

Park Road St Helens Limited

Draper House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services well-led?

Good



Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service managed medicines safely and followed good practice with respect to safeguarding.
- Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

However:

the trained nurse schedule at the service alternated between one and two nurses on day shift during the week, and we noted that on a day with one nurse it was difficult for the nurse to take a break from work. This was more likely as the service operated two wards over two floors.

Summary of findings

Our judgements about each of the main services

Service

Long stay or rehabilitation mental health wards for working age adults

Rating

Good



Summary of each main service

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- The service was well led, and the governance processes ensured that ward procedures ran smoothly.

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Summary of findings

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Summary of this inspection

Background to Draper House

Draper House is a 14-bed rehabilitation service located in St Helens. It provides patient focused and evidence-based care which is bespoke to each individual and their needs. Their aim is to plan with the patient their recovery journey from the point of referral to recovery and enable a supportive and transitional discharge period which aims to be facilitated in a seamless manner. The service ethos embraces recovery principles and incorporates interventions which promote and enable the rehabilitation pathway within a locked environment.

The service is for female patients over the age of 18 years, with the facility for both detained and informal patients, covering complex mental health disorders including personality disorders. The service has two wards across two floors, Bluebell and Blossom, at the location. At the time of the inspection, there were 13 patients admitted.

The service is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983, and treatment of disease, disorder and injury. At the time of inspection, the service was without a registered manager as the previous registered manager had left. An application has been made for another senior manager to take the role of registered manager. There was a controlled drugs accountable officer.

This was the second inspection of the service: the first inspection took place in March 2020. There were no improvements required following the inspection in March 2020.

We carried out this focused inspection of two key questions, safe and well-led, as a result of concerns about patient safety, culture and governance.

What people who use the service say

During the inspection we interviewed four patients at the service and reviewed a recent submission to the Care Quality Commission by one of the patients. All of the patients spoke very highly of the service. Patients told us they felt safe. Just prior to the inspection we received a complimentary letter from a patient at the service, thanking the staff at the service for their work.

How we carried out this inspection

The focus of the inspection was two key questions, safe and well-led. During the inspection, the team:

- visited both wards at the hospital, with a total of 13 patients across the wards, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with the applying registered manager and nominated individual
- spoke with four other members of staff including two recovery workers, one occupational therapy aid, and one registered nurse (also the deputy manager for the service)
- spoke with four patients who were using the service
- reviewed four client care and treatment records
- attended two ward medication rounds
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service **SHOULD** take to improve:

- The service should ensure that there is always one trained nurse in the ward area, and that staff can take regular breaks during their shift.

Our findings


Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Long stay or rehabilitation mental health wards for working age adults

Good 

Safe	Good 
Well-led	Good 

Are Long stay or rehabilitation mental health wards for working age adults safe?

Good 

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. The service utilised a risk assessment tool that had been designed with pandemic guidance in mind, and we saw evidence that this was still in use. Staff wore masks and observed handwashing guidance, whilst giving instruction to patients to maintain their own safety.

Staff could observe patients in all parts of the wards. The design of the location did not lend itself to easy visual observation of all patients in the wards, but we saw staff were always moving around the service, talking to patients and checking their welfare.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The service conducted environmental risk assessments. All rooms contained anti-ligature fixtures and fittings and an anti-ligature audit was carried out on a monthly basis. Patients were also risk assessed for access to areas that might be of risk.

Staff had easy access to alarms and patients had easy access to nurse call systems. All staff were carrying personal alarms and each bedroom had nurse call/alarm buttons on the wall.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. We did a tour of the hospital during the inspection, noting that furniture had been maintained and was still suitable for the service. Cleaning staff were present during the inspection and the wards looked clean.

Staff made sure cleaning records were up-to-date and the premises were clean. Each ward had a cleaning log, this outlined whether a room had been deep-cleaned or given a general clean, as well as the corridors and the stairways. The service also maintained a monthly environmental cleanliness audit tool, completed by the manager or the infection prevention and control lead at the service.

Staff followed infection control policy, including handwashing. We saw staff wearing face masks, washing their hands, and ensuring patients were also informed of the need to follow relevant guidance.

Clinic room and equipment

Long stay or rehabilitation mental health wards for working age adults

Good 

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Following information of concern about the management of medication, we reviewed both clinic rooms and observed two medication rounds. There were two clinics at the service, one on the first and one on the second floor (the ward layout mirrored itself across the two floors). The clinics were small but had all necessary equipment. It was noted that the fridge door lock on Blossom ward was broken (the key had snapped in the lock), but the fridge was empty, with items requiring refrigeration kept on Bluebell ward. New medicine cupboards had been ordered: they were due to arrive within 6 weeks. Storage cupboards were found to be overly stocked with medication, but new wall mounted cupboards had been ordered to help organise stock. In an engagement meeting with the service held shortly before the inspection, we were informed that the system of stock checking had not been very efficient. At the time of the inspection, the service was working with a pharmacy company, and a new regime of training, monitoring and recording of the administration of medication had been implemented. All necessary resuscitation and emergency drugs were checked, in date and available to staff as and when needed.

Staff checked, maintained, and cleaned equipment. All items were checked and within date.

Safe staffing

The staff knew the patients and received basic training to keep people safe from avoidable harm. There were some vacancies and on some shifts, only one qualified staff member on duty which meant they were unable to take regular breaks.

Nursing staff

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. Staffing numbers were calculated for each shift, considering levels of observation and the need for external trips from the service. On each shift there would be one trained member of staff and six health care assistants. This could increase to nine health care assistants, dependent upon high levels of observation where required. Staffing rotas showed consistent over-staffing at the service.

However, three days a week there was only one qualified staff member on shift, meaning the nurse on duty could not always take regular breaks without limiting the presence of a qualified nurse in the ward area. A qualified nurse had been employed just before the inspection, and further interviews were taking place shortly after the inspection for the remaining vacant position.

The service had reducing trained staff vacancy rates. At the time of inspection, there was one trained nursing staff vacancy, a nurse had been employed that week, with interviews for the other post the week after inspection. There were five vacancies for health care assistants. The service was actively recruiting into these vacancies.

The service had low and / or reducing rates of bank and agency nurses. We were told that agency trained nursing staff were only used to cover for annual leave, if there were no other trained staff available. Managers would try to utilise staff from a sister unit in the first instance.

Long stay or rehabilitation mental health wards for working age adults

Good 

The service had low and / or reducing rates of bank and agency nursing assistants. The service used agency health care assistants on average two per shift. The service managers told us that most of these staff were experienced at the service, and that they considered that any agency staff who worked at the service for more than four weeks as experienced.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

The service had reducing turnover rates. Managers at the service told us that some staff had left following the departure of the previous manager, but managers were keen to ensure that the remaining and new staff adhered to the rehabilitation unit ethos, and this would lead in their treatment for patients.

Managers supported staff who needed time off for ill health. There was a policy in place for management of leave for those staff who were in ill health.

Levels of sickness were reducing.

Patients had regular one to one sessions with their named nurse. We reviewed four sets of care records and saw that one to one sessions were taking place with patients. Patients told us that there were always lots of staff around, and they were approachable if anyone needed to talk or get help.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients told us that if an activity could not take place, it was normally rescheduled for another time, and that often this happened because staff had to respond to actions from other patients at the service.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. We looked at handover information and saw that the information contained risk assessments and behavioural prompts for each patient.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. The service had an on-call system with a responsible clinician available after office hours. Staff were also aware how to contact emergency services should the need arise.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The July matrix used by the service to monitor mandatory training showed that online training was averaged at 81% among 29 staff at the service. There were several staff who were new or had been absent from work, leading to a lower average than expected. Face to face training showed staff were up to date with their training in immediate life support, basic life support, safeguarding and breakaway training.

The mandatory training programme was comprehensive and met the needs of patients and staff. The service had just started a new form of breakaway training that expanded the role of staff in restraint situations to not only rely on physical intervention, but other types of intervention designed to calm a patient.

Long stay or rehabilitation mental health wards for working age adults

Good 

Managers monitored mandatory training and alerted staff when they needed to update their training. Figures were recorded and checked as a key performance indicator.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. A review of four patient care records showed admission risk assessments as well as regular updates.

Staff used a recognised risk assessment tool. The service used the standard tool for the assessment of risk (STAR) assessment tool.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Care records showed that patient risk was monitored and identified, with action plans or positive behavioural support plans in place to deal with risks.

Staff identified and responded to any changes in risks to, or posed by, patients. We reviewed the records of a patient who had been involved in a number of incidents resulting in restraint. Staff had reviewed the patient's treatment plan and reported the patient was now making steps forward and we could see the number of incidents were decreasing.

Staff followed procedures to minimise risks where they could not easily observe patients. The design of the location meant that some parts of the wards are not easily visible, but we saw staff constantly moving around the wards to minimise risks. Patients told us that there were always staff around and available to them.

Staff followed hospital policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Staff told us it was very unusual to search a patient's bedroom or conduct pat-down searches, as each patient was individually risk assessed and a care plan in place. The service had a list of prohibited items, all items prohibited were generally accepted unacceptable in a hospital, such as illicit drugs, weapons and alcohol.

The service was a locked rehabilitation service, admitting both patients detained under the Mental Health Act and those who were informal. There were signs in the service informing informal patients that they could leave the service at will. At the time of inspection there were no informal patients at the service.

Use of restrictive interventions

Levels of restrictive interventions were low and/or reducing. The safe interventions programme that the service was undertaking identified different levels of interventions that meant that restrictive interventions were used only as a last resort.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff were involved in the safe interventions training programme, a programme designed to incorporate other interventions than just physical restraint. Most restraints or interventions at the service related to one patient, and records showed staff used de-escalation techniques in the first instance before resorting to restraint. During the inspection, we saw an incident involving a patient on enhanced observations. Staff responded to the incident efficiently and calmly, working as a team to politely move other patients away from the incident whilst de-escalating the situation. The incident was resolved without restraint.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. The service had a rapid tranquilisation policy. At the time of the inspection, no one at the service was prescribed rapid tranquilisation as an intervention.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Safeguarding training was mandatory at the service, including face to face training.

Staff kept up to date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the hospital safe. There was a child visitor policy in place at the service, the policy was up to date, and staff were aware of it.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had raised three safeguarding alerts in the two months prior to inspection.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. Staff had easy access to clinical information, and it was easy for them to maintain quality clinical records – whether paper-based or electronic. Patient notes were stored electronically, staff used laptops and electronic hand-held devices to record notes. Patient notes were secure and available to staff when required. Paperwork was stored securely and regularly scanned into the system.

Long stay or rehabilitation mental health wards for working age adults

Good 

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The risk register at the service identified issues with medication management. In an engagement meeting prior to the inspection, we were told that the ordering process for medication was not efficient. At the time of inspection, a contract with a pharmacy provider had been agreed. We found that the pharmacy provider had supported the service to develop a robust medication ordering process to ensure safe medication management, including the use of electronic prescription and an ordering system. The system automatically identified when stock of medication was low. We looked at the contract and the service level agreement, this indicated a marked improvement in the way medicines management was taking place. We observed two medication rounds, and saw that staff were proficient in the use of the system and understood how it worked.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Multi-disciplinary team meetings were held to regularly review patient medication, and patients were able to ask questions about their medication.

Staff had difficulties storing and managing medicines. Prescribing documents were stored in line with the provider's policy. We saw that stock medication cupboards were overly full at the time of inspection, but we were made aware of the order of new cupboards for the clinics. We also noted a damaged lock on a clinic refrigerator, one that was not in use at the time, with relevant medication able to be stored in the refrigerator in the other ward clinic.

Staff followed current national practice to check patients had the correct medicines. This was confirmed by the electronic prescription system.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. As part of the agreement with the pharmacy provider, training and information was included in the package.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Multi-disciplinary team meetings and regular checks were in place to ensure that all medication was relevant to the patient and in their best interest.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance. The service followed national guidance regarding medication and physical health, with three-monthly blood tests and electro-cardiogram checks for those on anti-psychotic medication, as well as physical observation checks for all patients every Sunday. As part of the hospital's coronavirus guidance, daily temperatures were recorded for patients and staff used the national early warning score to monitor patients.

Track record on safety

The service had a relatively good track record on safety. The service had a recent incident where a patient with cognitive difficulty was able to get into the service car park after an agency staff member left a door unsecured. The patient was led back to the service by a member of the public.

The incident was investigated by senior management, and concerns were raised regarding staff not following security procedures. The manager identified the need for further staff training, on both environmental and relational security, which had been undertaken at the time of the inspection.

Long stay or rehabilitation mental health wards for working age adults

Good 

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff told us that they would report anything untoward that happened at the service, and if they were not sure they would approach senior staff to discuss the matter. All staff were empowered to report an incident using the electronic reporting system.

Staff reported serious incidents clearly and in line with hospital policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Health care assistants were able to describe duty of candour and gave examples of incidents that would require full disclosure to both patients and family.

Managers debriefed and supported staff after any serious incident. Staff told us that they felt that they needed to ‘learn together’ after incidents and included patients in the process.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us meetings were held, with the focus on learning rather than attributing blame.

Staff met to discuss the feedback and look at improvements to patient care. Staff told us they had team meetings, one to one supervision, and that handover was another opportunity to pass on information.

There was evidence that changes had been made as a result of feedback. The recent incident of a patient accidentally being allowed to leave the location for a short time led to further training and a review of both physical and relational security. The incident had not occurred again, and all staff were aware of the need to ensure that security protocols were followed.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Good 

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. They understood the service they managed, and it followed a recognised model for rehabilitation care. Patients and staff knew who they were and could approach them with any concerns.

The service had struggled to retain a registered manager since a previous manager left in November 2020. Current management felt that the service was not being led in a rehabilitation direction, and that there was more a “low secure”

Long stay or rehabilitation mental health wards for working age adults

Good 

mindset. This ran contrary to the aims and vision for the service. Management felt that the new deputy manager at the service had brought a renewed determination to ensure that the recognised rehabilitation model was followed and progressed. The manager who had applied to be registered manager of the service was also the registered manager of a sister service. Whilst it was acknowledged that the manager could not give full time to the service, it was felt that this would not cause concern. Staff told us they felt the service was more focused on the rehabilitation of their patients and pointed to the upcoming discharge of a patient who had made great strides during treatment.

Managers had responded in a positive and constructive manner during the pandemic, and engagement with the service showed that contingency planning was effective.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team. We saw the vision and values of the service on walls and notice boards for all to see. Staff were aware of them and told us that they were a "reflection" of the service, staff told us that no one wanted the patients "to be in a service for the rest of their lives".

Culture

Staff felt respected, supported and valued. They said the service promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear. There had been recent changes in registered manager and two potential registered managers had left the role after a short time. The hospital risk register also identified a risk of staff whistleblowing as some staff were unhappy with decisions being made by managers. As a result of this, we looked at the culture of the service. We found that although restrictive interventions were used, staff saw them as a last resort, and we could see evidence of a reduction in incidents for one patient. Staff reported they felt able to speak up for themselves and the new manager was driving the focus on rehabilitation and people being able to move back out into the community. Care plans were individualised and we did not see blanket restrictions in place.

A staff survey conducted in 2021 showed that 65% of staff felt valued in their role. 60% of staff said they would recommend Draper House as a place to work, with another 27% not stating whether they would or not, and only 13% saying they would not recommend Draper House as a place to work. 50% of staff said they felt they had opportunities for development, with another 36% neither agreeing or disagreeing, and 14% felt they did not have adequate opportunities for job development. The staff we interviewed told us they felt it was a happy staff team at the service, although some said they would prefer more regular staff than agency being used. Staff also told us they had no issues with raising concerns to management. The service had an accountable drugs officer, a safeguarding lead and a Caldicott guardian.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well. The service used key performance indicators that were updated and monitored using the Care Quality Commission's five key questions. The spreadsheet included data regarding staff numbers, staff turnover, agency hours, complaints, care plan audit results, staff meeting numbers, and separate sheets for referrals and discharges.

The work of the service to utilise the services of a pharmacy provider showed that the service was moving forward and was aware of the previous shortfall in medicine management.

Long stay or rehabilitation mental health wards for working age adults

Good 

The service used patient outcome measures such as the Health of the Nation Outcome scale to measure patient progress through treatment.

The service had a reducing restrictive intervention programme in place. The service used positive behavioural support plans to good effect, reducing the requirement for restraint in some cases. The new approach to breakaway and restraint training supported this approach.

Management of risks, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff could submit items to be included in the risk register; we were told that the risk register had been taken to the last staff meeting and the nature of it explained and how it was used, in order that staff had a better understanding of risk at the service.

Quality at the service was monitored by the nominated individual, administrators, charge nurses, the multi-disciplinary team and ward staff. This took place at a daily morning meeting, as well as a review of incidents, monthly incident review, medicines management, governance meetings, health and safety meetings, and patient community meetings.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service used an electronic record system for all notes pertaining to patient care. Staff had access to computers and hand-held devices that were linked to the record system, so they could access information immediately. This was of help in trying to de-escalate a situation, by accessing up to date and relevant information of a patient and their care plan without leaving a potential risk situation.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service had been registered with the accreditation for inpatient mental health service scheme (AIMS) and was progressing, however with the pandemic and consideration of possible impact the registration was put on hold. The manager said they were hoping to restart the registration process leading to full accreditation.