

Rosebank House

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Rosebank House as **requires improvement** because:

- There were blind spots that undermined staff's ability to undertake effective observations.
- Staff were not undertaking or recording the minimum level of observation of patients.
- There were numerous ligature points, no ligature cutters nor a ligature risk assessment.
- The hospital did not fully comply with same sex accommodation guidance.
- Temporary staff had not received an adequate induction.
- There was no system in place to check the competence of staff to administer medicines safely.
- Staff did not always follow medicines management policies.
- Clinical nursing staff were not involved in clinical audits.
- There were no clear recovery pathways in patients care plans.
- The service did not use outcome measures when supporting people.
- Care plans did not reflect patients' specialist needs.
- There were no audits or plans to review the hospital's effectiveness in meeting the needs of patients who may have autism or a learning disability.
- There was an absence of internal monitoring to improve services.
- When an audit did identify gaps, no robust action plan was put in place.

- The provider was not adequately monitoring the risks around staff skill mix to meet considerable variances in patients' needs and risks.
- The provider had not taken steps to assure itself about patients' safety.

However:

- There were sufficient numbers of staff on duty to meet people's needs.
- The hospital was clean and well maintained.
- There was emergency equipment available in the event of a health crisis and this was checked daily.
- Medication was prescribed within National Institute for Health and Care Excellence (NICE) guidelines.
- There was good monitoring of patients physical health needs, and treatment was sought promptly, when required.
- Staff received regular supervision.
- We observed consistent supportive and caring interactions between staff and patients.
- Patients were treated with dignity and respect.
- A recent patient satisfaction survey was positive about the service, 100% of patients felt listened to.
- The hospital had suitable furniture and equipment to meet people's needs.
- There was an interpreting service available if required.
- There was good access for people who may be wheelchair dependent.
- Patients had access to an art therapy room, computer room and meeting space.
- Locally staff reported feeling well supported and enjoyed working in the service.

Summary of findings

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Requires improvement 

Rosebank House

Services we looked at:

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

Summary of this inspection

Background to Rosebank House

Rosebank House is an independent hospital that provides open rehabilitation inpatient services. The hospital accommodates up to four women and nine men who require mental health care and treatment to support them move to more independent living. At the time of the inspection there were 12 patients.

Patients admitted to Rosebank House are usually stepping down from locked mental health inpatient wards.

At the time of the inspection the hospital had admitted people with a wide range in needs and age. The service had also admitted patients with a learning disability.

Rosebank House is registered to provide the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983 and Treatment of disease, disorder or injury. There is a registered manager in post.

En-suite male and female bedroom accommodation is located on separate floors. There was disabled access within the hospital with an adapted male bedroom.

Partnerships in Care Limited became the registered provider of Rosebank House in June 2015. This means that this was the first inspection of the service under the new provider.

Our inspection team

Team leader: Zita McCarry, Inspector

The team that inspected the service comprised three CQC inspectors, a Mental Health Act Reviewer and a clinical psychologist providing specialist advice.

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all areas of the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with the registered manager and regional manager
- spoke with five other staff members; including nurses and psychologist
- received feedback about the service from commissioners
- spoke with an independent advocate
- collected feedback from three patients using comment cards
- looked at five care and treatment records of patients

Summary of this inspection

- reviewed 11 patients risk assessments
- carried out a specific check of the medication management
- looked at the clinical area emergency equipment
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

All the patients were positive about the service they received. They were particularly positive about their interactions with all grades of staff. They told us they were treated with dignity and respect.

Eleven patients completed a survey undertaken a month before the inspection 100% of them confirmed that they felt staff listened to them.

In the same survey just over half the patients said they were clear about the work they need to do to achieve their goals.

Some patients who had been at the hospital for many years told us they felt that the hospital was their home.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **inadequate** because:

- Patient's individual risk assessments were significantly out of date.
- Staff had not carried out environmental risk assessments, including ligature risk assessments or infection control audits.
- There were numerous ligature points throughout the building, but no ligature cutters onsite.
- The layout of the building, which included blind spots, undermined staff's ability to undertake effective observations.
- Staff were not undertaking or recording the minimum level of observation of patients set out in the observation policy.
- The hospital did not fully comply with same sex accommodation guidance
- Temporary staff had not received an adequate induction.
- There was a lack of learning from incidents.
- There was no system in place to check the competence of staff to administer medicines safely.
- Ten consecutive audits had identified consistent gaps in medication records, but no action plan was developed or implemented to address this.

However:

- There were sufficient numbers of staff on duty to meet people's needs and these were adjusted to meet needs.
- Staff had undertaken mandatory training and knew how to report safeguarding concerns.
- Medicines were stored appropriately and securely.
- There was emergency equipment available in the event of a health crisis and this was checked daily.

Inadequate



Are services effective?

We rated effective as **requires improvement** because:

- Clinical nursing staff were not involved in clinical audits.
- There were no clear recovery pathways in patients' care plans.
- Care plans did not reflect patients' individual needs.
- There were no audits or plans to review the hospitals effectiveness in meeting the needs of patients who may have autism or a learning disability.

However:

Requires improvement



Summary of this inspection

- Medication was prescribed within appropriate guidelines.
- There was good monitoring of patients physical health needs and treatment was sought promptly, when required.
- Staff received regular supervision in their work.
- Patients were informed of their rights under section 132 of the Mental Health Act and associated Code of Practice.

Are services caring?

We rated caring as **good** because:

- We observed consistent supportive and caring interactions between staff and patients.
- Patients were treated with dignity and respect.
- A recent patient satisfaction survey was positive about the service, 100% of patients felt listened to.

However,

- Patients' community meeting had little effect on how the service was delivered.
- Patients were not always involved in planning their goals.

Good



Are services responsive?

We rated responsive as **good** because:

- At the time of inspection 27% of patients had been in the service for over 12 years and considered the hospital as their home. This meant there was a lack of recovery-orientated focus to the support provided.
- The staff did not record and monitor informal complaints from patients.
- Information of how to make a complaint was not in an accessible format for all patients to access.

However:

- Patients were able to prepare hot drinks and snacks when they wished.
- Patients were provided with a key to their rooms so could keep their belongings secure.
- The hospital had suitable furniture and equipment to meet people's needs.
- There was an interpreting service available if required.
- There was good access for people who may be wheelchair dependent.
- Patients had access to an art therapy room, computer room and meeting space.

Good



Summary of this inspection

Are services well-led?

We rated well-led as **requires improvement** because:

- There was an absence of internal monitoring to improve services.
- When an audit did identify gaps, no robust action plan was put in place.
- The provider was not adequately monitoring the risks around staff skill mix to meet considerable variances in patients' needs and risks.
- The provider had not taken steps to assure itself about patients' safety.

However:

- Locally staff reported feeling well supported and enjoyed working in the service.
- When we escalated our concerns to the provider they took immediate action to address our feedback.

Requires improvement



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.

- At the time of inspection there were four patients detained under the Mental Health Act 1983.
- All of the permanent staff had received training in the Mental Health Act. However, six of these pre-dated the Mental Health Act 1983: Code of Practice published in 2015 which meant that not all staff were up-to-date with the current guidelines.
- Patients told us that they were aware of their rights under the Act. That they had care plans which they felt involved in, but did not have copies. Patients were aware of their section 17 leave arrangements and had copies of these forms.
- There was evidence in the files scrutinised that patients were being informed of their rights under section 132 of the Act and associated Code of Practice.
- Leave was authorised on a standard system, with patients being assessed prior to leave and their attire noted.
- In three of the files scrutinised no review date was indicated on the section 17 form completed by the responsible clinician. One file had an out of date section 17 form that had not been struck through or removed.
- Mental Health Act administration was completed by a local NHS trust who provided support and legal advice on the implementation of the Act and Code of Practice. Section papers were available, although initially difficult to find due to archiving. We spoke with the mental health act administrator who agreed to ensure that a new folder of appropriate section papers would be completed as it appeared that when new files had been started old papers had been archived. The approved mental health professional (AMHP) reports were not available in files scrutinised. Detention papers were stored appropriately.
- Capacity to consent to treatment was assessed and recorded by medical staff in all files scrutinised. Medication given was appropriately authorised. We did not see any assessments of patients' mental capacity undertaken since the provider took over the service in June 2015.
- Regular audits were completed by staff from the local NHS trust under contractual arrangements.
- Independent mental health advocacy services (IMHA) were provided by an independent advocacy organisation. The advocate visited monthly and those dates were displayed on notice boards. In addition, the advocate attended when requested.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff had received training in the Mental Capacity Act, including Deprivation of Liberty Safeguards. We did not see any assessments of patients' mental capacity that had been undertaken since the provider took over the service in June 2015.
- No patient in the service was subject to Deprivation of Liberty Safeguards.

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	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

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

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

Inadequate 

Safe and clean environment

- Patient bedrooms were on both the ground and first floors. The layout of the wards did not facilitate good observation. The entrances to eight bedrooms, located at the end of corridors, were set back into alcoves which created blind spots. There were no viewing panels on bedroom doors and some patients chose to spend long periods in their room.
- We observed numerous ligature points in private and shared areas throughout the service. There were no ligature cutters available for staff to use in an emergency. The provider had not undertaken a ligature risk assessment. This meant that these risks had not been identified or action taken to reduce them.
- Staff did not consider the identified ligatures as a risk. They told us that because patients were in recovery they would not self-harm. We escalated our concerns to the provider who took immediate steps to address the issues we raised.
- The risks to patient safety in relation to ligatures or mixed sex accommodation were not reduced by staff observations. Staff were not following the provider's observation policy, which stated, "recorded checks must be made on all patients on all wards day and night".

There were no records of checks undertaken. Staff told us that patients in the service did not require the provider's minimum level of observation and that it was unnecessary for the patient group.

- All areas of the hospital were visually clean and well maintained. Patients told us they were satisfied with the level of cleanliness in the service. However, staff did not undertake infection control audits and this may have put patients at risk of acquiring infections.
- The provider had not undertaken an environmental risk assessment. This meant there were no plans in place to identify or reduce possible risks to patients, staff or visitors.
- All staff had access to alarms. Each patient bedroom was fitted with a call system so they could summon assistance if necessary.
- Patients' accommodation was provided in private bedrooms with en-suite facilities. Bedrooms were arranged in same sex areas. However, there was no provision for same sex communal areas. Female patients did not have access to a "women only" lounge or day room. Female patients wishing to access the computer had to do so via the male patient accommodation area.
- There was a fully equipped clinic room. Equipment was clean and well maintained and all emergency equipment checks were carried out daily.

Safe staffing

- There were six qualified nurses' posts, two of which were vacant at the time of our inspection. The service had nine whole time equivalent recovery support workers posts with one vacancy at the time of our

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

inspection. In the three months before our inspection the service had used temporary agency or bank staff to cover 288 shifts in the service, with a further 33 shifts being covered by permanent staff working additional hours.

- Staff shift patterns had recently changed. Nursing and support staff had recently started working long days. This provided better continuity for patients and reduced dependency on temporary staff.
- Day and night shifts consisted of one registered mental nurse and two recovery support workers. The registered manager confirmed that staffing levels never fell below this. Both the hospital manager and deputy manager worked 9am to 5pm Monday to Friday. Whilst this meant there was no senior management on site in the evenings and weekends there was an on call system to deal with out of hours issues.
- Staff reported that they felt there were sufficient numbers on duty to support the patients. They said that activities were never cancelled because of insufficient staff and this was confirmed by patients.
- Agency and bank staff were employed to cover shifts as necessary. We saw that no shift was left without cover. The hospital manager told us they took steps to ensure that the service and patients knew these workers. We saw that agency nurses frequently lead both day and night shifts. However, not all agency staff were provided with an adequate induction.
- Senior hospital staff told us they adjusted staffing levels to meet the needs of the patients. We saw that additional staff were booked to support a patient through their stay in another service, that if required additional staff were booked to meet an individual's personal care needs. Staff supported patients to attend community outings. Patients described attending a recent firework display and the rotas confirmed additional staff were booked to enable their attendance.
- Rotas reflected that there was a qualified nurse in the service at all times. Patients told us they had an opportunity to speak to staff at any time, and that they meet with a nurse twice a week to discuss their progress. Staff did not always record these meetings as part of the patients' recovery plan.

- Staff told us that patients leave was rarely cancelled and that ensuring patients leave was facilitated was considered a priority in the service. Patients confirmed this to us.
- Staff had undertaken recent mandatory training, in areas such as health and safety, infection control and fire safety. The training in emergency first aid and first aid at work for the majority of staff had not been undertaken since 2012 and 2013 respectively and so staff might not be up-to-date in the latest techniques to keep patients safe.

Assessing and managing risk to patients and staff

- Staff had not used any restraint in the six months prior to the inspection. There was no seclusion room within the hospital.
- We reviewed 11 patient risk assessments and these were all out of date. Whilst these were detailed; many had not been reviewed for some years and it was not clear how relevant they were. Of the 11 risk assessments checked, the most recent was over seven months old and had not been reviewed or updated. Five were written in January 2014 and one in October 2013. This meant there was a potential for patients and staff to be put at risk where this was not being reviewed regularly.
- We saw there had been an incident where deterioration in a patient's health which lead to aggression had been reported to the police. There had been no record of any learning from the incident although we saw that there may have been an opportunity for earlier intervention when the patient had refused to comply with their prescribed medication.
- Staff were still using the previous provider's policy and procedure for the management of violent and aggressive behaviour. This document was due to be reviewed in November 2014, so was outdated. There were no recorded incidents of restraint.
- Staff told us they used a de-escalation approach if patients became unsafe or agitated. They said that they did not use any form of restraint and if a patient's behaviour escalated they called the police.
- There had been no safeguarding concerns raised within the service since the service registered under the new

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

provider. However, staff had received training in safeguarding adults and children and were able to describe the provider's adult and child safeguarding processes.

- We looked at the medicines management processes. Medicines were stored appropriately and securely. Prior to the recent change in staffing rota to provide more consistent staff, the use of temporary staff to cover shifts resulted in inconsistency in the care and treatment provided to patients. There were repeated errors in the recording of patients' medication. There was no process in place to ensure an agency nurse was competent in the management and administration of medication. Staff highlighted to us that some agency staff were poor at sharing of information. Patients were put at risk because serious risks had not been shared with senior staff. When we checked, we found that the particular temporary nurse had not been provided with an adequate induction to lead the shift.

Track record on safety

- Since the service was registered under the new provider there had been one serious incident regarding patient aggression.

Reporting incidents and learning from when things go wrong

- Staff were aware of how to report incidents such as falls and aggression and had received training in how to log incidents on the computerised system.

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 viewed the care records of five patients. Three of these were up-to-date. One of these was holistic. None of the care plans were recovery-orientated. All

admissions to Rosebank House were planned. Patients' needs and risks were assessed when they were admitted. Patients also had full physical health examinations on admission to the service.

- Patients' ongoing physical health conditions were managed by a local GP surgery. Staff supported patients to attend their GP or if necessary the doctor visited the hospital. Where patients had physical health care needs, these were addressed in their care plans. The care records for one patient showed that they had timely medical intervention because staff had maintained good monitoring and recording of their observations. Staff then supported the patient during their acute hospital admission. However, one patient did not have a care plan that met an identified need of theirs and there were no clear arrangements in how to best support the patient. This meant that they were not always provided with care and treatment that met their identified need.
- At the time of our visit the provider had just introduced a new electronic care record system, which was in a period of transition. Staff also had access to detailed paper based records.

Best practice in treatment and care

- The hospital used the 'star recovery' plans which focused on patients' individual strengths and their personal resources as the means of supporting their recovery. However, staff had not consistently used this planning tool to support patients' recovery. Records showed that only 40% of qualified staff had received training in the 'star recovery' programme. Of the five care plans we reviewed, we found that whilst they were detailed, they lacked a recovery-orientated approach to meeting patients' needs and supporting them to move to a more independent environment.
- The service did not use outcome measures when supporting people. This meant that there was no evidence of people's health or wellbeing changing while in the service
- There were two consultant psychiatrists that covered the unit. They both prescribed medicines in accordance with The National Institute for Health and Care Excellence guidelines. It was confirmed by the host mental health trust that both consultants frequently made medicines related enquiries through their

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

Medicines Information Service based in Reading. The medical staff also attended medicines management training courses on psychopharmacology, which promoted good prescribing guidelines.

- Patients were not provided with ongoing individual psychological therapy. A psychologist visited the hospital once a week to provide a group focused activity. The hospital had a meeting room that was also used as an art therapy room. Groups were provided by an occupational therapist who visited two days per week. This did not promote a recovery focussed programme.
- Staff had not taken steps to use tools to audit and improve the service for patients who may have a learning disability or autism. The service had not used the Green Light Toolkit to audit and improve the service, as recommended by the Department of Health. This meant that patients who may have autism or a learning disability were not always provided with the opportunity for best care and treatment to meet their individual needs.

Skilled staff to deliver care

- The multi-disciplinary team included professionals such as consultant psychiatrists, occupational and a psychological therapists. These staff were employed by the host mental health trust. Mental health nurses, management and ancillary staff were employed by the provider.
- New permanent staff received an induction into the service. When agency staff were used to fill vacant shifts, efforts were made to book staff that were familiar with the hospital and provide continuity for patients. These temporary staff did not receive adequate inductions despite some being booked to lead a shift. This put patients and others at risk.
- At the time of inspection 100% of staff had received an appraisal of their work. All qualified staff had recently received training in how to provide formal structured supervision. Staff told us they received supervision every four to six weeks. However, we saw that new staff had had not been allocated a mentor or supervisor to provide additional support that could help them adjust to their new role.

- Staff had not been provided with training to meet the needs for patients who may have specialist needs. This meant that patients who may have had a learning disability or autism did not have their care and treatment delivered by staff that fully understood their condition.
- Given the range of age and needs of the patient group there was no evidence that the staff had been trained in how to meet people's diverse needs.

Multi-disciplinary and inter-agency team work

- Commissioners, who purchase the service for patients, considered the service responsive and flexible.
- With the recent move to long shifts staff handover took place in the morning and night.
- Staff told us that care coordinators in the community were invited to care programme approach reviews. They told us that maintaining contact with care coordinators could be challenging. In a recent patient survey 45% of patients did not know who their care co-ordinator was.

Adherence to the Mental Health Act and Code of Practice

- At the time of inspection all of the permanent staff had received training in the Mental Health Act. However, six of these pre-dated the Mental Health Act 1983: Code of Practice published in 2015 which meant that not all staff were up-to-date with the current guidelines.
- There was evidence in the files scrutinised that patients were being informed of their rights under section 132 of the MHA in line with the Code of Practice. Patients told us that they were aware of their rights and section 17 leave arrangements, where they held copies of these forms. They had care plans which they felt involved in, but did not have copies.
- We saw that leave was authorised on a standard system, with patients being assessed prior to leave and their attire noted.
- In three of the files scrutinised there was no review date indicated on the section 17 form completed by the responsible clinician. One file had an out of date section 17 form that had not been struck through or removed.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

- Patient's medication was appropriately authorised. Consent to treatment was assessed and recorded by medical staff.

Good practice in applying the Mental Capacity Act

- All staff had received training in the Mental Capacity Act, including Deprivation of Liberty Safeguards. We did not see any assessments of patients' mental capacity that had been undertaken since the provider took over the service in June 2015.

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

Good



Kindness, dignity, respect and support

- Throughout our inspection we observed consistently supportive and relaxed interactions between all staff and patients. Patients told us they found staff to be very approachable and caring. The positive tone of the interactions between staff and patients was reflected in patients' daily progress notes. A recent patient satisfaction survey found that 100% of patients said they were treated with dignity and respect.

The involvement of people in the care they receive

- Patients were supported to familiarise themselves with the hospital when they were admitted. They were provided with a 'welcome brochure' that told them about what to expect from the service and some of the rules.
- Patients told us they knew about their care plans but these did not always reflect their personal views or goals for recovery. Of the care plans we viewed, three of the five care plans did not show patient views.
- The provider commissioned an advocacy service which visited the hospital once a month or more frequently, if requested. The service was advertised and contact details were provided to patients so they could make contact independently.
- Patients' community meetings were chaired by staff. The minutes of the three most recent meetings showed

that these were mostly information giving around health and safety, cleaning procedures or how to raise a complaint. There was no record that these meetings were used to enable patients to become involved in decisions about the service.

- The provider sought feedback about the service provided to patients. We saw that this was very positive particularly in relation to information provided, relationships with staff and quality of food.

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 mean time from referral to initial assessment was 72 hours, and mean time from initial assessment to onset of treatment was two weeks.
- At the time of inspection the bed occupancy was 100% and we were informed there were no delayed discharges. The hospital manager told us that the average length of stay in the service was 18 to 24 months, although this was flexible. However, at the time of our inspection 27% of patients had been in the hospital for over 12 years. Some patients told us they were at a stage in their life where they felt the hospital was their home. This meant that they and the service were not focusing on moving to a less supported environment. This was reflected in the lack of recovery-orientated care planning.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a clean, tidy and well maintained clinic room with an examination couch for physical health examinations.
- The provider ensured there was a range of furniture and fittings that met the range of physical health needs of patients. The clinic room was equipped with an examination couch for physical health examinations.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

- Patients had access to meeting rooms, a computer suite and art therapy room. At the time of the inspection there was no broadband provided for patients' use but otherwise facilities were in good order and well maintained.
- For patients who did not have access to a personal mobile phone there was a payphone fitted with a privacy hood so patients could make personal calls.
- Patients had access to an equipped kitchen so they could prepare their meals, snacks and hot drinks as required. This meant that patients were provided with domestic facilities to promote their independence. Staff supported cooking sessions with individual patients, which included shopping and preparing the food. They reported favourably on the food provided to them in the hospital.
- Patients were provided with a key to their bedroom so were able to keep their belongings secure. In the shared kitchen, each patient had their own lockable cupboard to store their personal foodstuffs.
- Patients were allowed to decorate their rooms and could have a television or radio in their rooms if they wished.
- Patients were supported to undertake meaningful activities both in the community and in the service. They could attend a work opportunity placement called Ways and Means twice per week for which they were paid per session worked. Patients also undertook in-house activities to promote their independence such as cleaning their own bedroom and food preparation with the support of staff. Patients who were physically unable to undertake such tasks were supported by staff.

Meeting the needs of all people who use the service

- There was a lift that ensured patients with mobility needs could access the first floor, on which a bedroom had been adapted to enable wheelchair access. On both floors patients were provided with assisted bathrooms.
- Patients were provided with information about advocacy services, their rights as informal patients, local services and how to make a complaint. This information was not presented in an accessible format for patients who may have had a learning disability.

- Staff told us they could access an interpreting or signing service for patients, if one was required.

Listening to and learning from concerns and complaints

- There had been one formal written complaint recorded by a patient about a maintenance issue. This had been addressed by the provider, upheld and resolved to the patient's satisfaction. There had been no other complaints recorded in the service.
- Patients were provided with information on how to make a complaint. They told us they would feel comfortable raising a complaint with staff. The provider did not record or monitor informal complaints made by patients. This meant that the one complaint detailed above may not be an accurate reflection of patients' concerns or comments.

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

Requires improvement 

Visions and values

- At the time of inspection the staff were still in a period of adjustment to a new provider of the service, such as changes to shift patterns, policies and procedures and electronic recording and reporting systems. Not all were able to tell us about the provider's vision and values and the team were undertaking work to agree service objectives to ensure these reflected the new provider's values.
- Within the hospital all the staff we met told us they felt well supported by the hospital manager and enjoyed working in the service. Staff felt optimistic about working in the service and were positive about changes being implemented. For example staff reported that the new shift pattern reduced the use of agency staff, the frequency of handovers and therefore increased the time spent with patients.

Good governance

- The provider did not have appropriate training audits to identify training and development needs of the team.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

- An internal medicines records audit had been undertaken. Whilst it identified areas for improvement there was no accompanying action plans, and as a result the same problems such as 'gaps in medication records' had been repeatedly identified over 10 consecutive audits. There was no effective action being taken to prevent recurrence and minimise risks to people.
- The lack of clinical audits meant that the provider did not have sufficient oversight of the risk management processes within the service. This meant that patients' safety and wellbeing were put at risk because concerns were not identified and measures put in place to mitigate against them. Similarly, there was a lack of audit of care plans, infection control, ligature risks or staff supervision. This meant that the provider failed to actively review and improve its service.
- The service adhered to the Mental Health Act and staff were aware of their responsibilities in relation to the Mental Capacity Act.

Leadership, morale and staff engagement

- We were told there were no staff performance concerns nor allegations of bullying or harassment within the staff team. Staff told us they felt well supported by their manager, and felt they could raise concerns with them.
- Staff reported they enjoyed their job and got satisfaction from seeing patients move on to more independent living. They told us they enjoyed working within their team although some said they felt additional challenges when working with agency staff.
- Staff told us they knew the provider had a whistleblowing policy and would know where to find it if necessary.

Commitment to quality improvement and innovation

- The service had not participated in any accreditation schemes for inpatient rehabilitation service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure ligature risks are identified and action taken to mitigate against these risks.
- The provider must ensure that staff adhere to the protocol regarding patient observations.
- The provider must ensure there is a system in place to assess staff competence before they administer patients' medications.
- The provider must ensure that the hospital complies with same sex accommodation guidance in relation to communal areas.
- The provider must ensure that all temporary staff have an adequate induction for the role they are to undertake.
- The provider must ensure that individual risk assessments of patients are kept under regular review and updated to reflect changing needs.
- The provider must ensure that all staff receive appropriate training to meet the needs of the patient group.
- The provider must review its governance processes to ensure effective monitoring and continual improvement within the service.
- The provider must ensure that learning from incidents is used to inform practice.

- The provider must ensure that clinical audits are carried out and recorded in order to enable the provider to learn from the results and make improvements to the service.
- The provider must undertake audits of the environment and infection control practices to ensure the premises is safe and hygienic for the patients and staff.
- The provider must ensure that the care plans are person-centred, recovery focussed and with a specific focus on individual needs, such as a learning disability.
- The provider must ensure that the hospital uses outcome measures when supporting people to monitor and evidence patient progress.
- The provider must ensure that the hospital participates in clinical audits to ensure the support they provide to patients is effective and of high quality.
- The provider must ensure that all complaints from patients are recorded, whether verbal or written.
- The provider must ensure that information of how to make a complaint is readily available in an accessible format for all patients to access.

Action the provider **SHOULD** take to improve

- The provider should ensure that all staff undertaken training in the Mental Health Act 1983: Code of Practice published in.
- The provider should ensure that the placement of patients who have been at the hospital for a number of years is kept under review.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met:

- Care plans were not person-centred or recovery focussed.

This is a breach of Regulation 9(3)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met:

- The service did not comply with same sex accommodation guidance in relation to communal areas.

This is a breach of Regulation 10(2)(a)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

How the regulation was not being met:

- Patients were not protected from the risk of harm from ligature as no assessment had been undertaken to identify these risks and no measures in place to mitigate the risk.

This section is primarily information for the provider

Requirement notices

- There were no ligature cutters.
- The environmental risk assessment did not mitigate against blindspots.
- Staff were not undertaking minimal patient observations.
- Individual risk assessments of patients were not kept under regular review or updated to reflect changing needs.
- Staff competency in administration of medication was not assessed.

This was a breach of Regulation 12 (1)(2)(a)(b)(c)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

How the regulation was not being met:

- The provider did not undertake audits of the environment and infection control practices to ensure the premises is safe and hygienic for the patients and staff.

This was a breach of Regulation 15 (1)(2)

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

How the regulation was not being met:

- The staff did not record and monitor informal complaints from patients.
- Information of how to make a complaint was not in an accessible format for all patients to understand and use.

This was a breach of Regulation 16(1)(2)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

How the regulation was not being met:

- There was a lack of governance processes to ensure effective monitoring and continual improvement within the service.
- There was a lack of learning from incidents to inform practice.
- The hospital did not participate in any clinical audits. This meant that we did not see evidence that the support they offered people who used the service was effective, efficient or of a high quality.
- The team did not use outcome measures when supporting people. This meant that there was no evidence of people's health or wellbeing changing while in the service.

This section is primarily information for the provider

Requirement notices

This was a breach of Regulation 17(1)(2)

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

- Temporary staff did not receive an adequate induction.
- Staff were not trained to meet the different needs and abilities of the patients.

This is a breach of Regulation 18(2)(a)