Enbridge Healthcare Limited

Magna House

Inspection report

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Date of inspection visit: 27 July 2021
Date of publication: 04/10/2021

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

Are services safe?	**Inadequate**
Are services effective?	
Are services caring?	**Insufficient evidence to rate**
Are services responsive to people's needs?	
Are services well-led?	**Insufficient evidence to rate**

Summary of findings

Overall summary

Redwood Ward was visibly dirty, we found high- and low-level dust, in stairwells and corridors. We found a significant insect infestation at the entrance from the indoor corridor to the conservatory, which was the main lounge of the ward.

The ward had multiple blind spots that were not mitigated by the use of mirrors.

Two staff we spoke with were not aware of what to do in the event of a fire.

Managers had not ensured staff and patient safety; patient and staff alarms were ineffective and staff did not respond when both patient and staff alarms were activated.

Managers had not ensured security within the ward area, we found the main door to exit the ward was unlocked and patients could easily leave the ward without the required permissions.

Managers failed to ensure that patients on Redwood Ward had access to working showers in their ensuite bathroom or safety mirrors to attend their personal hygiene. Staff told us they provided handheld glass mirrors which they would hold up to support patients to shave, this compromised their dignity and privacy. We checked all 11 showers on the ward to see if they were in working order. Only four had fully functioning showers. Two patients on the ward were in bedrooms that did not have a working shower. Evidence provided after the inspection demonstrated the showers were subsequently fixed.

Managers had failed to ensure staff and patient safety on Redwood Ward. Staff could not tell the inspection team how they would respond if they identified a fire on the ward. Neither staff member could tell us where the fire point alarms were. We were concerned that if a fire did break out staff did not have the right level of awareness or training of how to raise the alarm to keep service users and other staff members safe.

Due to the substantial concerns we found during the inspection we instructed the provider to relocate patients from Redwood Ward to another ward in the hospital. This was done immediately.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults		Redwood Ward was visibly dirty, we found high- and low-level dust, in stairwells and corridors. We found a significant insect infestation at the entrance from the indoor corridor to the conservatory, which was the main lounge of the ward. The ward had multiple blind spots that were not mitigated by the use of mirrors. Two staff we spoke with were not aware of what to do in the event of a fire. Managers had not ensured staff and patient safety; patient and staff alarms were ineffective and staff did not respond when both patient and staff alarms were activated. Managers had not ensured security within the ward area, we found the main door to exit the ward was unlocked and patients could easily leave the ward without the required permissions. Managers failed to ensure that patients on Redwood Ward had access to working showers in their ensuite bathroom or safety mirrors to attend their personal hygiene. Staff told us they provided handheld glass mirrors which they would hold up to support patients to shave, this compromised their dignity and privacy. We checked all 11 showers on the ward to see if they were in working order. Only four had fully functioning showers. Two patients on the ward were in bedrooms that did not have a working shower. Evidence provided by the provider following the inspection demonstrated the showers were subsequently fixed Managers had failed to ensure staff and patient safety on Redwood Ward. Two staff could not tell the inspection team how they would respond if they identified a fire on the ward. Neither staff member could tell us where the fire point alarms were. We were concerned that if a fire did break out staff did not have the right level of awareness or training of how to raise the alarm to keep service users and other staff members safe.

Summary of findings

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Summary of this inspection

Background to Magna House

Magna House is a 29 -bed hospital in Lincolnshire, providing care, treatment and rehabilitation services to people who are experiencing mental health issues. It has been registered with the Care Quality Commission since August 2020 for the following regulated activities:

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

Treatment of disease, disorder or injury.

Magna House has a registered manager and was inspected in June 2021 and was rated as good overall with safe being requires improvement.

The hospital comprised of four cottages,

Aspen – seven female beds

Beech one – five male beds

Beech central – three male beds

Beech two – three female beds

All the above bedrooms are single ensuite and are on the ground floor.

Redwood ward has 11 ensuite bedrooms and is situated on the first floor of the hospital.

We carried out this unannounced focused inspection on 27 July 2021 following concerns around a recent serious incident at the hospital, we attended at strategy meeting with the provider and CCG whereby we were not assured staff were adhering to the absent without leave policy.

We were made aware at the strategy meeting that the provider had opened an additional 11 beds on the first floor of the hospital, named Redwood Ward. During the registration process conditions were placed on the provider over concerns about the suitability for patients to be admitted to the first floor environment.

Due to the serious concerns we found regarding the environment and patient and staff safety we conducted the inspection in the area known as Redwood Ward specifically and looked at the safe domain only. We found areas of practice which did not meet the legal requirements and have acted under our enforcement powers. Owing to this, the rating for safe has gone down to inadequate.

How we carried out this inspection

How we carried out the inspection

Summary of this inspection

This was an unannounced focussed inspection looking at the safe key line of enquiry in the safe domain only.

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, which was compliant with all COVID-19 government and Care Quality Commission guidelines, the team:

visited the hospital and inspected the care environment on Redwood Ward

spoke with two patients in person

spoke with three other members of staff: including the head of operations, head of compliance, head of care and quality and deputy hospital director.

What people who use the service say

One patient told us he was happy with his bedroom and staff cleaned it well. However, he said the shower was not working and the drain was dirty and full of hair which he stated was not his. He was not aware of how he could access a working shower in a vacant bedroom.

One patient said the food is nice, however they said they had no notice prior to the move to Redwood Ward, they were just told to pack their belongings into black bin bags and move.

One patient told us they were unhappy that they had moved ward, they were told to pack their possessions in black bin bags and move wards with no notice.

Whilst we were talking with one patient he took his shoes off as he said his trainers were not comfortable. We saw that his toenails were very long and dirty and needed specialist attention. We brought this to the hospital managers for immediate action to be taken.

Areas for improvement

Action the provider MUST take to improve:

The provider must ensure:

Blind spots and ligature points are risk assessed and plans put in place to reduce, eliminate and mitigate these risks. Regulation 12 (1)(2)(b)

Staff follow the provider's observation policy when patients are in the lounge (conservatory) and garden area. Regulation 12 (1)

Call bells for service users and staff's personal alarms are fit for purpose and properly maintained. Regulation 12 (1)

Staff are fully aware of and trained in fire procedures. Regulation 12 (2)(c)

All bathrooms on Redwood Ward have safety mirrors in place. Regulation 15 (1)(e)

Summary of this inspection

Staff adhere to safety and security procedures on Redwood Ward, by ensuring all external locks are appropriately secured. Regulation 15 (1)

Flooring is appropriately fixed to the floor to reduce the risk of slips, trips and falls and infection control risks. Regulation 12 (2)(d)

All broken glass panels are replaced to reduce the risk to patients. Regulation 12 (2)

The air conditioning unit in the conservatory is repaired and a thermometer installed to monitor the temperature of the room. Regulation 15 (1)(e)

Ensure that all Wooden cladding in the garden is securely fixed. Regulation 15 (1)(e)

The provider must ensure that all insect infestations are addressed, and the ward monitored for further outbreaks. Regulation 15 (2)

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	Inadequate	N/A	Insufficient evidence to rate	N/A	Insufficient evidence to rate	N/A
Overall	Inadequate	N/A	Insufficient evidence to rate	N/A	Insufficient evidence to rate	N/A

Long stay or rehabilitation mental health wards for working age adults

Safe	Inadequate
Effective	
Caring	Insufficient evidence to rate
Responsive	
Well-led	Insufficient evidence to rate

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

Inadequate

During our inspection we became aware of concerns on Redwood Ward. We found areas of practice which did not meet the legal requirements and have acted under our enforcement powers. Owing to this, the rating for the safe domain has gone down to inadequate

Safe and clean care environments

Safety of the ward layout

We found a lack of safe care and treatment and poor environment on Redwood Ward; as a result, we believe that service users would or may have been exposed to the risk of harm".

Staff could not easily observe patients in all parts of the ward. On the ground floor the area next to the meeting room could not be observed unless staff were in the area. Both staircases leading to the upstairs bedroom corridor had blind spots at the bottom and the top of the stairwell. Additionally, the banister rails each had two potential ligature points. Whilst closed circuit television was in use, it did not mitigate these risks.

We found the bedroom corridor had three blind spots; these had not been mitigated using convex mirrors. We observed during this inspection that this corridor was not always observed by staff. In the garden on the left-hand side of the conservatory there was a blind spot, and a potential ligature point from two window fittings.

We were not assured that patients were receiving safe care and treatment on Redwood Ward. During the inspection, we observed the deputy hospital director asking a member of staff if a patient was in the conservatory unaccompanied. The member of staff confirmed this was case. The deputy hospital director then informed the staff member that all patients needed to be supervised at all times when in the conservatory or garden area. At this time the closed-circuit television was not being monitored as there was no staff in the office on the ward.

Managers had not ensured that call bells for service users and staffs personal alarms were fit for purpose and properly maintained. The call bell system, that allows service users to summon help if required on Redwood Ward were not

working effectively. An inspector and a service user pressed the call bell. On both occasions no staff responded. The alarm did not sound in the bedroom corridor (where it was activated) but on the ground floor of the ward. Whilst the alarm panel in the office told staff what room had requested help, there was no light outside the bedroom signifying that help was required. If staff were not in the office, there was no other way of identifying who needed help and where.

We were not assured that the staff call system was operational. Whilst staff carried personal alarms which they could activate if they needed support. We asked two separate staff members to activate these alarms. No alarm sounded on either occasion. With the second member of staff we waited for two minutes and then asked the staff member to use their radio to summon help. Staff arrived in under a minute, but their first response was to ask where on the ward they were needed. We were concerned that asking for help via the radio in an emergency staff or a service user would be left in potentially dangerous situations longer then needed because staff could not identify where in the ward the incident was occurring.

Two staff we spoke with on Redwood Ward could not tell the inspection team how they would respond if they identified a fire on the ward. Neither staff member could tell us where the fire point alarms were. We were concerned that if a fire did break out staff did not have the right level of awareness or training of how to raise the alarm to keep service users and other staff members safe.

Managers failed to ensure that patients on Redwood Ward had access to working showers in their ensuite bathroom or safety mirrors to attend their personal hygiene. Staff told us they provided handheld glass mirrors which they would hold up to support patients to shave, this compromised their dignity and privacy. We checked all 11 showers on the ward to see if they were in working order. Only four had fully functioning showers and we saw plugs in the ensuite showers were visibly dirty. Two patients on the ward were in bedrooms that did not have a working shower. Evidence provided after the inspection demonstrated the showers were subsequently fixed.

Managers did not ensure the safety and the security of the ward environment. We found two doors that were unlocked. One door led to a non-service user area, with potential risk items present. The other door was to the airlock entrance and exit for the ward. If the service user had accessed this area, they would have been able to leave the hospital grounds. Staff were not aware of this until we informed them.

We found other areas within Redwood Ward that compromised the safety of staff and service users with no plans in place to address them.

In the dining area, the flooring (linoleum) next to radiator had lifted off the floor, creating a trip hazard and an infection control risk.

Managers had not ensured broken windows had been replaced, reducing the risk to patients. Any further damage would break it completely There was also wooden cladding on this section of the building. One of the panels of cladding was not securely fixed and exposed nails were clearly visible. The air conditioning unit in the conservatory was broken. Due to the hot weather we were concerned that this conservatory would be too hot for the service users to use. There was no thermometer for staff to monitor the temperature. In the entrance to the conservatory there was an insect infestation, that had not been addressed.

Maintenance, cleanliness and infection control

Long stay or rehabilitation mental health wards for working age adults

Managers had not ensured patient areas were fit for purpose. Communal areas on the ward were visibly dirty, we found high- and low-level dust, in stairwells and corridors. We found a significant insect infestation at the entrance from the indoor corridor to the conservatory, which was the main lounge of the ward.

Whilst here was enough furniture for the patients to sit on in the conservatory, there was only two chairs in the quiet room for 11 patients.

Due to the substantial concerns we found during the inspection we instructed the provider to relocate patients from Redwood Ward to another ward in the hospital. This was done immediately.

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

Insufficient evidence to rate

This was a focused inspection and we did not re rate this key question. Staff did not involve patients when making decisions about moving wards or ensure that patients could attend to all aspects of their personal hygiene in private. Staff did not support a patient to understand and manage their care or access specialised services.

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

Insufficient evidence to rate

This was a focused inspection and we did not re rate this key question. However; we were concerned that leaders did not have the skills, knowledge and experience to perform their roles. The systems and procedures within the service did not ensure that the premises were safe and clean, or that staff had the required training to keep patients and staff safe. Additionally, leaders did not ensure that patients were involved in the decision made about changes to the service.