine based on the advice from their pharmacy, but had administered this anyway. When we raised this to their attention, they reported this as an incident.
- Staff did not have a detailed cleaning rota for the clinic room or their clinical equipment. This meant that staff could not guarantee the room had been cleaned to reduce the risk of infection. We brought this to their attention and they put one in place.

However:

- The hospital complied with mixed sex guidelines from the Department of Health.
- Staffing levels were good and where there were vacancies, these posts were being recruited to. This meant that leave was not cancelled for patients.
- Staff had assessed the environmental risks of the hospital and were mitigating risks to patients.

Are services effective?

Good

We rated effective as good because:

- Staff holistically assessed the patient's recovery needs on admission and we saw good patient involvement in this process.
- Patients could access professionals from a range of mental health disciplines who had access to specialist training. These staff received supervision and appraisals appropriately.

Summary of this inspection

- Staff worked to engage with patients' care co-ordinators, home teams and local clinical commissioning groups. They had also reached out and held meetings with local residents to help address their concerns with the hospital.

However:

- We saw that documentation for consent to treatment under the Mental Health Act (a T2 form) did not always include all the medicine that staff were giving patients.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with kindness and respect. They fostered an atmosphere of respect and acceptance for people with protected characteristics such as age, race and sexual orientation.
- Patients said they were well supported by staff that genuinely cared about them and respected their individual needs and beliefs.
- Patients were involved in their own care through their care planning, and were involved in decisions about the service through community meetings. Some patients were trained to help recruit new staff.
- Carers and patients were given the opportunity to give feedback to the service and we saw that staff acted on this to make positive changes for patients.

Are services responsive?

Good

We rated responsive as good because:

- The average length of stay was within the time that we would expect of this type of long stay rehabilitation service. Bed occupancy ranged from 67% to 87%.
- Staff helped patients to maintain valuable relationships with relatives and friends from their home areas. They supported patients to visit them, and supported visitors to visit patients.
- Staff planned for patients discharge early in their admission, there had been one delayed discharge but this was because of a lack of an appropriate community placement for that patient.
- There were reasonable adjustments to allow patients with mobility difficulties to receive care at the hospital.

Summary of this inspection

- Patients had access to meaningful activities throughout the week and staff supported them to engage with local community services.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- There were not adequate processes to ensure that all safeguarding referrals were raised promptly to the local authority, or to ensure that the Care Quality Commission was promptly notified of allegations of abuse as required by the regulations set out in the Health and Social Care Act.
- Systems did not ensure that staff reported all incidents or fully documented discussions after incidents or updated risk assessments appropriately. We saw staff discuss incidents and handover changes in patient's presentation but could not always find that this was documented appropriately.
- The protocol for storing mental capacity assessments did not ensure that these were always documented or accessible to relevant staff. They were stored on a staff member's individual drive rather than the care notes, and we saw some instances where capacity should have been assessed had no associated decision-making process documented. There was also no procedures to ensure that staff knew their role in making these decisions.
- Audit procedures did not highlight these governance issues so that managers could address them.

However:

- Staff were positive about their new hospital director and felt their new leader was approachable and supportive. They said there was an open-door culture and they felt they could raise concerns without fear of retribution. This had led to staff having a culture of respect and pride in working at the hospital.

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.

Mental Health Act training was mandatory for clinical staff. The hospital reported that 98% of staff had received the training. All the patients were detained under the Mental Health Act at the time of this inspection.

Staff had access to the provider's policies on how to apply the Act, as well as a Mental Health Act administrator who provided advice. The administrator completed audits to help ensure that the legal paperwork was completed properly. However, there were occasions where paperwork to track if a detained patient had consented to medicine (and if they had not) and that this was being administered in line with the Act, was not always fully complete.

From our review of care records, we saw that staff were explaining patients' rights to them regularly, and in a way they could understand.

Patients had easy access to an independent Mental Health Act advocate who visited the hospital weekly.

We spoke with five patients who all said their section 17 leave had never been cancelled because of lack of staff. We saw that staff were completing appropriate checks of patient's wellbeing before they left for their leave and that there were posters advising informal patients of their right to leave if they wished.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training on the Mental Capacity Act (MCA) was mandatory and the service reported 93% of staff were up to date on this training. There were no patients with a deprivation of liberty safeguards authorisation in place (or applied for) at the time of this inspection.

Staff told us that there was a provider policy on consent, and consent was reflected in other relevant policies

Staff understood some of the basic principles of the MCA. However, some staff felt that it was the remit of the hospital social worker or doctor to make decisions about mental capacity but staff didn't understand their role in contributing to decisions about capacity. We saw that although there was space on the electronic records to document mental capacity, this was not always completed. Staff were instead storing decisions about mental capacity, including the documentation of best interest decisions on their individual work drive, which was inaccessible to other members of the clinical team. This issue had not been picked up by the services clinical audits. The provider was able to provide us with the documentation after the inspection. Once we received these records, we saw that staff had included relevant people in the decision-making process and had documented the decisions clearly.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

Staff assessed and mitigated the environmental risks of the unit. They routinely assessed ligature points in the unit (places where a cord or rope could be tied for self-harm) and mitigated the risks of these points with staff observation, and through their referral criteria. Staff also completed regular checks of the fire alarms and evacuation procedures.

Staff could easily observe different areas of the ward. Blind spots (places on the ward that couldn't be easily observed) were mitigated by use of convex mirrors, and by extra staff that were tasked with observing the ward.

The hospital took male and female patients. The layout of the ward met the specifications of national guidance from the Department of Health on eliminating mixed-sex accommodation. Male and female bedrooms were on different wards. There were single sex lounges, and people did not need to pass bedrooms belonging to people of a different sex to access bathroom facilities.

Staff had access to alarms to summon help if needed, and radios to give detail if needed. These alarms were regularly checked.

At the time of our inspection, the ward was visibly clean with furnishings in good repair. We saw that visual checks of the cleanliness of the ward were carried out, and the service had cleaning staff. However, we saw that there were no processes in place to ensure detailed cleaning of the clinic room where patients were seen or of the equipment used to monitor patient's physical health. Staff completed a visual check of the cleanliness weekly, but this would not remove the risk of infection. We raised this with staff on the inspection and they put in place a more detailed cleaning rota. There were handwashing posters at handwashing stations to remind staff on correct handwashing technique to reduce the spread of infection.

The clinic room had appropriate emergency equipment. Staff checked this equipment weekly to ensure it was fit for purpose. The clinic room for the hospital also had equipment to take physical health observations, and this was calibrated appropriately.

Safe staffing

The Copse had almost recruited up to its established staffing numbers. The established levels of staff were 10 whole time equivalent (WTE) nurses and 31 WTE healthcare assistants. There were four WTE vacancies for nurses, and three WTE vacancies for healthcare assistants. However, four staff were in the process of completing pre-employment checks, two for nursing vacancies and two for healthcare assistant vacancies.

Staff turnover was low, at the time of inspection it was 1.4%. Staff sickness was 2.8% over the year before this inspection. The service was using locum nurses to cover its vacancies and reported 208 shifts covered by agency between 1 May 2018 and 31 July 2018, and 21 shifts covered by bank staff. Nineteen shifts could not be covered by bank or agency in that period. Staff said it was generally easy to get agency staff, except where the cover was very last minute.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staffing levels could be changed to meet the needs of the patients at the hospital, and general staffing ladders were in place to set staffing based on the number of patients that were at the hospital. Where agency staff were needed, they were given an induction to the unit and the hospital tried to block book the same agency staff to provide consistency for the patients.

The hospital psychiatrist was available three days a week. Outside of those hours there was an on-call rota and cover available from another nearby hospital owned by the same provider.

Overall, most staff were fully up to date with their mandatory training. Ninety-one percent of staff were up to date overall, and none of the training topics had completion rates below 75%. This included training in the recovery model the service used, called the recovery star.

Assessing and managing risk to patients and staff

We reviewed the care records of five patients. Staff had made detailed and appropriate assessments of patients' risk and had used a recognised risk assessment tool (the historical clinical risk management-20). These assessments were part of patients' admission, and were updated throughout their time at the hospital. However, we saw that in five cases, there had been incidents that should have prompted a change in the patient's risks assessments but these had not been updated.

There were appropriate rules to help keep patients safe, including a list of banned items. Where there were additional restrictions (such as times to go out and smoke), these were discussed with patients in fortnightly community meetings where patients could feedback to staff if they had any concerns.

The hospital had to stop being a smoke free site, as there had been substantial complaints from their neighbours about patients using their leave to smoke off site. The hospital had built a smoking shelter on site, and had a nurse that had been trained in smoking cessation.

All the patients were detained under the Mental Health Act at the time of this inspection, but there were posters advising informal patients of their right to leave in case informal patients were admitted.

There was no seclusion room at the hospital and we did not see any patients being secluded at the time of this inspection. Staff reported that there had been one use of rapid tranquilisation (the administering of medicine to reduce aggression) in the past year, and they reported 19 restraints in the six months before this inspection. They said that none of those restraints involved patients being held prone (face down on the floor) but we saw one recorded incident where a patient was held prone to administer their medicine.

Patients had positive behavioural support plans to help reduce the need for restraint and we saw in the incident reports we reviewed that staff tried to de-escalate patients first and followed best practice by not restraining patients longer than necessary. While we saw that staff were reporting incidents of restraint, they had not documented checking the physical health of the patient they had sedated to manage their aggression. Physical health monitoring is important after administering rapid tranquilisation to ensure that the patient's breathing and heart rate are not affected, which would put them at risk of suffocation.

Safeguarding

At the time of this inspection, all the appropriate staff had received training in identifying and reporting safeguarding concerns. The hospital had a safeguarding policy and there were posters throughout the site prompting staff and patients to raise concerns if they had them. Staff reported they had raised 20 safeguarding referrals since January 2018. However, staff did not fully recognise their role in reporting safeguarding concerns. We saw that safeguarding concerns were left to the hospital social worker to report to the local authority, with no clear or effective contingency plans in place to make sure these referrals were raised when that member of staff was on leave or ill. We saw that two referrals had been waiting nine days to be raised. This meant that safeguarding concerns were not reviewed by the appropriate independent bodies, potentially putting patients at further risk. We raised this with staff, and they made the referrals.

There were procedures in place to keep visitors (including children) safe when they visited their relative. They could meet their relatives off the ward in meeting rooms, or in the community if their relative had leave.

Staff access to essential information

Staff used electronic systems to keep their care records. These systems were password protected to help protect patients' privacy.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Medicines management

Generally, staff followed good practice in managing medicines. However, there were some areas of practice that presented some potential risks for patients. Some patients were prescribed a medicine called clozapine. This medicine can have a serious effect on patients' physical health, including a risk of seizures and other potentially fatal heart conditions. To ensure patients safety, national guidance is to slowly increase the dose given to patients over time (titration) until they get to the medical dose, and to monitor their physical health while doing this. If a patient has not had the medicine in over 48 hours, this process should be repeated. While patients are on this medicine, regular health checks ensure that they are well. We saw that four patients were receiving this medicine. Staff had not documented physical health checks regularly in three of these records. We saw evidence that one patient had not been taking their medicine as prescribed and there had been a gap of 72 hours between their doses of clozapine. Staff had not re-titrated that patient back onto the medicine, against the advice they received from their pharmacist and had documented that they should not administer the dose in the patients care record. Staff had not recognised this was an incident that needed reporting until we highlighted it to them at which point they raised it as an incident. We raised this with the hospital director at the time of inspection and they put in place an audit to check that these physical health checks were being carried out.

Track record on safety

There had been a serious incident in the year before this inspection that was awaiting an inquest by the coroner. There had been an internal investigation.

Reporting incidents and learning from when things go wrong

Staff did not always report incidents that they should have. Incidents were reported by an electronic system. Incidents that were reported were then discussed at daily meetings but discussion were not always documented and patient care plans were not always changed as a result. However, we observed one of these meetings and saw that staff discussed any changes to patients' presentation, any incidents that had been reported and changes in patients' risk. Incidents that were reported were reviewed by managers at both a local and provider level and learning shared across hospitals. The learning from these incidents were shared through email and where necessary, supervision as well. However, we saw that in five cases since January 2018, this process had not been documented well. This meant that there was a risk that learning would not be fully imbedded.

Staff said that they had not had an incident that would trigger their duty of candour but they had received training on it, and could access their company policy on it.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed the care records of five out of the 15 patients at the service at the time of this inspection. Staff had holistically assessed patients' needs in a timely way after their admission, as well as assessing some needs prior to admission. These assessments included the patients' views and we saw that there was good documentation of patient involvement in their care plans. However, the service had adopted a new recovery model (the Recovery Star) in the three months before this inspection, and not all the records we saw had been guided by this recovery model.

Best practice in treatment and care

Long stay rehabilitation services aim to help patients transition from inpatient services to meaningful lives in the community or a community placement. This service focused on individualised plans of meaningful activities, including working on skills for daily living. There was a generalised timetable too, but this was under review at the time of this inspection. In line with best practice, staff were providing opportunities for patients to develop daily living skills and to apply for work opportunities. Patients could apply for, and be trained to be part of interview panels for staff, as well as a variety of other work opportunities, such as delivering papers. The senior occupational therapist was

also building links with a local college to provide learning opportunities for patients. A past patient had been successful in volunteering in a charity shop nearby. The service did not have links with the recovery college.

The hospital contracted a general health nurse and a GP to visit the ward regularly to help meet patients' physical health needs.

A dietician had recently been employed and there were adapted kitchens to help patients learn how to prepare their own food as part of their recovery plan. We observed a session and saw that staff were supportive in helping patients meet their goals.

Staff used recognised assessment scales such as the Liverpool university neuroleptic side effect rating scale, and the malnutrition universal screening tool. Staff had begun using the recovery star model to help guide patients care towards individual recovery goals.

Patients could access nationally recommended psychological therapies from the hospital's psychologist in line with guidance (QS80) from the National Institute for Health and Care Excellence.

Clinical staff took part in audits of their practice to ensure good performance. This included having clinical audit leads, as well as participating in national audits such as the prescribing observatory for mental health.

Skilled staff to deliver care

Patients had access to professionals from different mental health backgrounds. The clinical team comprised of a clinical psychologist, a psychiatrist, a social worker, occupational therapists, registered mental health nurses, a registered general nurse, a GP and a dietician. The staff we spoke to were experienced in working in long stay rehabilitation services and were qualified to undertake their role.

There was a comprehensive induction program for new staff. This included classroom training, supernumerary shifts and competency assessments. New starters also had a probationary period. After this period, staff could discuss their training needs in supervision and in their yearly appraisals. We reviewed eight staff appraisals and saw good focus on helping staff to develop their skills.

Staff had access to individual and group supervision where they could discuss their clinical practice. We reviewed five supervision logs and saw that where issues were raised, there were associated action points to resolve the issues. The service reported that in the year up to August 2018, supervision rates (percentage of staff who had received supervision in line with the company policy) ranged from 77% for nursing staff, to 100% for psychology. At the time of this inspection, all staff had received an appraisal.

Staff had access to specialist training to help them complete their roles. On the first day of the inspection, staff were attending training on relational security, and they had booked training on working with patients with co-morbid substance misuse.

Multi-disciplinary and inter-agency team work

Staff held multidisciplinary ward rounds weekly, each week focusing on a different ward. This meant that patients were reviewed in depth monthly. This complimented the daily handovers that were attended by nursing staff, and by the wider multidisciplinary team during the working week.

Staff reported good working relationships with the patients' care co-ordinators. They invited them to ward rounds, and to care plan approach meetings. As patients could be admitted from all over the country, the staff focused on working with patients' home teams to ensure they did not lose valuable links to people in their area. This included facilitating trips home, and visits from family and relatives to the hospital.

There had been some concerns raised about the service by their neighbours. These centred around patients smoking in the neighbourhood while on leave, rather than smoking on hospital grounds. To help build better relationships, staff held six monthly meetings with local residents to help address their concerns, and had built a smoking shelter on site for patients.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training was mandatory for clinical staff. The hospital reported that 98% of staff had received the training. All the patients were detained under the Mental Health Act at the time of this inspection.

Staff had access to the provider's policies on how to apply the Act, as well as a Mental Health Act administrator who provided advice. The administrator completed audits to help ensure that the legal paperwork was completed

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

properly. However, there were occasions where paperwork to track if a detained patient had consented to medicine (and if they had not) and that this was being administered in line with the Act, was not always fully complete.

From our review of care records, we saw that staff were explaining patients' rights to them regularly, and in a way they could understand.

Patients had easy access to an independent Mental Health Act advocate who visited the hospital weekly.

We spoke with five patients who all said their section 17 leave had never been cancelled because of lack of staff. We saw that staff were completing appropriate checks of patient's wellbeing before they left for their leave and that there were posters advising informal patients of their right to leave if they wished.

Good practice in applying the MCA

Training on the Mental Capacity Act (MCA) was mandatory and the service reported 93% of staff were up to date on this training. There were no patients with a deprivation of liberty safeguards authorisation in place (or applied for) at the time of this inspection.

Staff told us that there was a provider policy on consent, and consent was reflected in other relevant policies

Staff understood some of the basic principles of the MCA. However, some staff felt that it was the remit of the hospital social worker or doctor to make decisions about mental capacity but staff didn't understand their role in contributing to decisions about capacity. We saw that although there was space on the electronic records to document mental capacity, this was not always completed. Staff were instead storing decisions about mental capacity, including the documentation of best interest decisions on their individual work drive, which was inaccessible to other members of the clinical team. This issue had not been picked up by the services clinical audits. The provider was able to provide us with the documentation after the inspection. Once we received these records, we saw that staff had included relevant people in the decision-making process and had documented the decisions clearly.

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

Good

Kindness, privacy, dignity, respect, compassion and support

We attended one assisted cooking session, a multidisciplinary meeting and a patient's care review. We saw staff treating patients with dignity and compassionate respect. Staff spoke to patients with kindness and spoke about them respectfully. This was also echoed in the language staff used when reporting incidents. We saw that staff worked with patients to help create an environment where patients respected people with protected characteristics such as age, race and sexual orientation.

The five patients we spoke with were all very complimentary about the way staff interacted with them. They said they felt safe and supported when staff were caring for them. They felt staff were open and receptive to their individual needs and beliefs.

Staff worked with patients towards a set goal of recovery that aimed to help them move on from the hospital with as much independence as possible and to empower them in managing their daily lives. There was a pathway to help patients self-administer their medicines when they were ready.

Involvement in care

The admission process to the hospital sometimes included a graded admission to the unit, to allow patients to adjust to the new surroundings and feel more comfortable with the change from their last hospital. As part of the admission process, they received a welcome booklet with information about the service, as did their carers/relatives.

Patients felt that they were included and central to their care at the hospital, and we saw good documentation of how they had been involved in their care plans.

Staff were aware of their responsibilities to communicate with patient in a way they could understand. To this end, they could access information in a variety of languages and in easy read.

To help patients gain experience of paid work, some patients were recruited, trained and paid to be part of the recruitment panel for staff.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

There were opportunities for patients to provide feedback via surveys, and while they were in treatment through community meetings and patient forums. The service was in the process of collecting friends and family surveys from carers.

An independent advocacy service attended the hospital weekly, and the patients we spoke with were aware of their role and how they could help them.

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

Good

Access and discharge

The hospital was split into four wards. Average bed occupancy ranged from 67%-87% per ward over the year before this inspection. For long stay rehabilitations services of this type (long term high dependency units) we would expect an average length of stay between one and three years. This service had average lengths of stays within this guidance. Average length of stay at the hospital ranged from 286 days to 439 days.

Patients were accepted from throughout the country, and staff worked to ensure links with patient's home teams were kept ensuring that patients did not lose valuable relationships in their home area. Once patients were admitted, their room was kept for them while they were on leave.

Patients were occasionally moved within different wards in the hospital, but this was only done when there were clinical reasons to do so.

From a patient's first ward round, staff planned for discharge. These discharges were planned, and took place at appropriate times of day. There had been one delayed discharge in the year before this inspection. This had been because of a lack of appropriate community placements.

Staff liaised with clients' care co-ordinators and home care team to help ensure smooth discharge from the hospital.

The facilities promote recovery, comfort, dignity and confidentiality

Patients had individual rooms, with lockable storage, and keys to ensure their belongings were kept safe during their treatment. They could personalise their rooms.

All the wards had good access to outside space, and access to single sex lounges and adapted kitchens for patients to use. Patients could meet visitors in meeting rooms away from the ward. Some staff said that there was sometimes a lack of space to hold activities on site, but that this was managed by having individual patient activities in the community.

Patients could access their own mobile phones, and could also use the ward telephone to make phone calls in private. If patients did not have their own phone, they were given a ward mobile phone to use while on leave in case of emergency.

As well as encouraging patients to cook for their own meals, meals were provided to meet their dietary, religious and cultural needs. Patients could also access hot drinks and snacks 24/7.

Patients' engagement with the wider community

Staff worked with patients to try to engage them in meaningful opportunities in the local community. For example, supporting them to volunteer at local charity shops. Staff were in the process of making an arrangement with a local college that they hoped would allow greater opportunities for patients from January 2019.

The hospital helped support visits for carers, as well as visits for patients back to their local area to ensure that they maintained relationships where they lived.

Meeting the needs of all people who use the service

There were reasonable adjustments to the facilities to allow access for people with mobility issues. These included lifts, and adjusted bathrooms.

There was information available to patients on a variety of topics, including reminding them how to access advocacy and how to complain. Staff could also access easy read information and interpreters for people that needed them.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The hospital provided food to meet patients dietary, cultural and religious needs. Staff also had access to information about local religious services to help meet patients' religious needs.

There were occupational therapy assistants on shift at weekends, and staff planned activities for patients so that they had access to meaningful activities throughout the week, not just Monday- Friday.

Listening to and learning from concerns and complaints

The hospital reported nine complaints since January 2018. Of these, two were upheld, and one was partially upheld. None were referred to the ombudsman. The hospital also reported two compliments in the same period.

The five patients we spoke with were not only aware of how to raise complaints, but felt these would be addressed by staff in an appropriate way, without any fear of recrimination.

Staff responded to complaints, and investigated them in line with their policy. We saw that where learning had been identified, this was put into action and changes were made. For example, increasing the number of occupational therapy assistants over the weekends to ensure that patients could access leave and activities throughout the week.

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

Requires improvement

Leadership

Staff benefitted from skilled and approachable leadership. The hospital director had been in post less than six months, and staff said they found them to be approachable and supportive. The hospital director had received leadership training, and was booked onto further leadership training in December 2018.

Vision and strategy

The provider had a set of corporate values. Staff knew what these were and tried to embody them in their work. The values also formed part of the structure of their appraisals.

Staff told us that senior leaders in their organisation had visited and were approachable should staff have any concerns.

Staff worked towards a shared idea of what recovery is. They saw recovery as improving the patient's management of their condition, improving their physical health, and self-esteem. They aimed to move patients on with as much independence as possible and empower them to be in charge of their daily life.

Culture

There was a culture of respect and pride in working for the hospital. Staff said they felt their morale was good, that they worked well together and felt they were supported by each other regardless of their level in the organisation.

The provider had a speak up guardian and staff knew how to raise concerns. Staff told us that they felt they could raise any concerns without fear of retribution.

There were no active cases of performance management during this inspection. However, the hospital director was able to explain how they would manage poor performance in staff to help them to maintain their role and provider better care.

We reviewed eight appraisals and saw that they focused on career development for staff, and included staff goals and what they would need to achieve them.

Governance

Governance systems did not always ensure that key aspects of care were carried out and documented and audit procedures did not highlight these risks. Despite training and a policy, systems to ensure prompt raising of safeguarding referrals did not always work. Staff left the referrals for a single member of staff, and there were unreliable procedures in place for when that person was sick or on leave. We saw two occasions where referrals had not been raised for nine days. These referrals had also not been raised as notifications to the Care Quality Commission. This meant that managers could not guarantee that concerns were being raised to the appropriate bodies for investigation in a timely way, which put patients at risk of further abuse.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Systems to ensure staff always reported incidents were not effective. In addition, there were no effective systems in place to ensure staff always recorded their learning from incidents from daily meetings and updated patient's risk assessments after incidents had occurred. This meant that incidents were not always reported in a timely manner, and when they were the learning from them may not be imbedded, potentially leading to incidents re-occuring.

Procedures for recording decisions where there were concerns that a patient might not have the mental capacity to make decisions did not ensure that these judgements were easily available to staff and despite training, staff were still not clear of their role in assessing mental capacity, and left it to a single member of staff to do this. This meant that staff were at risk of potentially acting unlawfully when treating patients against their wishes.

However, there were good systems in place to ensure staff received appraisals and mandatory training.

Management of risk, issues and performance

The hospital director had control over the local risk register, and discussed this with staff at team meetings. Staff felt they could raise concerns to the risk register and that the risk register matched the challenges the service faced.

Information management

Staff did not raise any concerns about the burden of collecting data for clinical audits.

There was adequate access to equipment to access the electronic records system, and the provider had placed a further order for equipment to further improve access for staff. The electronic record system was password protected and set up to help protect the confidentiality of patient records.

The hospital director received updates on the performance of the hospital against key performance indicators regularly. This information was displayed in a way that was easy to understand and track performance over time.

Engagement

The service produced a newsletter to keep patients and carers up to date with changes to the service. Staff also received bulletins to keep them up to date with any learning from incidents in the rest of the provider group, and to update them on relevant changes to policies or procedures. The hospital also sent monthly updates to the local clinical commissioning groups that funded patients to receive care there.

Staff gathered feedback from patients and carers to help improve the service, and important changes were discussed in community meetings. Staff also met with local residents every six months to help build better relationships with the local community.

Learning, continuous improvement and innovation

The service was not taking part in any research at the time of this inspection, and was not accredited with any nationally recognised accreditation schemes. However, staff did meet with other healthcare providers in their area to discuss how to improve the quality of care in the region.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that physical health checks are completed and documented after staff administer rapid tranquilisation medicine.

The provider must ensure that physical health checks are completed for patients appropriately when they receive clozapine.

The provider must ensure that systems are in place to ensure that safeguarding referrals are raised promptly.

The provider must ensure systems are in place to ensure that all incidents are reported and the learning from them is documented.

The provider must ensure that staff are aware of their role in decisions in relation to the Mental Capacity Act and that these decisions are documented appropriately and accessible to relevant staff.

Action the provider SHOULD take to improve

The provider should ensure that all appropriate medicines are included in consent forms for patients detained under the Mental Health Act.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Safe care and treatment Physical health checks were not completed after administering rapid tranquilisation medicine, meaning patients could be at risk of over sedation. Physical health checks were not being completed for patients on clozapine, putting them at risk of side effects and cardiac issues. Staff had documented that they should not administer a dose of clozapine after receiving advice from the pharmacy but had done so anyway. They had not raised this as an incident until we highlighted it to them. This put the patient at risk of cardiac issues, and meant that the incident had not been investigated and acted on in a timely way This was a breach of regulation 12 (2) (a) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Good Governance Systems were not in place to ensure safeguarding referrals were raised promptly to the local authority or that the Care Quality Commission was notified of allegations of abuse

This section is primarily information for the provider

Requirement notices

Decisions about a patient's mental capacity under the Mental Capacity Act were not always clearly documented or available to the relevant staff

Systems were not in place to ensure that staff always documented discussions after incidents or updated patients risk assessments.

This was a breach of regulation 17 (2) (b) (c)