Rhodes Wood Hospital

Quality Report

Shepherds Way
Brookmans Park
Hatfield
AL9 6NN
Tel: 01707 291500
Website: www.elysiumhealthcare.com

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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

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.

Overall summary

We did not rate this inspection. The ratings from the inspection which took place 09 to 11 April 2019 remain the same. This was a focused, unannounced inspection, to follow up on enforcement action we issued to the provider after our last inspection.

At the last inspection, we issued enforcement action because the provider was failing to provide safe care and treatment to young people. The provider was required to make significant improvements in different areas. These, specifically were:

- the safe management of ligature risks
- staff knowledge, understanding and implementation of seclusion
- staff response to alarms
- thorough checking of emergency bags
- infection control
- timeliness and completeness of individual patient risk assessments
- the safe management of Section 17 leave.

During this inspection, we found some areas of significant improvement. The provider had acted upon previous concerns raised. Therefore the warning notice has been lifted. However, we did serve an urgent notice of decision, around the management of seclusion and long-term segregation.

Summary of findings

Ligature risk assessments identified all potential ligature risks across the hospital. Each risk contained mitigation, so staff knew how to manage identified risks. Staff knew where ligature risk assessments were, and could refer to them easily.

The provider had invested in a new alarm system across the hospital. All clinical staff carried personal alarms. Alarms were routinely tested and charged to ensure they were in full working order. When an alarm was activated, it sounded across the hospital. Viewing panels had been installed in all three wards, which directed staff to the location of the alarm.

Nursing staff checked all three emergency bags across the hospital regularly. All equipment and medicines which should have been present, were present. Staff had recorded contents accurately.

Staff adhered to infection control when disposing of both general, and clinical waste across all three wards. Nursing staff had appropriately labelled sharps bins, used these appropriately, and they were not over filled.

Staff completed an individual risk assessment of each young person upon, or shortly after admission. Risk assessments contained appropriate and up to date information around risks, to include how staff managed these as safely as possible.

Doctors recorded the parameters of authorised leave clearly. Specific duration of leave was stipulated for all young people. Staff recorded the names of escorts in most instances. Staff, where appropriate, had identified and recorded details of the home address for when young people were to reside with parents. Staff recorded episodes of leave, including views on how the leave went, from young people, staff or family members / carers as appropriate. Staff had implemented and discussed contingency plans with young people, in case leave did not go as well as expected.

However,

Staff were not clear as to what seclusion and long-term segregation was, and could not clearly explain the differences between the two. Seclusion and segregation paperwork had been put in place so staff could record any instances. However, the paperwork was incomplete and not comprehensive. We found a lack of care planning, and limited records to show reviews of young people in seclusion or long term segregation had taken place. We could not ascertain, in a number of records viewed, the length of time the seclusion or segregation had lasted. Secluding or segregating young people for any longer than absolutely necessary is an infringement of their human rights. We were not assured that staff understood or followed, the Mental Health Act Code of Practice, in relation to seclusion and segregation safeguards.

Summary of findings

Contents

Summary of this inspection

Background to Rhodes Wood Hospital

Rhodes Wood hospital is a registered location under the provider of Elysium Healthcare Limited. The hospital comprises of three different wards: Shepherd, Cheshunt and Mymwood Place. Shepherd and Cheshunt wards can accommodate males and females, between the ages of eight and 18 years, who have a primary diagnosis of an eating disorder. Mymwood place is a neuro-developmental service, which can accommodate males and females, between the ages of 12 to 18. The provider has agreed with NHS England, that they will not accept any further admissions onto Mymwood place. There are ongoing discussions about the future of this ward. There are a total of 42 beds across the hospital. Mymwood Place has 12 beds, Cheshunt ward has 15 beds, and there are a further 15 beds on Shepherd ward.

The CQC registers Rhodes Wood Hospital to carry out the following legally regulated services/activities:

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

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

The hospital has been registered with CQC since October 2016. Since this time, the service has been inspected twice. The overall rating following the first inspection was good in 2017. The second inspection was in April 2019, and the service was rated as inadequate. Following this inspection the provider was told to make significant improvements in seven areas of care and treatment.

At the time of this inspection, the hospital did not have a registered manager. The provider have confirmed that they are in the process of submitting a new application. We will continue to monitor this.

Our inspection team

The inspection team comprised of one Mental Health Act Reviewer, and two Inspectors.

Why we carried out this inspection

We inspected Rhodes Wood Hospital in April 2019. At this time we identified that the provider was failing to meet Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. As a result of this, we took enforcement action against the provider and issued a warning notice under Section 29 of the Health and Social Care Act 2008. We issued this, as we identified:

- The provider did not have robust management of ligature risks. Ligature risk assessments did not identify all potential risks and did not contain adequate mitigation of risks. Staff could not refer to the ligature risk assessments easily as they were held centrally, as opposed to being available on each ward.
- Staff had used seclusion of patients on two occasions, and had failed to recognise, or record this as seclusion. Therefore, documentation had not been completed, in line with hospital policy and the Mental Health Act Code of Practice.
- Not all staff carried alarms. Staff were able to summon assistance via calls bells across the hospital. However, when the alarms sounded, it only alerted staff who were located in certain offices. This had caused some delays in staff response to alarms.
- Staff had not checked the contents of the emergency bag on Cheshunt ward properly. Staff had signed to indicate that all contents were present and correct. We found this to be innacurate, as we identified that some emergency medicines were absent.

Summary of this inspection

- Staff were not adhering to infection control principles in relation to waste management. We found general waste in clinical waste bags and sharps bins. Nursing staff had failed to date or sign a sharps box upon opening.
- Staff were not undertaking individual risk assessments for young people in a timely way following admission. We found that risk assessments were not always comprehensive.
- Staff had failed to manage Section 17 leave adequately. We found many gaps, including specific durations of leave; names of escorting staff; details of home address when the young person was on home leave; a lack of a contingency planning for if things went wrong, and staff had not always recorded how the leave had gone, from the perspective of the young person, escorting staff, or appropriate others.

This inspection looked specifically at these areas of concern. This inspection was focused and unannounced. We do not revise ratings following inspections of this type.

How we carried out this inspection

We have reported specifically upon the seven areas of concern listed in the warning notice. All of these concerns fell into the key question of safe. Therefore, our report does not include all of the headings and information usually found in a comprehensive report. We have not re-rated this service. The ratings from the last inspection remain the same.

During the inspection visit the team:

- visited all three wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for young people
- examined the management of ligature risks
- looked at all three wards to check that infection control was being adhered to, in relation to waste management
- looked at the emergency bags on each ward
- spoke with five young people who were using the service
- spoke with the hospital director
- spoke with 12 other staff members, including the clinical lead, maintenance manager, lead social worker, service lead, nurses and therapeutic care workers
- looked at 18 individual risk assessments of young people, and two care and treatment records
- reviewed 17 leave episodes and corresponding paperwork
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five young people who were receiving care and treatment at the hospital. All told us they felt safe on the wards.

Each young person could tell us what leave they had, and said that staff facilitated this. All young people told us that staff completed paperwork before they went on leave, to include writing down what they were wearing and how they were feeling.

Young people felt there was mostly enough staff, although one commented these were not always regular staff.

Young people told us that they saw staff respond to incidents quickly when the alarms sounded.

One of the five young people told us that others had been nursed in seclusion, although none of the five young people interviewed had experienced this.

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safety of the ward layout / ligature management

Staff assessed, monitored and managed ligature risks appropriately. We found staff had made significant improvements in the hospitals ligature risk assessments. The ligature risk assessment was comprehensive and identified all potential ligature points. This assessment had been signed off both clinically (by the hospital director), and from a Health and Safety perspective (the maintenance manager). The assessment clearly told staff how to mitigate every identified risk. Examples included young people must have supervised access to certain areas, or certain rooms would be kept locked when not in use.

Additionally, the provider had completed a “visual map” of each ward. This highlighted different potential ligature points / hot spots, via colour coded symbols. At a glance, staff could easily identify environmental areas of concern. Each nursing office had a map on display on the walls, for all staff to see. Additionally, for young people who had been assessed as at risk of tying a ligature, a ward map was within their enhanced observation paperwork.

Staff we spoke with were able to explain what a ligature risk was and were familiar with the ligature risk assessment and corresponding visual maps. All staff knew where these were located. Each clinical staff member was issued with ligature cutters at the commencement of their shift. These were carried securely in a pouch, attached to a belt.

Safety of the ward layout: Access to alarms

The hospital had invested in a new alarm system. When an alarm was activated, it sounded across the hospital. Therefore, all staff could hear, and were aware that assistance was required in a timely manner. Wall panels linked to the alarms had been installed within each clinical area, to direct staff to where assistance was needed. There were plans for a further 18 wall panels to be put in, including in the entrances to all wards and at the top of the stairwells. The maintenance manager also had plans to install further call points across the hospital.

All clinical staff were issued with a personal alarm at the commencement of each shift. The hospital had introduced a new system, whereby all incoming staff members handed over their time-sheet, in exchange for a belt, pouch, personal alarm, fob to access clinical areas and ligature cutters. At the end of their shift, staff handed these back and had their time-sheet returned. Staff tested alarms weekly and checked batteries daily to ensure they were working. Staff we spoke with told us they always had access to an alarm.

The hospital had also implemented the use of portable radios, as an additional safety measure. This enabled staff to be able to communicate between wards when necessary. The nurse in charge, along with the designated responder of each ward, were issued with a radio at the commencement of their shift. Each ward had two radios. Additionally, other staff held one – to include the maintenance support manager, housekeepers and the school. There was a protocol in place for proper use of the radios. Training in the use of radios was included within the security training for all staff.

Staff we spoke with were pleased with the new alarm system, and felt confident that colleagues would assist them promptly when the alarms were raised. The senior staff regularly tested staff response times to alarms. They routinely pulled an alarm and waited for staff to attend. They also conducted scenario's, such as a ligature incident, or a patient collapse, to aid staff learning and identify any potential difficulties which could arise. We saw records of this.

The provider had invested in installation of CCTV across the hospital, in communal areas. Senior hospital staff used CCTV to review incidents, or assist with investigations or allegations made about the care of patients.

Assessing and managing risk to patients and staff: Seclusion and long-term segregation

The hospital did not have seclusion rooms. However, staff confirmed, that on occasions, seclusion, or long-term segregation, had been used to safely manage some young people. We were also made aware that staff used the term 'defacto seclusion' and described this as a process where staff secluded young people for very short periods in their bedrooms. The provider did not comply with guidance within the Mental Health Code of Practice for seclusion and long term segregation. This contravenes the human rights of young people.

Staff had received training on seclusion and long-term segregation. However, seven out of nine front line staff we spoke with, were unable to clearly explain the meaning of seclusion and long-term segregation. They could not tell us the difference between the two. Different staff described three female young people as being nursed in long-term segregation. We were told that these particular young people were mostly "nursed in their rooms", although they did on occasions go out. Senior staff confirmed that two male young people had been nursed in either seclusion or long-term segregation since our last inspection.

We were not assured that staff applied appropriate safeguards to young people who were being cared for in this way. The provider had implemented seclusion paperwork, in the form of a seclusion pack. Within this, all documentation necessary was available to staff, to ensure that each episode of seclusion or long-term segregation was accurately recorded. However, we found, in all ten records viewed, this paperwork was incomplete and not comprehensive. We were not assured that the provider had made notifications to stakeholders about restrictions placed on patients. We were made aware, following inspection, that commissioners and local authorities had not received notifications from the provider about young people who had been nursed in seclusion or long term segregation.

We reviewed ten seclusion records for episodes which had been recorded between 23/07/2019 and 03/10/2019. We could not ascertain which young people had been nursed in seclusion, and which had been nursed in segregation in seven out of the ten records. Staff had not recorded this. Records did not specify whether each young person was able to leave the designated room or area in which they were being cared for. In addition, records did not state where the seclusion or long-term segregation had occurred, other than which ward.

Staff had recorded the start and end times of seclusion or long-term segregation in just four of the 10 records. The remaining six either had a start time, or an end time, but not both. Therefore, we were unclear how long young people had been nursed in these conditions.

There were numerous gaps in recording. Of the 10 seclusion records viewed, only three young people had an available corresponding care plan. The paperwork enabled staff to record reviews of the seclusion by members of the multi-disciplinary team, but this was inconsistently completed. Staff had recorded that a doctor had visited the appropriate ward to review the seclusion, on three out of the ten occurrences. One entry specified the time the doctor attended. The other two entries had no time recorded. We saw no evidence of any other reviews in records. Staff had clearly recorded, in two out of the ten records, 15-minute observation sheets for the young people. The remaining eight records had no observations recorded within the available observation sheets.

We viewed the care plans of two young people, who had been subject to either seclusion or segregation on several occasions. We found that neither had a care plan in place to indicate that they had been nursed in seclusion or segregation. Staff had comprehensively completed mental health and risk management care plans. These included using the least restrictive interventions, including how to de-escalate and restrain the young person if necessary. However, staff had not referred to either young person having been nursed in isolation from others, through either seclusion or segregation.

Child and adolescent mental health wards

On one occasion, staff had to terminate an episode of seclusion, as the young person was causing significant damage to property within the room, and was at risk of hurting themselves. If an individual is placed into seclusion, the room should be fit for purpose, as stipulated in the Mental Health Act Code of Practice. Rooms should be minimally furnished, and not contain fittings, or other items which have the potential to cause harm.

Infection Control

We viewed all three clinic rooms. We found that staff had disposed of general waste and clinical waste appropriately. The provider had placed laminated signs on each bin, reminding staff of what could, and could not be placed within each bin. This had been effective.

All sharps boxes were appropriately labelled, dated and signed. None were over filled. All contained appropriate contents.

Emergency bags

We checked the emergency bags on all three of the wards. Equipment was tested, working and in date. Staff checked the emergency bags daily. Some medicines on one ward had just expired. However, we saw email communications between the nurses and the pharmacist, confirming that this was on order. This medication was accessible on another ward if needed.

Risk Assessments

We reviewed 18 risk assessments. Staff had completed individual risk assessments for each young person upon admission, or shortly following admission. Staff had ensured that risk assessments were up to date and accurate. Staff had identified previous and current risks. Management of these risks was clear. For example, some young people were being nursed on enhanced observations at particular times of the day to minimise specific risks.

Management of Section 17 leave

We reviewed 17 leave episodes. In all leave authorisation forms viewed, the parameters of the leave were clear. The doctor had specified the duration of the leave. Nurses had mostly recorded the escorting staff names. Staff had recorded details of the home address for when the young people were to reside with parents during leave.

Nursing staff, upon recording episodes of leave, included views on how the leave went, from the young person, staff, and families or carers where appropriate. Nursing staff had implemented, and discussed contingency plans with young people, in case leave did not go as well as expected.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Requires improvement

We did not inspect this key question during this inspection.

Are child and adolescent mental health wards caring?

Requires improvement

We did not inspect this key question during this inspection.

Are child and adolescent mental health wards responsive to people's needs?
(for example, to feedback?)

Good

We did not inspect this key question during this inspection.

Are child and adolescent mental health wards well-led?

Inadequate

We did not inspect this key question during this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that they review systems and processes that follow guidance for seclusion and long term segregation.

The provider must ensure that all episodes of seclusion and long-term segregation are fully documented and reviewed in accordance with the Mental Health Act Code of Practice. The provider must consider the individual human rights of young people.

The provider must ensure that all young people have a care plan which details how seclusion and long-term segregation are safely applied.

The provider must ensure they notify stakeholders of any young person that is nursed with restrictive interventions.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We are serving an urgent notice of decision under Section 31 of the Health and Social Care Act 2008.** We have imposed the following conditions for the regulated activities: The Registered Provider must provide the Care Quality Commission by 5pm every Friday with a log of all incidents where any restrictions on a patient's movements have taken place. The Registered Provider must provide the Care Quality Commission by 5pm every Friday with records for each episode of seclusion. This must include: • The start and end time for each episode of seclusion. • Confirmation of the authorisation for seclusion and by whom. • Complete records to show regular reviews and other information as required by the Mental Health Act Code of Practice. The Registered Provider must provide the Care Quality Commission by 5pm every Friday with all records of long-term segregation, care plans for each patient subject to segregation, multi-disciplinary team reviews of said segregation and safeguarding referrals. The Registered Provider must provide the Care Quality Commission with an action plan to review its processes for seclusion and long-term segregation and all essential safeguards surrounding this. The Registered Provider must send to the Care Quality Commission all reports made to the Local Authority and stakeholders regarding all incidents of long-term segregation and seclusion.