Bestwood Hospital

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Requires improvement
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 this service as requires improvement because:

- Staff did not update care plans regularly enough and although care plans did show some patient involvement they did not show the plans had been developed in a collaborative way. This meant changes in care may not be carried out correctly and patients may not have discussed choices about how their care is given. Staff were in the process of reviewing care plans in accordance with the new owner, St Andrews policies and procedures.
- Patients did not have enough meaningful activities, which meant the patients were not being prepared sufficiently for a move into the community.
- Staff had not received regular supervision.
- Not all staff had completed mandatory training and the uptake of specialist training was low.
- Staff had not received training in the Mental Health Act, although staff showed a good understanding of their responsibilities.
- Not all staff had undertaken Mental Capacity Act training.
- Staff did not review capacity and consent assessments for day to day decision making.
- The provider did not involve patients and staff with the running of the service.
- There were no patient or staff surveys, or community meetings to gain feedback on patient care provided by the previous provider.
- There had been no community meetings or surveys to assess any patient feedback around their care provided by the previous provider.
- There were no easy read information leaflets about patients' rights, or information on how to complain on display.
- The use of stable doors on the flat entrances created confusion over whether the patient was secluded, segregated or being observed.

However:

- At the time of the inspection a new provider, St Andrews, had been managing the service for a month. Although there was more still to do, it was evident the provider had introduced many positive changes. The changes introduced had only recently been implemented and did not affect the ratings in this report.
- Carers said they were involved and felt staff kept them informed.
- Patients said nurses treated them in a caring way, with respect and dignity.
- St Andrews senior management staff had visited the hospital and staff had visited other locations within the organisation.
- There were enough staff to meet patient needs and services kept patients 'safe from avoidable harm'.
- Staff felt positive about the new provider St Andrews and reported an increase in morale.

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Summary of findings

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Summary of this inspection

Background to Bestwood Hospital

Bestwood is an independent hospital for people who are detained under the Mental Health Act. The location provides a locked rehabilitation service and people live in their own self-contained apartments with their own garden. The hospital aims to provide slow stream rehabilitation into a community setting for individuals who may have come from settings of increased security. On the day of our visit, there were two residents. Four apartments were empty. Specialist nursing care is available and provided at the service. This includes learning disabilities.

The hospital has a secure gate to the site and visitors cannot enter freely.

At the time of our inspection, Bestwood had been under new ownership for a month by the new owners St Andrews Healthcare. There was no registered manager.

The proposed registered manager was present on the day of our inspection and we were aware the proposed manager had made an application to the Care Quality Commission (CQC) and the application was under consideration.

The CQC had inspected the hospital on 20 May 2013 and 27 February 2015. At the February inspection we found the provider had not met Regulation 9 HSCA (RA) Regulations 2014 Person-centred care, Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 17 HSCA (RA) Regulations 2014 Good governance.

A warning notice was issued in relation to Regulation 17. A follow-up inspection took place on 21 July 2015. At that inspection, all requirements had been met.

Our inspection team

Team leader: Nicholas Warren

The team that inspected the service comprised two CQC inspectors and an expert by experience (someone with experience of similar services).

The team would like to thank all those who met and spoke to inspectors 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?

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

- looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with the manager and the forthcoming registered manager
- spoke with five nurses
- spoke with two carers

Summary of this inspection

- spoke with an independent advocate
- looked at two care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Bestwood Hospital

At the time of our inspection, Bestwood was registered with the CQC to provide the following regulated activities:

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

Treatment of disease, disorder or injury.

The new owners had plans to change the role of the hospital to a residential care home and remove the regulated activity: Assessment or medical treatment for persons detained under the Mental Health Act 1983.

The manager and the hospital (Bestwood) known now as Winslow were registered with the CQC from the 3 August 2016, with the same regulations as Bestwood. The provider (St Andrews) will apply again to remove the regulated activity when it has satisfactorily discharged the detained patients.

What people who use the service say

Carers said staff were caring, polite and supportive. They believed their relatives were safe.

However, carers felt there was a lack of experienced and regular staff. The carers told us they knew how to make a complaint.

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 care plans in place did not reflect the two patients were subject to long term segregation as defined in the revised Mental Health Act 1983: Code of Practice (DH, 2015) where the patient is restricted from mixing freely with other patients on a ward on a long-term basis to manage the risk of harm to themselves and others. We discussed this with managers at the time of our inspection and we have now seen updated plans.
- Staff training in dealing with challenging behaviour and ligature cutters use was not up-to-date. Ligatures are cloth or rope type items used by patients to harm themselves. Staff use ligature cutters to remove these items.
- Staff did not recognise when confinement became seclusion.
- Although there was a defined process in place to learn from incidents there were some reported incidents where management had made no plans to reduce those incidents occurring again.

However:

- Records showed staff addressed the physical health needs of the patients.
- There were enough staff to meet patient needs and services kept patients 'safe from avoidable harm'.
- The small clinic room had the necessary emergency equipment.
- There was low use of agency staff since the new provider had taken over.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not review care plans regularly.
- Patients did not have easy read care plans available to read.
- Staff did not review capacity and consent assessments for day to day decision making. Staff had only completed a few capacity and consent assessments.
- The hospital did not have a comprehensive audit programme in place, and a low number of clinical audits occurred.
- The uptake of specialist training was low, out of 26 eligible staff 12 had received epilepsy awareness training and seven autism training; four staff attended an introduction to mental health.

Summary of this inspection

- Staff had not received training in the Mental Health Act, although staff showed a good understanding of their responsibilities.
- Not all staff had undertaken Mental Capacity Act training.
- Audits of the implementation of the Mental Health Act and Mental Capacity Act had not taken place.

However:

- The local GP provided physical health care to patients.
- Patients received information about their rights under the Mental Health Act and had access to independent mental health advocates to support them in exercising their rights.
- Staff implemented the National Institute of Health and Care Excellence guidance for medication prescribing, psychological therapies and the treatment of autistic spectrum disorder, learning disability, physical healthcare, and rapid tranquilisation.
- Staff assessed patients' progress using national outcome measures and could describe their progress.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Care plans did not show they had been developed in a collaborative way.
- There were no patient involved plans for their thoughts about how they would like to receive help and care if they became unwell. These are known as advance statements.
- There had been no community meetings or surveys to assess any patient feedback around their care.
- Patients and carers felt there were too many new staff that needed more experience to understand patient needs.

However:

- Patients had been offered copies of their care plans.
- Patients took part in their multidisciplinary team meetings.
- Patients said staff treating them were friendly, caring and respectful and we saw staff treating them with dignity and kindness.
- Carers said they were involved and felt they were informed and up-to-date.
- Carers and patients said nurses treated patients in a caring way, with respect and dignity.
- Patients knew how to contact the advocacy service when needed.

Summary of this inspection

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The apartments had two-part 'stable doors'. The fact that the lower section of these could be locked with the upper part left open meant staff were unsure whether the patient was held in seclusion. Seclusion is the supervised confinement of a patient in a room.
- There were no easy read information leaflets about patients' rights, or information on how to complain on display.
- Staff provided activities, but they were limited and poorly planned.

However:

- Staff planned discharge around the wishes of the patient.
- Staff planned and prepared food purchasing and cooking with the involvement of the patient.
- Bedrooms were personalised.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There were no current key performance indicators to gauge the performance of staff.
- There was poor understanding among staff of the Mental Capacity Act and confusion over patients in long-term segregation.
- Management had not actively analysed daily patient incidents to help minimise these incidents reoccurring.

However:

- Morale and job satisfaction had recently improved.
- Managers could make quick decisions about local issues.
- Management had started to develop team objectives and staff confirmed this.
- Senior management staff had visited the hospital and staff had visited other locations within the organisation.

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.

- Although staff we spoke with showed a good understanding of the Mental Health Act and capacity, they had not received training on the Mental Health Act.
- Medical staff assessed capacity to consent to medication. Treatment authorisation forms and medication charts were together, so that staff understood the legal authority under which they were providing medication.
- Patients had received information about their rights under the Mental Health Act. Review and renewal of detentions had taken place. Patients had weekly access to independent mental health advocates to support them in exercising their rights.
- The Mental Health Act administrator from a local NHS trust provided administrative support on the implementation of the MHA; however, St Andrews Mental Health Act administration would take this function over soon.
- The Mental Health Act administration office had not carried out any audits.
- Staff completed detention paperwork correctly and it was up to date. Approved mental health professional reports were available.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There had been no Deprivation of Liberty Safeguards applications made in the previous six months.
- Eighteen out of 26 staff (69%) received training in the Mental Capacity Act through electronic learning modules. St Andrews Healthcare set a target for all staff to complete training by the end of July 2016.
- There were limited capacity and consent assessments for day-to-day decisions recorded by staff. Reviews of capacity and consent did not occur frequently, for example, staff had not reviewed capacity assessments for managing money and going out into the community since April 2016.
- Staff we spoke with did not know the Mental Capacity Act definition of restraint: restricting a person's freedom of movement, whether they are resisting or not. Staff considered restraint as a last resort following de-escalation.
- Staff described how they would obtain advice about the Mental Capacity Act within St Andrews Healthcare.

St Andrews Healthcare was in the process of instigating monitoring arrangements for the Mental Capacity Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- Patients had their own flat and access was by a stable door. Staff had good line of sight over the two patients due to their observation levels and both had staff escorts if they left their living area.
- A ligature risk assessment had been undertaken since St Andrews had taken over and plans were in place to remove unnecessary ligature points. A ligature point is a place to which patients intent on self- harm could tie something to harm themselves. A previous Bestwood audit showed there were few ligature points. Staff reduced the risk from these by constantly observing patients.
- Not all staff had been trained in the use of a ligature cutter in an emergency. Only 76% of staff had completed training on use of the ligature cutter.
- The hospital complied with guidance on same sex accommodation, as there were no shared lounges and the flats were for single sex only.
- The clinic room was clean, tidy, and fully equipped with accessible resuscitation equipment. There was no couch and patients were seen in their own apartments. Staff regularly checked and ensured equipment worked correctly and kept a record of this. There was also a separate defibrillator in each apartment as well as a first aid kit. A defibrillator is a device that delivers an electrical current through the chest that aims to shock the heart and is used after someone has suffered a heart attack.
- Electrical equipment had the appropriate safety stickers attached. This showed staff tested equipment on a regular basis to ensure it was safe to use.
- There were no identified seclusion rooms. A seclusion room is a designated safe room where the supervised confinement of a patient takes place. Its aim is to contain severely disturbed behaviour that is likely to cause harm to others.
- We were unable to view the occupied rooms as this could have negatively affected the patients. From the doorway, we could see the rooms were clean and fairly well maintained.
- Domestic and nursing staff cleaned rooms daily and supported patients to clean their rooms.
- There were alcohol wash containers around the unit and we saw staff use these. There were also notices in prominent places reminding people to use the alcohol wash to ensure good hand hygiene.
- The cleaning staff had a rota. This demonstrated they cleaned the hospital regularly.
- The new owners had started an environmental risk assessment when they took over the service. An environmental risk assessment provides a planned procedure for predicting potential risks to human health from the environment. There was also a plan to update the whole unit, which would include removing the stable doors and redecorating each patient apartment. This was explained to the inspection team as we toured the hospital.
- Staff had personal safety alarms from the start of each shift and tested them daily.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Safe staffing

- It was unclear how the previous provider, Bestwood, had arrived at its staffing figures as it was no longer present as the owner. We could only look at the staffing data for June 2016, the month St Andrews had taken over. Data previously provided to CQC was no longer relevant due to the change of provider.
- St. Andrews was in the process of reviewing its staffing but was currently operating on the same levels as the previous provider.
- St Andrews operated a two-shift pattern, days and nights.
- St Andrews reported it was running on one manager, one qualified nurse and five or six support workers daily. There was also a team leader available. At night, there was one qualified nurse and four support workers.
- Staff we spoke with felt there had been little use of agency staff since St Andrews started and sickness and staff turnover had improved.
- Records showed agency staff had covered two shifts between 1 June 2016 and 30 June 2016.
- The staffing rotas for the same period confirmed there was a minimum of five staff on duty each day with 13 out of 28 shifts showing there were six staff. This did not include the qualified member of staff. There was a qualified nurse on every shift and when multidisciplinary meetings took place, there were extra qualified staff.
- The manager was able to adjust staffing levels daily to take account of case mix and had the opportunity to use bank staff from St Andrews' bank team where needed.
- There were no communal areas at Bestwood as each patient had their own self-contained flat.
- There was sufficient staffing to ensure the named nurse provided one-to-one time with their patients weekly. This was important to ensure the patient's views were listened to about their plan of care.
- Each patient had a local GP who carried out a yearly physical check as well as providing care for routine medical problems.
- Staff and carers told us the service cancelled section 17 leave at times. This was due to either the patient's presentation or lack of staff. Section 17 leave is authorised by a responsible clinician when someone is detained under the Mental Health Act and includes activities such as supervised shopping trips.
- Bestwood provided data that said staff had received and were up-to-date with appropriate mandatory training and the average mandatory training rate for staff was 79%. However, the figures did not match what all staff told us on inspection. Staff reported they had either not had recent training or had not taken any training in some areas. St Andrews had recognised this and immediately started its own mandatory training programme. Managers gave us dates for when staff would complete this training.

Assessing and managing risk to patients and staff

- The two patients at Bestwood were subject to long-term segregation, as defined in the revised Mental Health Act 1983: Code of Practice (DH, 2015) where the patient is restricted from mixing freely with other patients on a ward on a long-term basis to manage the risk of harm to themselves and others.
- Both Bestwood and St Andrews' policies stated patients subject to long-term segregation should have a daily review and staff supporting patients who are long-term segregated should make written records on their condition on at least an hourly basis.
- We saw staff had recorded weekly patient reviews. The last documented review for both patients had been 6 June 2016 and, although staff documented in the care plans and daily running records, this was not hourly.
- At the time of our visit, staff were putting in place long-term segregation care plans for patients.
- There had been seven incidents of restraint (a situation that physically keeps someone under control) involving one patient at Bestwood in the six months prior to April 2016. Bestwood had not provided exact dates. Restraint was not in the prone position. Prone restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position.
- However not all staff had recently been trained in dealing with challenging behaviour and they told us there were not always enough available staff trained to deal with these incidents.
- Staff only used restraint after alternative de-escalation techniques had been attempted. These techniques try to help calm the situation down.
- Doctors had not prescribed rapid tranquilisation medication. This is medication that nursing staff can give to a person who is very agitated or displaying aggressive behaviour to help quickly calm them.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- There were two set of care records to look at. Each contained risk and management plans. This showed staff had addressed the patients' individual needs and safety concerns. Staff had updated these on 6 June 2016.
- There were no blanket restrictions in place. This refers to rules that restrict a patient's liberty and other rights, which staff routinely apply to all patients, without individual risk assessments to justify their application.
- Bestwood policies and procedures were not available for us to view because St Andrews had taken over. St Andrews had introduced up to date policies but staff were still undergoing transition and training to use them.
- The hospital did not use seclusion. However, we read in both patients' notes about the use of the stable doors. It was not clear from this if patients had given staff permission to close the top half of the door. We saw clinical notes indicated staff had closed them at times when the patient had been unwell and it was not clear whether the patient had consented. This would mean the patient had been secluded.
- Staff knew of the safeguarding procedures and knew how and where to report a safeguarding concern. Safeguarding is a process that helps to protect people's health, wellbeing and human rights. Staff reported safeguarding issues to the manager and then reported to the local safeguarding team if necessary. There had been five safeguarding concerns and no alerts raised with the CQC between April 2015 and April 2016.
- Staff completed medication administration records (MARs) and we saw staff had completed these correctly. Staff audited the MARs weekly. Staff were still using some of the old provider's records and this could potentially cause confusion for bank or agency staff. The GP provided patient prescriptions and a local pharmacist picked these up to dispense the medication.
- There was a temporary building (portacabin) which provided a visitors' areas within the hospital. Staff would accompany any children visiting and visits followed the St Andrews' policy on safeguarding children.

Track record on safety

- Bestwood reported one serious incident which had resulted in the suspension of admissions to Bestwood Hospital.

Reporting incidents and learning from when things go wrong

- Staff understood what constituted an incident and how and who to report it to. Staff described the incidents they had reported and told us they went to the qualified nurse and were then sent to the manager. A computer-based reporting system had been introduced recently and staff were encouraged to report incidents through this.
- Staff spoke to patients and informed them when things went wrong. Staff said they wanted to be open and honest with the patients.
- Management reviewed all reported incidents. Staff discussed lessons learnt from incidents in supervision. Management also sent out the information in a circular, discussed it in team meetings, and posted it on staff notice boards.
- Staff had a debrief after serious incidents and further support was offered.
- Senior staff did not feel lessons had been learnt from some incidents. We were given examples of where incidents had been reported about patients' behaviour and no change had taken place to reduce these incidents.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Records confirmed patients received comprehensive assessments following admission. Patients received a range of assessments from medical and nursing staff, occupational therapists, psychologists, and speech and language therapists. St Andrews Healthcare was introducing the Camberwell assessment of needs and adapting it for patients. This is a questionnaire used to assess a wide range of needs experienced by adults who have developmental and intellectual disabilities.
- Each patient had a physical healthcare plan and each addressed the individual needs of the patient.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff said they implemented positive behaviour support plans. Individual risk assessments led to implementation of positive risk strategies as part of positive behaviour support. This is a behaviour management system used to understand what maintains an individual's challenging behaviour. The positive behaviour support process involves information gathering, goal identification, support plan design and implementation. Records showed triggers and warning signs with strategies to minimise these. Staff demonstrated good understanding of each patient's behaviours and care needs but had a poor understanding of why some behaviour occurred.
- Each patient had a detailed care plan. Carers confirmed they knew about them. Patients said they were involved in developing their care plan, which staff read out to them. However, there were no easy read versions and the written records did not reflect the full involvement of the patient.
- Healthcare assistants said the care plans were too long to read and they needed a summary to understand them.
- Staff had not consistently updated the care plans.
- Their last review of constipation care plans and a physical healthcare plan was in April 2016. They had not reviewed speech and language communication plans since July 2015. The use of a wheelchair care plan was last reviewed in November 2015.
- We reviewed communication passports for both patients. These were comprehensive and visible in the patients' apartments. These identified communication aids used with individual patients such as colour mats.
- The local GP provided ongoing physical healthcare, monitoring, and yearly assessments. These were detailed and included information on diabetes and weight management.
- The service used paper-based patient records and stored them in the nursing office. Plans for transition towards the St Andrews Healthcare electronic patient records were in place.

Best practice in treatment and care

- The hospital was adopting the policies and procedures of St Andrews and these were available on the intranet. There was recognition the existing policies and procedures were hospital focused and followed national and professional guidelines. Staff understood that in the transition to becoming a residential nursing home new policies would need to reflect best practice guidance from the Social Care Institute for Excellence.
- Staff implemented the National Institute of Health and Care Excellence guidance for medication prescribing, psychological therapies and the treatment of autistic spectrum disorder, learning disability, physical healthcare, and rapid tranquilisation.
- Psychologists completed profiles of patients, involving families, and carers. They used these to support the patients' care plans.
- The hospital stated it did not use the "green light" toolkit. This helps services to assess how good their service is in meeting the needs of people with learning disabilities.
- Records we reviewed showed staff sought advice from specialist diabetic nurses.
- Assessments of dietary needs took place, for example, staff worked hard to support patients with their diabetic diet. Patients were independent and bought their own food through individual shopping budgets and by cooking for themselves in their own apartments.
- Health of the Nation Outcome Scores measured the progress patients made. Nursing staff could describe the progress and achievements of each patient in moving towards independence.
- The service did not have a comprehensive clinical audit programme. The level of clinical staff participation in clinical audits was low. Only two audits had taken place since November 2015. These were routine medication and clinic room audits to look at the ordering and administration of medication and the accuracy of the prescription charts, and medical record audits to monitor care planning and consent.

Skilled staff to deliver care

- A range of mental health disciplines provided input into the ward. Patients received visits from St Andrews social workers twice weekly. Medical staff were contracted from the local mental health trust. However, this was due to change to a responsible clinician employed by St Andrews Healthcare. The psychologist attended weekly to work with patients and take part in the multidisciplinary meetings. A speech and language therapist from another mental health NHS trust carried out screening and reviews of patients once a fortnight. The speech and language therapist from St Andrews

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Healthcare would provide future care. Therapists assessed the sensory needs of patients and specialist nurse practitioners from St Andrews worked with the nursing team to promote ways of greater engagement of patients in their treatment. The occupational therapist and psychologist worked together to ensure individualised patient-specific activities were planned. There were three mental health and two learning disability nurses employed to provide specialist care and treatment.

- Staff reported ad hoc induction in the previous organisation. In July 2016, healthcare assistants were due to undertake learning through a work programme St Andrews Healthcare provided for all healthcare assistants in the organisation. Healthcare assistants could study for the care certificate and St Andrews supported healthcare assistants to train as nurses.
- Staff were positive about the benefits of the reflective practice sessions they received. This enabled understanding of patient behaviours and needs.
- Staff reported previous access to supervision was poor. This had improved as staff had begun receiving supervision under the St Andrews Healthcare policy.
- Twenty-seven permanent non-medical staff had received an appraisal in the previous year and two had not. Plans were in place to complete the appraisals by July 2016.
- Specialist training uptake was low. Out of 26 eligible staff, 12 had received epilepsy awareness training and seven undertook autism training. Positive behaviour support training had been taken up by 20 staff, and staff reported they needed more training on this. Only four staff had attended training on the introduction to mental health. Staff were enthusiastic and looking forward to training provided by St Andrews Healthcare.
- Plans were in place to provide multi-agency public protection arrangements (MAPPA) training for staff from July 2016. MAPPA is a set of arrangements established by police, local authorities and the prison service in the local area to manage the risk posed by sexual and violent offenders.
- Staff from the hospital had visited other St Andrews Healthcare sites to understand the place of the hospital in a larger organisation providing a diversity of clinical pathways, and the part the hospital would play in this. St Andrews Healthcare had started to train staff to develop skills to support the transition of the service.
- St Andrews Healthcare had implemented its disciplinary and grievance procedures. At the time of the visit there were no disciplinary or grievance cases.

Multi-disciplinary and inter-agency team work

- Weekly ward rounds took place to see the patients. Monthly multidisciplinary meeting took place in which families and advocacy were invited. Carers confirmed they received care programme approach minutes, and they could contribute in clinical meetings.
- Staff explained that, under new processes introduced by St Andrews Healthcare, they had greater involvement in the multidisciplinary meetings. A new communication processes had been set up to keep staff informed of the outcomes of the meetings.
- Staff and patients reported the transition from one organisation to another had led to positive benefits in care and treatment. Staff described management consultations about changes in practice as “brilliant”.
- Nursing staff conducted handovers of clinical care at the end of each shift relating to each patient, their behaviours, risks, anxieties, and care provided. Staff were allocated to work with each individual patient. Staff were informed of professionals who would be visiting that day.
- All staff were part of the wider St Andrews on-call system. This increased access to a wide range of advice and professionals and reduced isolation of the hospital.
- Staff provided weekly updates to commissioners about each patient.

Adherence to the MHA and the MHA Code of Practice

- Staff we spoke with showed a good understanding of the Mental Health Act. One staff member reported learning about the Act had been through experience and attendance at multidisciplinary team meetings. However, staff had not received training on the Mental Health Act.
- Doctors assessed and recorded each patient’s capacity to consent to medication treatment. Treatment authorisation forms were attached to medication charts, so staff understood the legal authority under which they were providing medication. A second opinion appointed doctor had visited and reviewed the treatment authorisation form for a patient.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Patients had received information about their rights under the Act. Review and renewal of detentions had taken place. Patients had weekly access to Independent mental health advocacy to enable them to exercise their rights.
- A Mental Health Act administrator from a local NHS trust provided administrative support on the implementation of the Act; however, no audits had been carried out at the time of inspection. This function was transferring to St Andrews Mental Health Act administration.
- Staff completed detention paperwork correctly and kept it up to date. Approved mental health professional reports were available.
- The hospital was working towards transitioning to a residential home and would no longer be the detaining authority, however would take patients on community treatment orders. The multidisciplinary team had considered the option of community treatment orders for existing patients.

Good practice in applying the MCA

- The hospital had not made any applications for Deprivation of Liberty Safeguards in the previous six months.

At the time of the inspection Bestwood had given figures that showed 18 out of 26 staff (69%) had received training in the Mental Capacity Act through electronic learning modules. St Andrews Healthcare had reviewed the training figures and set a target for all staff to complete the provider training by the end of July.

- Staff had read the St Andrews Healthcare policy on the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Staff we spoke with described how they encouraged patients to make choices and specific decisions, demonstrating a good understanding of best interests. They were aware the impending change in service to a residential home would require increased patient choices and consent. However, records showed staff recorded few assessments of capacity and consent for day-to-day decisions. Where they were in place frequent review did not take place, for example, we found capacity assessments for managing money and going out into the community were last reviewed in April 2016.
- Staff were not aware of the Mental Capacity Act definition of restraint. Staff considered restraint as a last resort following de-escalation.
- Staff described how they would obtain advice about the Mental Capacity Act within St Andrews Healthcare.
- St Andrews Healthcare was in the process of instigating monitoring arrangements for the Mental Capacity Act.

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

Requires improvement

Kindness, dignity, respect and support

- The inspection team observed staff treating the patients with dignity, kindness and with respect.
- Patients reported staff were friendly, caring and respectful.
- Not all staff understood the individual needs of the patient. Management told us further training was to be provided to help staff have a better understanding of the patient group.

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The involvement of people in the care they receive

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- We could not see any previous records to allow us to judge how patients may have been involved with the admission process. New documentation available to us on the day showed any future admissions planned to involve the views of the patient and would have a process in place to help the patient become orientated to the service.
- Patients had some involvement in the development of their care plans and took part in their multidisciplinary team meetings. The care plans they did not show that staff had developed them in a collaborative way. One patient told us staff offered a copy of their care plan but they chose not to have one.
- Patients knew how to contact the advocacy service when needed.
- Carers had said they were involved and felt staff kept them informed.
- Carers commented that sometimes staff had given them incorrect information.
- There had been no community meetings or surveys to assess any patient feedback around their care.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- We did not see any evidence that suggested patients were involved with the planning of the service.
- There were no plans in place of advance decisions An advance decision is a statement of instructions about what medical and healthcare treatment you want to refuse in the future, in case you lose the capacity to make these decisions. For example, you could use it to say you do not wish to be resuscitated if you develop certain medical conditions in the future.

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

Requires improvement

Access and discharge

- Between November 2015 and April 2016, bed occupancy had been at 33.3%. This had been due to lack of referrals as reported by Bestwood and also the local commissioners restriction on admissions.
- The service had previously taken referrals from all areas as it offered a specialised service.
- Due to the type of service, beds would always be available when a patient returned from leave.
- Staff had moved one patient from his flat to another so redecoration could take place. The managers told us this rarely happened. Some staff reported this had unsettled the patient because the new flat was smaller.
- Staff arranged discharge to meet the needs of the patient and the service would discharge at an appropriate time of day. We discussed this with the manager because there were no discharge records to look at.
- If a patient's mental health deteriorated then the service would have beds available in a suitable acute setting if appropriate or their care plan would be reviewed and they would be able to remain at their flat.
- Between November 2015 and April 2016, there had been one delayed discharge due to problems with the placement.

The facilities promote recovery, comfort, dignity and confidentiality

- Each flat had a kitchen, bathroom, bedroom and dining area, and had access to a private garden.
- We saw (in one case through the front door) the rooms had been personalised to varying degrees by the patients.
- Patients had somewhere secure to store their possessions in their own flat.
- Access to the flat was through a 'stable door'. The fact that the lower section of these could be locked with the upper part left open meant staff were unsure whether the patient was held in seclusion. Management acknowledged 'stable doors' had not promoted least restrictive practise and plans were in place to remove these doors.
- There was a quiet room available for patients to meet visitors if needed. Carers reported they had not used these rooms.
- Staff supported patients to make private phone calls.
- There was no shared kitchen or restaurant on site so the patients and staff bought food to help the patients prepare their own meals as part of their rehabilitation process.
- Patients could make hot drinks and snacks when they wanted to.
- Although activities were provided seven days a week there were no planned meaningful daily activities. One patient's activities were very basic and staff brought in their own activity ideas for the other patient. St Andrews had recently arranged for an occupational therapist to visit twice a week to help arrange activities for the patients. This had already started on the week of our visit.

Meeting the needs of all people who use the service

- Adjustments had been made for people with a disability. This included easy access ramps for wheelchair access.
- Staff told us there was access to interpreters if needed.
- Patients were involved with the choosing of their own food so any religious or ethnic needs would be met.
- Staff supported patients with any spiritual beliefs if needed. There was no visiting chaplaincy service.
- We did not see accessible easy read information on areas such as treatments, local services, patients' rights, and how to complain.

Listening to and learning from concerns and complaints

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Bestwood reported there were two complaints received in the 12 months prior to February 2016. One complaint was upheld. It concerned the quality of care and the staff turnover. An action plan had been produced to address the concerns raised but we could not see how this was shared with staff. The other complaint was not upheld and also concerned the quality of care for patients.
- In the time since St Andrews had taken over 1 June 2016) there had been no complaints.
- St Andrews had recently written to relatives and carers to tell them about their complaints policy.

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

Requires improvement

Vision and values

- Staff we spoke with were very pleased to be working for the new provider. St Andrews had a set of vision and values that were not fully implemented at the time of the inspection because of the short time since it had taken over.
- The new management had started to develop the team objectives to meet the provider's values and objectives and staff we interviewed confirmed this.
- The manager had seen all but two staff since the purchase to discuss their role in the new organisation.
- Management from St Andrews had visited Bestwood and management had arranged for staff to visit St Andrews' head office and other locations to help the integration of Bestwood. Staff reported they felt part of the new provider's team.

Good governance

- Prior to 1 June 2016 overall governance of staff had been poor. There had been a lack of training and supervision. There had been low participation of staff in clinical audit. There was poor understanding among staff of the Mental Capacity Act and confusion over patients in long-term segregation. Management had not actively analysed daily patient incidents to help minimise these incidents reoccurring. The proposed registered manager recognised the problems above and had made plans to address the issues.
- The integrated governance group reviewed audits undertaken, but did not challenge the absence of an audit programme.
- There were no current key performance indicators to gauge the performance of staff.
- The manager and the proposed registered manager had the authority to make most decisions without delay and one staff member was complimentary in how quickly a request had been met. There was adequate administrative support available both at Bestwood and from St Andrews' head office.
- Management had introduced weekly reflective practice sessions for staff and the staff felt these were useful.

Leadership, morale and staff engagement

- No local staff surveys were carried out for this service.
- Sickness and absence rates were nine per cent over the period 15 April 2015 to 15 April 2016.
- There had been no bullying and harassment cases in the same period.
- Staff knew how to use the whistle-blowing process. There had been three whistle-blowing alerts between 13 April 2015 and 12 April 2016. Inspectors had used this information in a previous inspection.
- Staff told us they could raise concerns without fear of victimisation. At the inspection, we received information about one alleged incident regarding victimisation of staff from a previous manager but we were unable to find evidence to support this.
- There had been an increase in morale and job satisfaction since St Andrews had become the new providers. Staff felt more of a team now.
- There had been no opportunities for leadership development.
- Staff said they told patients when things went wrong and supported the patient where necessary.
- Staff had not been offered the opportunity to give feedback on services and input into service development. St Andrews were developing its plans to involve the staff through team meetings.

Commitment to quality improvement and innovation

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- The hospital was not involved in any research or quality accreditation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must make sure staff receive mandatory training and training in the Mental Health Act as well as specialist training to meet the needs of patients.
- The provider must ensure the patients have involvement with their care and the care plans are updated in a timely manner.
- The provider must ensure staff have access to regular supervision.
- The provider must ensure the use of stable doors on the flat entrances are monitored effectively.

Action the provider SHOULD take to improve

- The provider should ensure staff receive any specialist training required to meet the needs of all their patients.
- The provider should ensure clinical audits are carried out and recorded in order to enable staff to learn from the results and make improvements to the service.
- The provider should ensure activities are planned and meaningful.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Patients care plans were not updated regularly and did not show enough patient involvement. This was a breach of regulation 9(1)(a)(b)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Not all staff had received supervision. Staff were not routinely trained in the Mental Health Act and the Mental Capacity Act. Uptake of specialised training was low. This was a breach of regulation 18(2)(a)(c)

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 How the regulation was not being met: The provider had not ensured that learning from incidents had been reviewed appropriately. This was a breach of regulation 17 (2)(b)

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

There were no patient or staff surveys, or community meetings to gain feedback on patient care.

The provider did not involve patients and staff enough with the running of the service.

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

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.