St Matthews Hospital

Quality Report

St Matthews Hospital
21-23 St Matthews Parade
Kingsley
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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 St Matthews Hospital as requires improvement because:

- The service had blind spots, which were not addressed by any mitigating actions.
- Ligature assessments were not robust and did not cover all areas of the building.
- The process for ensuring that staff received feedback from incidents and complaints was not robust. Staff did not understand what lessons had been learned from, or how they were shared.
- Training compliance was below the providers' target of 90% at 75% and there was a discrepancy over data. Compliance to the Mental Capacity Act training was low at 68%.
- Blanket restrictions were in place for patients to have access fresh air.
- Pat down searches were being conducted in the entrance to the service. This practice compromised patients dignity and privacy and was a blanket restriction.
- Relevant checks that are required under the regulation of fit and proper person had not been undertaken.

However:

- The service was clean, presentable and well maintained.
- Data supplied by the provider showed compliance with supervision of 87%.
- Data supplied by the provider showed compliance with appraisal of 84%.
- Staff were aware of the provider's visions and values and demonstrated these in their behaviours.
- We observed staff to be passionate and motivated to meets the patients' care needs.
- Staff demonstrated a good understanding of patients' individual needs
- All patients had received a timely risk assessment on admission. There was evidence that risks assessments are updated after incidents.
- The Mental Health Act administrators had good oversight of the service, they provided support to the services and staff were aware of how to contact them.
- Shift to shift handovers were taking place daily.
- Senior managers had good oversight of the services and clinical governance.

Summary of findings

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Requires improvement

St Matthews Hospital

Services we looked at

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

Summary of this inspection

Background to St Matthews Hospital

St Matthews Hospital is part of the St Matthews Healthcare Limited group. The hospital is a low secure rehabilitation service, which provides psychiatry, psychology, rehabilitation and wellbeing therapies for men under the age of 65. The hospital is purpose built and has 16 inpatient beds spread over three floors. At the time of the inspection there were 11 patients, all detained under the Mental Health Act.

St Matthews Hospital is regulated by the Care Quality Commission (CQC) for:

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

The service has a registered manager.

The CQC first registered St Matthews Hospital in January 2008 and again in 2013. The CQC last inspected the hospital in March 2016 when the service was rated overall as good, with safety rated as requires improvement. Following this inspection the provider was told to take the following action to improve:

- The provider must ensure that the fridge in the clinic room be checked, to maintain accurate temperature, and that staff complete daily temperature control records and report all incidents when the fridge temperature is not correct.
- The provider must ensure that emergency equipment including the defibrillator is easily available when required.
- The provider must ensure that the restrictive practice of hourly smoking breaks is removed.
- The provider must review its medical on call arrangements, and be consistent across the whole service.

The provider was told that they should ensure that all nursing staff and healthcare assistants have up to date recorded supervision records and annual appraisals.

Our inspection team

Team leader: Susan Haynes.

The team that inspected St Matthews Hospital consisted of one inspection manager and four inspectors.

The inspection team would like to thank all of the staff and patients who we met and were interviewed during the inspection.

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?

Prior to this inspection, we reviewed information that we held about the location, asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- looked at the quality of the service environment and observed how staff were caring for patients
- spoke with seven patients who were using the service
- spoke with the registered manager and deputy manager of the service
- spoke with five other staff members; including the consultant psychiatrist, nurses, and healthcare support workers.
- Collected feedback from seven patients using comment cards
- Collected feedback from 15 professionals and two carers using comment cards
- Looked at seven care and treatment records of patients carried out specific checks of the clinic and medication management on the service
- 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 to seven patients at the service. Overall patients found staff helpful, polite and respectful.

Patients informed us that both leave and activities were sometimes cancelled due to staffing issues. However examination of six months staffing rotas and key performance indicators showed that staffing did not have an impact on activity. In an audit carried out by the provider only three episodes of leave had been cancelled in a three month period.Two patients indicated that they did not feel safe on the service.

We found that patients were involved in their care planning process and received copies of their care plans, unless they indicated that they did not wish to do so. We also found that family and carers were involved in the patients care.

Patients told us that access to the garden was restricted to every ninety minutes with the exception of unescorted or escorted leave.

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:

- The service had blind spots which were not addressed by mitigating actions.
- Ligature risk assessments were not robust and did not cover all areas of the building or accurately reflect all risks.
- Staff did not understand what lessons learned were or how they were shared.
- Training compliance was below the providers' target of 90% and there was discrepancy over data.
- Mental Capacity Act training compliance was 68%
- Blanket restrictions were in place to access fresh air.

However:

- The service was clean, tidy and well maintained.
- The clinic was fully equipped clinic rooms and there were access resuscitation equipment and emergency drugs on the service.
- Staff undertook a risk assessment with every patient upon admission.
- All staff had access to personal alarms.
- Cleaning records were up to date and demonstrated that staff regularly cleaned the environment.
- The service had appropriate medical cover.
- There was a robust process in place for reporting and documenting incidents.
- Medication management was safe and well managed.

Are services effective?

Good

We rated effective as good because:

- All patients had an assessment within twenty four hours of admission.
- All patients received on going comprehensive physical health assessments and on-going physical health monitoring.
- All care plans were up to date, patient centred, recovery focused and holistic
- Staff follow National Institute for Health and Care Excellence guidance when prescribing medication.
- There was evidence of collaborative joint multi-disciplinary team working.
- The provider carried out regular audits to ensure that the Mental Health Act was applied correctly.

Summary of this inspection

- The compliance rate for staff receiving supervision was 87%
- We observed evidence of on-going clinical audit activity within the unit.

However

- Not all staff had received an annual appraisal.
- Only 68% of staff had received training in the Mental Capacity Act.
- Staff showed a minimal understanding of the Mental Capacity Act and its application.

Are services caring?

Good

We rated caring as good because:

- Staff were positive, supportive and caring in their interactions with patients.
- Patients described the staff as polite and helpful.
- Patients were actively involved in their care planning and given copies of their care plans.
- Staff demonstrated a good understanding of patients' individual needs, including care plans, observations and risks.
- All patients had access to independent advocacy.
- Patients were involved in decisions about the unit via the house meetings.

Are services responsive?

Good

We rated responsive as good because:

- Patient transfers and discharges were planned in advance and occur during normal working hours.
- Staff actively engaged with external agencies.
- The service had a full range of rooms and equipment in order to support treatment and care
- A visitors room was available for patient visits
- Patients had access to cold and hot drinks and snacks at all times
- Patients had good access to spiritual support.
- Information leaflets were available for patients.
- Patients advised that they knew how to complain, and forms were available on the service. The service had a comment box for comments that patients could use.

However

- The patient payphone was situated in the service entrance so was not private.

Summary of this inspection

- Staff carried out searches of patients in the entrance to the hospital.

Are services well-led?

Requires improvement 

We rated well-led as requires improvement because:

- The manager was not visible on the unit. Staff told us that the manager was inaccessible at times and was not visible within the service. This was experienced by inspectors during the visit.
- Oversight of compliance at service level was not thorough and robust, and senior managers resubmitted compliance data at the time of and following inspection.
- The manager had not identified all ligature points and the scoring within the risk assessment was not always accurately recorded.
- There was limited evidence that staff received feedback from incidents, lessons learnt, complaints or patients.
- Training compliance was 75% against a service target of 90%.
- Relevant checks that were required under the regulation of fit and proper person had not been undertaken.

However:

- Supervision compliance was 87%
- Appraisal compliance was 84%
- The vision and values of the service objectives were reflected in practice.
- There was evidence of staff involvement in clinical audit.
- Safeguarding and the Mental Health Act procedures were being followed.
- Service staff had the ability to submit items to the risk register.
- There was a strong sense of team working on the service.
- Oversight of compliance at service level was not thorough and robust, and senior managers resubmitted compliance data at the time of and following inspection.

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 11 patients detained under the Mental Health Act.
- Overall, 80% of staff had Mental Health Act training. Not all staff understood the Mental Health Act and its application. This was fed back to the managers on inspection who took immediate steps to arrange training in the near future.
- Qualified staff scrutinised Mental Health Act paperwork when patients were admitted to the service.
- All of the patients on the service had access to independent mental health advocacy. Contact details were clearly displayed in service areas.
- The service carried out regular audits to ensure that the MHA was correctly applied.
- There were copies of consent to treatment forms attached to all medication charts. All of these forms were in date and covered the medication being administered.
- Staff kept clear records of all section 17 leave granted and there was evidence of risk assessments being undertaken prior to, and following patients leave. These assessments were documented in the patients care records.
- All staff knew the Mental Health Act administrator, and how to make contact for advice and support.
- The provider had a Mental Health Act policy in place which staff could refer to if needed.
- The service carried out regular audits to ensure that the MHA was correctly applied and we saw evidence of follow up and correction when the Mental Health Act administrators identified issues. The administrator had oversight of the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Overall only 68% of staff had been trained in the Mental Capacity Act. Staff showed a minimal understanding of the Mental Capacity Act and its application.
- The service had a Mental Capacity Act policy in place that staff were aware of and could refer to.
- We found that patients were supported by service staff to make their own decisions, where it was appropriate.
- All staff knew how to contact the Mental Capacity Act administrator for advice and assistance when required.
- The MHA administrator had full oversight of adherence to the MCA across the service

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

- The layout of the service allowed staff to observe some but not all areas of the service. The service had blind spots in the main entrance, communal areas and upstairs corridors. Staff mitigated this risk with nursing observation; there were no mirrors or closed circuit television to assist with observation.
- We saw that ligature risk assessments were up to date but were not robust. We observed a number of ligature points across the service including; bedrooms and bathrooms. A ligature is a place to which patients intent on self-harm could tie something to harm themselves. The ligature risk assessment recorded door closures, door handles and windows as anti-ligature, which was inaccurate. The front entrance had not been included within the ligature risk assessment. Patients had access to this area. Staff had not identified all ligature points and the scoring within the risk assessment had been misinterpreted.This was brought to the attention of the manager.
- The service complied with Department of Health guidance on eliminating mixed sex accommodation and was male only.
- The clinic room was small with no room for an examination couch. A couch was located in an empty bedroom together with an ECG machine. We observed that emergency drugs were available that were in date and checked regularly.
- The service had no seclusion facility.
- The unit was clean, presentable and well maintained.
- Staff adhered to infection control requirements across the service including handwashing.
- Equipment was well maintained and checked weekly.
- We observed cleaning records which demonstrated that the environment was regularly cleaned.
- All staff had access to personal alarms.

Safe staffing

- A manager was in post who was supported by a deputy manager, five registered nurses and sixteen support workers. The vacancy rate was 22%. The manager told us that staff turnover for the last 12 months was at 50%.However, the provider submitted evidence following inspection to show that fourteen staff had left the service in 2017, four of who had converted to a contract as bank staff.
- The provider had estimated the number and grades of nurses required for each shift. This was one registered nurse and six support workers for each shift. The deputy service manager was also the service Occupational Therapist; who was supported by an occupational therapy assistant.
- Rotas examined showed that the actual nurse numbers matched the estimated number on most shifts. Patients and staff reported that there had been staff shortages on occasions.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Bank and agency staff were used to cover gaps in rotas. This usually involved regular agency staff members, who are familiar with the service. The use of agency and bank staff was 13% for support workers and 12% for registered nurses.
- The manager told us that they were able to adjust staffing levels daily to take account of case mix and additional observations. A recent review of staffing had been undertaken by senior management. The manager told us they had not been involved in this review.
- Qualified nurses were visible across the service and able to spend time with patients. At the time of inspection there were appropriate numbers of staff on duty and staff were engaged with patients.
- Managers told us that leave and activities were not cancelled due to shortages of staff. This was not confirmed by patients. Six of the seven patients interviewed told us their leave had been cancelled on occasions. Four patients told us that activities had also been cancelled due to poor staffing.
- There was medical cover across the day and night and a doctor was able to attend the service quickly in an emergency or for an admission. We saw evidence in care records of doctors reviewing patients' physical health. Patients confirmed that their physical health needs were being met and specific illnesses such as diabetes were managed appropriately.
- The provider submitted training data prior to inspection of tier 1 mandatory training, which showed compliance of 60%. Following inspection, senior managers submitted data to show a higher level of compliance of 75%. This was below the provider target of 90%. Compliance to Mental Capacity Act training was 68%. The induction programme consisted of reading key documents and policies. Many staff did not find this training robust or sufficient to their needs.

Assessing and managing risk to patients and staff

- There had been 14 episodes of restraint during the last six months, involving eight patients.
- Staff confirmed that restraint was only used after de-escalation has failed and that they were using the correct techniques.
- None of the restraints was in prone position (face down).
- We reviewed seven care and treatment records. All had risk assessments in place on admission. Risk assessments had been updated following incident.
- Staff used the providers' risk assessment tool to assess risk upon admission and then at regular intervals. We saw evidence of collaborative risk assessments.
- Patients told us that staff facilitated access to the garden every ninety minutes, with the exception of escorted or unescorted leave. Patients could access the garden at set times. Patients did have individualised smoking care plans and different levels of leave, in line with risk assessments. This was a blanket restriction. One patient had access to the garden at any time.
- All patients were detained under the Mental Health Act. Informal patients were not routinely admitted. Staff told us that in the event of an informal admission, the patient would be advised of their rights, and posters would be displayed advising the patient that they could leave the service at any time.
- Policies and procedures were in place for the use of nursing observations. Patients were nursed on enhanced observation where indicated by risk.
- The use of rapid tranquilisation followed National Institute for Health and Care Excellence guidance.
- Staff could explain what a safeguarding incident was and how to raise an alert. Most staff were familiar with the providers' electronic reporting system. Between October 2016 and 2017 the service raised 39 safeguarding concerns.
- We reviewed all patient charts and saw overall good medication management on the service. Medications were stored correctly
- There were procedures in place for children to visit the service. There was no dedicated child visiting room however; meeting rooms of the service were used for child visits.

Track record on safety

- There were two serious incidents in the last twelve months.
- One incident was in relation to a serious self-harm attempt that led to a patient death and the second was a burglary in the unit.

Reporting incidents and learning from when things go wrong

- Staff were aware of what incidents to report and the process for incident reporting. Staff advised that they reported all incidents and near misses.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff were open and transparent with patients about their care and treatment, including when things went wrong. The provider advised that the incident reporting system would prompt staff to say for each incident if duty of candour was relevant.
- Managers told us they discussed and analysed incidents within the hospital quality forum meeting. We saw minutes to confirm this. Managers told us these were then shared in handovers, displayed on the noticeboard and discussed in the staff meeting. However we found limited evidence that lessons learned had been disseminated or that staff were aware of lessons learnt.
- The managers told us that staff received debriefing following incidents. However the majority of staff did not confirm this.

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 seven care records. Staff completed comprehensive and timely assessments for all patients on admission.
- Care records showed that staff completed physical examinations on all patients. Physical health care plans in place for specific health needs. There was evidence of ongoing monitoring of physical health problems.
- Care plans were up to date, patient centred, recovery focused and holistic.
- All information needed to deliver care was stored securely in the service office and available to staff when required.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication. Antipsychotic medication was prescribed within the British National Formulary limits and monitoring was in place.
- The manager advised that a psychology assistant had commenced employment. We were advised that there had been a vacancy for some time and that patients were now being offered psychological therapies. An occupational therapist was in post within the service however was also the deputy manager. Therefore there was limited occupational therapy time on the ward.
- There was good access to physical healthcare. A General Practitioner visited the service fortnightly. All new patients were assessed on admission to the unit and registered with the General Practitioner.
- There were ongoing physical health assessments in place for nutrition. These included the malnutrition universal screening tool and nutrition assessments.
- The service used the health of the nation outcome score for all patients.
- Staff participated in a variety of audits including medication, mattresses, towel and duvet, money balance, fridge cleanliness, and Mental Health Act.

Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including a consultant psychiatrist, associate specialist, managers, nurses, health care support worker, and an psychology assistant, although there was limited occupational therapy input.
- The service had a number of new staff within the services.
- A corporate induction program was in place for all permanent staff. The corporate induction is two days face: face training, and is a mixture of practical and theory. The induction programme completed during the first two weeks of employments consisted of reading key documented and policies. Many staff did not find this training robust or sufficient to their needs.
- The supervision policy stated that staff should receive three monthly supervision as a minimum. The data submitted by the provider showed compliance of 87%. During inspection we sampled staff files that showed compliance of 83%.
- The data submitted by the provider showed 84% of staff had received an annual appraisal within the last twelve months. During inspection we sampled seventeen staff files, of which ten staff had received an appraisal. This is a compliance of 59%.
- Some staff stated that they are offered ongoing training that is role specific, although this was limited. Examples of ongoing training being undertaken included phlebotomy, diabetes management and wound care.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Managers indicated that they addressed poor performance promptly and effectively. We found evidence that active steps had been taken by the manager in response to an issue on the ward.
- The manager told us that a psychology assistant had commenced employment. We were advised that there had been a vacancy for some time and that patients were now being offered psychological therapies including assessment and psychological therapy. An occupational therapist was in post within the service however, they were also the deputy manager. Therefore there was limited registered occupational therapy time on the ward.

Multi-disciplinary and inter-agency team work

- Staff reviewed patients at the multi-disciplinary team meetings fortnightly. Staff described supportive working relationships across the multidisciplinary team.
- Handovers took place three times each day which staff reported as effective and informative. There was a monthly staff meeting within the service; however there was no set agenda and actions were not always followed up.
- Staff described good working relationships between the service and external agencies for example the local safeguarding team. Care coordinators remained in contact with patients during their stay within the ward.

Adherence to the MHA and the MHA Code of Practice

- Qualified staff scrutinised Mental Health Act paperwork when patients were admitted to the service.
- All staff knew the Mental Health Act administrator, and how to make contact for advice and support.
- Staff kept clear records of all section 17 leave granted and there was evidence of risk assessments being undertaken prior to, and following patients leave. These assessments were documented in the patients care records.
- Overall, 80% of staff had received Mental Health Act training. Not all staff understood the Mental Health Act and its application. This was fed back to the managers on inspection who took immediate steps to arrange training in the near future.
- There were copies of consent to treatment forms attached to all medication charts. All of these forms were in date and covered the medication being administered.
- The provider had a Mental Health Act policy in place which staff could refer to if needed.
- The service carried out regular audits to ensure that the MHA was correctly applied.
- All of the patients on the service had access to independent advocacy. Contact details were clearly displayed in service areas.

Good practice in applying the MCA

- Overall, 68% of staff had been trained in the Mental Capacity Act.
- There had been no Deprivation of Liberty Safeguards applications in the previous six months.
- Staff showed a minimal understanding of the Mental Capacity Act and its application.
- The hospital had a policy in place on the Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could access.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation and there were arrangements in place to monitor adherence.

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

Good

Kindness, dignity, respect and support

- We observed positive interactions between the staff and patients on the service. Staff were interacting and communicating effectively with patients within the service. These interactions were supportive and respectful.
- Patients described the staff as polite and helpful. Patients were positive about staff interaction and the support provided by staff.
- Staff demonstrated a genuine caring approach and commitment to patient needs. Staff had an understanding of the individual needs of patients.
- Care plans were personalised and patient centred.

The involvement of people in the care they receive

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- On admission patients were shown around the service. Staff provided them with information about meal times, treatment and activities and introduced them to the other patients on the ward.
- Patients were actively involved in their care planning. All patients were given copies of their care plans unless they indicated that they did not want a copy, which was documented. Care plans were recovery focused and promoted independence.
- Staff met with patients to discuss care and treatment. We saw evidence of this in care records.
- Patients on the ward had access to independent mental health advocacy. Posters were available and clearly displayed on the unit.
- Patients told us that family and carers were actively involved in their care and treatment.
- Patients were able to give feedback on the service they received via the house meetings.
- Patients had been involved in decisions about the service. Recent examples included choosing the colour of the ward carpet and their own bedding.

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 bed occupancy rate was 69% at the time of our visit.
- The ward accepted patients from a wide range of providers across the country.
- Patients always had a bed to return to following a period of leave.
- Patient transfers and discharges were planned in advance and occured during normal working hours.
- There were no delayed discharges from the ward. There had been three planned discharges since January 2017.
- Ward staff actively engaged with external agencies in the planning of patient transfers and leave from the ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a full range of rooms and equipment in order to support treatment and care. Patients had access to an activity room, a ward kitchen and interview room for one to one sessions.
- Patients told us that that staff did not always maintain patients' dignity and routinely searched them in a public area. They told us that they were uncomfortable with this process. This practice was not risk based and therefore not in line with code of practice guidance.
- There were appropriate rooms for visiting across the service and meeting rooms for multi-disciplinary meetings in communal areas off the ward.
- A payphone was available for patient use. Patients advised that this was not always private as the phone was in the entrance to the ward.
- There was access to outside space. This was restricted to every one and a half hours. This practice was not risk assessed and therefore not in line with code of practice guidance.
- Patients told us that they were happy with the meals provided, that food was of good quality and that there was a choice of menu.
- Patients had access to cold and hot drinks and snacks at all times.
- Patients were able to personalise their bedrooms, and that they had been able to choose their own duvet sets.
- Bedrooms on the ward were lockable therefore patients had somewhere secured to store their possessions.
- There was access to activities across the week. At weekends a reduced number of activities were delivered by ward staff.

Meeting the needs of all people who use the service

- The unit had a disabled access to the ward and there were six patient bedrooms on the ground floor. The ward had disabled bathrooms with grab rails. There were no assisted baths.
- Information leaflets were available for patients on services, patients' rights, how to complain and advocacy. Staff used the walls and notice boards for displaying information.
- We found that patients were offered a choice of food to meet both the dietary requirements of religious and ethnic groups.
- Staff had access to interpreters and translation services when required and information could be requested in different languages if required.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Patients had access to spiritual support. Patients were escorted where required to the local church and the unit was visited by local churches.

Listening to and learning from concerns and complaints

- During inspection we examined the complaints folder made available to us. It held 15 complaints for the period 02/02/2015 to 01/12/2017. Of these, eight complaints had been resolved within the provider's standard of 28 days. There were five letters of response and five outcome letters in the complaints folder. There was evidence that duty of candour had been observed in the one complaint where the threshold had been met. Managers informed us that the ward was in the process of moving to the electronic recording of complaints and some letters of response were held electronically and not in the paper file given. Following inspection the provider submitted evidence to show there were 11 complaints and all had received response letters.

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

Requires improvement

Vision and values

- The provider had set visions and values which were based on excellent mental health care, supporting people to work to services living a fulfilling life as part of the community.
- We observed that the vision and values were displayed across the service. The manager and some staff were aware of the service objectives. Staff demonstrated the values in their behaviours. Staff knew the senior managers in the organisation and confirmed that they were accessible when required.
- We observed that the director of nursing had a strong influence and good oversight on the unit. A number of staff commented that the service manager was not visible on the unit, although was supportive when approached.

Good governance

- Overall, 75% had received mandatory training, which was below the service target of 90%. Generally, staff that had completed the mandatory training did not feel it was sufficient for their role
- Managers advised that 87% of staff had received supervision in line with hospital policy.
- The provider submitted data showing overall 84% of staff had received an annual appraisal within the last twelve months.
- Managers advised that a sufficient number of staff of the right grade and experience cover shifts.
- Staff maximised shift time on direct patient care activities.
- Clinical staff participated in clinical audits on medication management, care plans, infection control, patient information and patient rights.
- The process for staff to learn from incidents, complaints and service user feedback was not robust. The organisation held quality improvement meetings and had a process of sharing lesson learnt via an alert that some staff were not aware of.
- Safeguarding and the Mental Health Act and Mental Capacity Act procedures were being followed on the unit. However staff understanding of both the Mental Health Act and Mental Capacity Act was limited.
- There was a blanket restriction in place for patients' access to fresh air. Patients could access the garden at set times. Patients did have individualised smoking care plans and different levels of leave, in line with risk assessments. This was a blanket restriction. One patient had access to the garden at any time. At the last inspection we asked the service to review the practice of 60 minute access to the garden. This practice is now every 90 minutes.
- Pat down searches were routinely being conducted in the entrance to the service. Whilst required in response to patient risks, this practice compromised patients' dignity and privacy.
- Staff had the ability to submit items to the risk register. This register was reviewed and updated in clinical governance meetings by the senior management team.
- The provider did not follow their policy to monitor the fitness of directors of St Matthew's Healthcare Ltd. We sampled three directors' files and found no evidence of relevant checks that were required under the regulation of fit and proper person.

Leadership, morale and staff engagement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The manager reported that the sickness and absence rate in the service was high and that there had been a 50% turnover in service staffing. This does not correlate with the information submitted by the provider that indicates that five staff members have left in the last twelve months, and a sickness rate of 1.5%. We were not confident in the manager's oversight.
- There were no reports of bullying and harassment at the time of our visit. Staff knew how to use the whistle blowing process and how to raise concerns.
- Staff indicated that they felt able to raise concerns without fear of victimisation.
- The manager and staff reported that morale had been adversely affected by pay and the recent review of stating levels.
- The manager and staff reported that morale had been adversely affected by staffing levels, pay and the recent review of stating levels.
- The manager reported that there are good opportunities for leadership development. Staff reported that additional training could be requested.
- Staff described a strong sense of team working on the service. Staff reported that they could rely upon one another for support and that they were a good integrated team.
- Staff advised that they are given the opportunity to give feedback on services and service developments in the monthly team meetings.
- The provider had two systems in place to file complaints. At a local level a paper system did not store the same documents as the electronic system. This meant oversight of complaints at service level was not robust.
- The provider had a process for providing feedback to staff for lessons learned, but this had not been disseminated at service level.
- The manager led staff meetings, but there were no set agendas and minutes reflected this. There were limited actions given to staff to address issues and items raised at previous meetings were not addressed at follow up meetings.
- Staff told us that the manager was inaccessible at times and was not visible on the service. This was experienced by inspectors during the visit.
- Oversight of compliance at local level was not thorough and robust, and senior managers resubmitted compliance data at the time of and following inspection.

Commitment to quality improvement and innovation

The service is participating in the National Schizophrenia audit with the Royal College of Psychiatry.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff receive mandatory training.
- The provider must ensure that ligature risk assessments are in place and include robust mitigation for identified risks.
- The provider must address the issue of blanket restrictions in relation to patients' access to fresh air and pat down searches.

Action the provider SHOULD take to improve

- The provider should ensure that all have a clear understanding of the Mental Capacity Act and Deprivation of Liberty safeguards and its application.
- The provider should ensure they carry out regular fit and proper person checks for directors of the company, and hold on file, necessary documentation relating to this regulation.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 • Good governance • The provider did not ensure there was oversight at local level of governance processes and systems to monitor and improve service delivery. This was a breach of regulation 17(1)(2)(a)

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 (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 Regulation 12: Safe care and treatment. • Not all environmental and ligature risks were assessed, mitigated and managed risk • There was a blanket restriction in place for patients' access to fresh air • Not all staff had received mandatory training required for their roles. This was a breach of Regulation12(1) (2) (a)(b)

This section is primarily information for the provider

Requirement notices