Southern Hill Hospital

Quality Report

Cooks Hill
Gimingham
Mundesley
Norfolk
NR11 8ET
Tel: 0333 220 6033
Website: southernhill.hospital@nhs.net

Date of inspection visit: 27 - 28 November 2018
Date of publication: 18/01/2019

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?	Good
Are services responsive?	Good
Are services well-led?	Good

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 Southern Hill as requires improvement because:

- The provider had not ensured the patient had a care plan which was holistic, included agreed goals, a review date and the patients voice, in a way the patient understood. This had not been identified as a need by the management team. The patients had not routinely been offered a copy of the care plans.The patient had to rely on memory or ward staff to reflect on actions agreed at multidisciplinary meetings.
- Staff did not consistently implement systems to ensure the security of the environment on the PICU ward. The provider had not ensured the premises used by the service were safe for their intended purpose. There was a lack of effective systems, checks and processes in place. There was a failure to meet best practice guidance as per the national association of psychiatric intensive care units.
- The seclusion room did not meet all the specifications recommended in the Mental Health Act code of practice.

However:

- We saw evidence of a culture were staff used least restrictive practices, using techniques requiring physical intervention as a last resort. Where it was necessary, these incidents were reported and staff and patients held a debrief. There was a lead staff member who reviewed any restraints for learning.
- The hospital employed a nurse who was dedicated to ensuring the physical health needs of the patients were met. The nurse had developed systems to ensure information was captured on admission and identified actions were carried out. We saw one-page care plans for staff to follow, aimed at supporting the person to address their physical health needs. Staff received training during induction and beyond to ensure all staff received the appropriate skills and awareness to carry out basic physical health monitoring, and the nurse was available on site to respond to queries.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement 	We rated this service as requires improvement

Summary of findings

Contents

Requires improvement

Location name here

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to Southern Hill Hospital

Southern Hill is an independent mental health care facility located in the North Norfolk countryside. The hospital has 28 beds for adults who require assessment and treatment in a mental health inpatient setting.

The provider is Southern Hill Limited.

The hospital comprises of two acute wards and a PICU (psychiatric intensive care unit):

Lincoln Ward is a female only ward with 13 beds.

Cavell Ward is a male only ward with 10 beds.

The PICU is a mixed sex ward with five beds.

At the time of this inspection, there were no beds in use on the acute wards.

There were three patients on the PICU ward at the time of this inspection. All the patients were female.

Southern Hill Hospital registered for the Care Quality Commission in May 2018 and admitted patients for the first time in June 2018. The hospital is registered to carry out the following regulated activities:

- Assessment and treatment for persons detained under the Mental Health Act 1993
- Treatment of disease, disorder or injury

The hospital has two registered managers in a shared role. The registered managers, along with the provider, are legally responsible and accountable for compliance of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) 2014 and the Care Quality Commission (Registration) Regulations 2010.

We inspected the PICU ward in full and commented where possible on the whole hospital, however the acute wards were empty at the time of inspection.

This is the first time the Care Quality Commission has inspected this hospital.

Our inspection team

Team leader: Jane Crolley

The team that inspected the service comprised three CQC inspectors and one registration team CQC inspector.

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 and asked stakeholders for information.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment

Summary of this inspection

- observed three episodes of care
- spoke with one patient who was using the service
- spoke with the registered managers and a ward manager
- spoke with 14 other staff members; including doctors, nurses, occupational therapist, clinical psychologist, health care assistants, Mental Health Act Administrator and senior managers
- talked with stakeholders
- we spoke with the hospital chef
- attended and observed one hand-over meeting
- looked at six care and treatment records of patients, three of which were historical records for patients who had recently been discharged
- carried out a specific check of the medication management and
- looked at a range of policies, procedures and other documents relating to the running of the service.

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 hospital staff did not consistently implement systems to ensure the security of the PICU. All staff had access to the PICU via swipe cards, even if they were not directly working on that ward. We heard staff discussing the risk of not always knowing who was on the ward. The hospital needed to ensure security arrangements were effective and we raised this during inspection. The hospital assured us they would consider this concern.
- The hospital did not ensure completion of daily environmental checks. This would identify concerns or issues relating to the buildings environment, checking for damage and new risks swiftly. Whilst we saw evidence of reporting of concerns, the audit trail did not reflect that daily checks were carried out and we could not be assured that risks were immediately identified. This created a risk to patient safety.
- The nursing office did not look onto the ward so people in the office could only see part of one corridor. Staff could not check before leaving the office that the corridor was safe, as there was no viewing panel to make this observation.
- The seclusion room did not meet all the specifications recommended in the Mental Health Act code of practice.
- Staff reported that alarms could not always be heard on Lincoln and Cavell when triggered by the PICU, depending on where staff where situated at the time it went off.
- Risk were not always updated when a patient was admitted to the PICU ward and immediately following an incident.

However:

- We saw evidence of a culture where staff used physical intervention techniques as a last resort. Where it was necessary, these incidents were reported and staff and patients held a debrief. There was a lead staff member who reviewed any restraints for learning.
- Patients were offered section 17 leave and there was sufficient staff to facilitate this.
- Staff followed good practice in medicines management following national guidance in the transportation, storage,

Summary of this inspection

administration and disposal of medication. There was a weekly audit carried out and issues identified were addressed. There was a monthly medication management committee in place, chaired by the medical director.
- We saw that patients had personal evacuation plans in place in case of emergency.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We saw in the patient records there were some care plans specific to a concern – such as violence and aggression or self-harm. However, there were no care plans which captured all needs that were personalised, holistic and recovery oriented. The patients had not been offered a copy of any care plans.
- The lack of a holistic care plan meant that patients did not have oversight of agreed actions and progress. There were no personalised goals. The section 17 leave form was not shared with the patient and as there was no leave care plan there was nothing for the patient to refer to regarding this. This meant the patient would have to ask staff about their leave arrangements. This could lead to confusion and miscommunication. Where there was a care plan around a specific need, such as self-harm or diabetes, the patients were not offered a copy and would not know what support they should receive.
- We saw staff explained to patients about their rights as a detained patient. However, we saw that one patient had not understood their rights. These were re-read weekly for 18 days and the patient continued not to understand their rights. A referral to the independent mental health advocate had not been made. We raised this with the hospital and action was taken immediately to address this.

However:

- A weekly multidisciplinary team meeting was held with the patients. Staff involved included ward nurses, an occupational therapist, doctors, a consultant psychiatrist and a clinical psychologist. Staff at the meeting reviewed the patients progress, incidents from the last week, medication and other treatment plans, physical health care, enhanced observations, issues related to the Mental Health Act and the patient views were documented and discussed as an integral part of the process.
- The hospital employed a nurse who was dedicated to ensuring the physical health needs of the patients were met. The nurse had developed systems to ensure information was captured on

Summary of this inspection

admission and identified actions were carried out. We saw specific care plans were written aimed at supporting the person to meet their physical health needs. This ranged from diabetes management to supporting a patient with injuries from acts of self-harm. Staff received training on induction to cover elements of physical health care and the nurse was available on site to respond to queries.

- The hospital managers provided new staff with an appropriate induction which met the care certificate standards requirements for healthcare assistants.

Are services caring?

Good

We rated caring as good because:

- Staff attitude and behaviour towards the patients was kind and compassionate. We observed discussions with and about the patients which were patient centred and responsive to the patients' needs. We saw emotional support and advice was offered appropriate to the patients' needs.
- One patient spoken with, told us that this was the best place they had ever been to and that the staff really cared. Patients felt listened to and were confident they could approach anyone of the staff and receive support. Patients said the staff treated them appropriately.
- We reviewed the multidisciplinary meeting minutes which reflected patients were involved with the planning of their care and their views were documented. There was evidence of patients' community meetings taking place, these were known locally as 'people's meetings'. This included the wider staff team, including the housekeeper and chef as appropriate.
- The occupational therapists completed a form with the patient to help identify their interests and hobbies to help when planning activities.

However:

- There was a lack of evidence in patient records and care plans about meeting the cultural and social needs of the patients.
- Patients were not provided with a holistic, comprehensive care plan.

Are services responsive?

Good

We rated responsive as good because:

- Patients could help in the preparation of meals and snacks.

Summary of this inspection

- There was a chef employed by the hospital who offered a wide and varied menu. The chef attended the peoples community meetings and responded to patient requests. Hot meals were offered daily, and could be adapted to meet the cultural, spiritual and religious needs of patients.
- We saw over 50 compliments about the service (both adult and acute wards) from former patients and their relatives.
- There was a system for reporting complaints or raising concerns. Patients felt able to raise a complaint.
- Patients could access the onsite gym where risk assessed to do so. This was a large area that facilitated a range of physical activities. The hospital also commissioned a sports therapist to run a session weekly.

However:

- There was no facility for a patient to have a physical examination if required on the ward.
- Patients on the ward were unable to access fluids freely without approaching staff. There was a beverage bay located just outside the ward. Only patients with Section 17 leave could utilise this.

Are services well-led?

Good

We rated well led as good because:

- The hospital had a governance structure which demonstrated key roles, accountability and responsibility.
- Staff were given the opportunity to access training and development. Ideas for improvement were listened to and discussed within the clinical governance framework.
- Staff spoken with felt respected, supported and valued. They were proud to work at Southern Hill hospital.
- Supervision figures improved each month and at the time of inspection the provider was meeting its own target of 85% compliance across the hospital site.
- Hospital managers responded immediately to concerns raised during inspection and developed plans to address those concerns.
- The HR processes ensured that there were appropriate background checks undertaken of staff including checking the disclosure and barring system and right to work.
- We saw a fire risk assessment was in place and actions identified to manage the risk. There were named fire marshals on site and staff knew what to do in the event of a fire.
- There was a significant number of compliments logged and personal letters of thanks from patients to the teams.

However:

Summary of this inspection

- There had been an information management concern raised. The provider told inspection staff that there had been an incident where a patient record was overwritten, and the previous version lost. Managers recognised this and spoke to the individual staff concerned, however there was no evidence of action being taken to prevent this occurring in the future. We raised this issue during inspection with the registered manager who agreed to address the concern.

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.

- Eighty-six per cent of staff were trained in the Mental Health Act. Staff demonstrated knowledge of the Mental Health Act, the code of practice and guiding principles.
- The hospital employed a dedicated Mental Health Act administrator who was involved with and had knowledge of all detained patients. Legal papers were scrutinised and when an error was detected this was acted upon.
- An independent mental health advocate attended the hospital upon request and staff knew how to request this. However, there were no leaflets or posters on display on the PICU ward advising patients of the role of the independent mental health advocate.
- Staff explained to patients about their rights as a detained patient. However, we saw that one patient had not understood their rights. The rights were re-read weekly for three weeks and the patient continued not to understand their rights. A referral to the independent mental health advocate had not been made. We raised this with the hospital and action was taken immediately to address this.
- Patients did not have a leave care plan and the section 17 form was not shared with the patient. This meant the patient would have to ask staff about their leave arrangements and had nothing to refer to.
- We saw evidence of regular audit of paperwork and scrutiny from the Mental Health Act administrator. However, this did not identify all errors as outlined above in this section of the report.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety per cent of staff had completed training in the Mental Capacity Act 2005 and deprivation of Liberty safeguards.
- There had been no applications made for deprivation of liberty authorisation since the hospital admitted their first patients in June 2018.
- We saw that patients' capacity was assessed and documented appropriately.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

- The ligature risk assessment had been updated regularly since the hospital opened in June 2018.
- The hospital policy required the ward manager to conduct a 'walkabout' to check the environment was safe. This walkabout was developed to identify concerns or issues relating to the environment. The 'walkabout' was to be carried out over a period of the week. Whilst we saw evidence of reporting of concerns, the audit trail did not reflect that daily checks of the environment were carried out consistently and we could not be assured that risks were immediately identified. This created a risk to patient safety. We recognised that at times there were gaps in recording due to the ward not having patients, however, it was not clear when these times were. Staff told us that the walkabout was lengthy and acknowledged it was not always done as expected if they were busy.
- The ward layout did not enable staff to observe all parts of the ward. Staff were aware of this and there were extra convex mirrors in place and staff undertook regular walks around the ward specifically to check on patients. There was CCTV in place. The nursing office did not look onto the ward so people in the office could only see part of one corridor. Staff could not check before leaving the office that the corridor was safe, as there was no viewing panel to make this observation.
- The ward staff did not have a robust system for knowing when staff attended the wards. All staff had access to the PICU, via swipe cards, even if they did not work there. This meant there was a risk of staff attending the unit and ward staff being unaware. We heard two staff discussing this risk.
- The hospital provided evidence of training for all PICU ward staff in relation to risk management. This included a section on best practice. This was in line with recommendations from the national association of psychiatric intensive care and low secure units (NAPICU) which advises that there should be an agreed approach to risk assessment, and that staff working directly with patients should be trained to incorporate the identification of risk.
- The ward at the time of inspection had female patients only. There was the capability of admitting male patients and staff showed us how this would be managed.
- All ward areas were clean, had good furnishings and appeared well maintained. Managers purchased appropriate furniture to maintain patient safety.
- Staff did not consistently complete the daily recording of cleaning for the small clinic room on the ward. There were gaps in recording, not all of which linked to when the ward was empty.
- Not all staff did not meet the providers dress code and could pose an infection and safety risk. This had been identified by the hospital from an internal audit as requiring action.
- Staff were concerned that alarms between Lincoln ward and the PICU were not heard and that the use of radios

were implemented as an interim measure to overcome this issue. The hospital have assured the inspection team that alarms could be heard, however staff did not have this view.

Safe staffing

- Between 20 April 2018 and 31 July 2018, there were 8% nursing vacancies in PICU and no vacancies within the multidisciplinary team.
- During inspection there was no use of agency or bank staff. This was partly because at the time, the two acute wards were empty. We saw staff from those wards working in the PICU. The acute ward staff, who where working on PICU, were not able to find information easily on the PICU. For instance, staff took two hours to find the ligature audit and a further hour finding the guidance to explain it. Staff spoken to advised they did not know where things were as they did not usually work on PICU. There was a concern that not all staff would know where all the risks were located.
- On the PICU, there was one ward manager and one nurse who were mental health nurses. In addition, there was one learning disability nurse and an adult nurse currently employed on the PICU; the adult nurse was part time. It would not be possible to cover the ward 24 hrs a day with appropriately trained staff with these few staff. However, as the acute wards were not full, there was mitigation to ensure adequate cover was in place at the time of the inspection. There was also an active recruitment programme in place.
- There was always a qualified nurse on the ward and a ward manager on site. There was no guarantee that the qualified nurse was a mental health nurse. However, there was always a ward manager on site who had this qualification who could provide clinical oversight.
- The ward manager could adjust staffing according to clinical need.
- The hospital had a staffing matrix which provided guidance on staffing levels according to the number of patients on the ward. We did not see any staff shortages, although we recognised that two wards were empty. Staff from the acute wards were working on PICU during the time of inspection. We could not make a judgment on staffing if all wards were full.
- We saw evidence of patient activities and access to leave and that there was sufficient staff to facilitate this.
- There were sufficient doctors to meet the needs of the patients, including an on-call system for out of hours.
- The hospital trained their staff in the use of physical intervention. This emphasised that physical intervention should only be used as a last resort. The training was 'protecting rights in a caring environment', abbreviated to PRICE. 100% of PICU staff and eighty-three per cent of staff across the hospital site had received this training and rotas ensured there were adequately trained staff on the ward. On the day of inspection, not all PICU staff on shift were trained.
- Training did not include the use of prone restraint as part of their emphasis on least restrictive practice. There was no evidence of prone restraint having been used. The hospital had dedicated staff to ensure staff received the appropriate training and knowledge. New staff were mentored for the first six months following PRICE training which included three formal reviews.
- The hospital monitored all mandatory training. This was logged centrally across the site. Training compliance overall was above the 85% target set by the hospital.
- The hospital provided figures that showed basic life support training compliance was 79% which did not meet the hospital's compliance target of 85%. However, during inspection, we saw that further training had recently been undertaken and we were satisfied this deficit had been addressed.

Assessing and managing risk to patients and staff

- Risk assessments were not always updated when a patient was admitted to the PICU ward. There were gaps with all three records we reviewed.
- We saw evidence of information received prior to admission regarding patient risk. All three patients had a risk screen on admission, although this information was not located in the same place so not easy to find. In one record, not all the information from the previous provider was captured and discussed at the multidisciplinary meeting.
- The weekly multidisciplinary meeting carried out a review of current clinical risks. This included a review of any incidents that may have occurred the preceding week. Changes to care would be made according to need. However, incidents were not added to the risk assessment when incidents occurred. We were concerned that as staff from other wards worked across the hospital, they would not always be familiar with current risks.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- There was evidence of care planning to support the patient during times of distress who required the use of medication or physical intervention.
- Improvements were needed to the patient records filing system to enable staff to find and review information easily. We were concerned as staff from other wards worked across the hospital meaning they were not always familiar with the patients' risks.
- We saw that patients had personal evacuation plans developed for use in case of emergencies.
- The hospital had an observation policy and we saw staff recorded when observations were carried out. We saw evidence of discussion of patient observation levels during handover, in morning meetings and during multidisciplinary meetings. However, there was a lack of detail of this discussion written in the patients' continuous notes, to reflect that observations were being reviewed daily.
- The observation sheets used by staff did not identify the risk the patients posed. This meant that staff may not know all the risks of the patient.
- We did not see evidence of blanket restrictions.
- There were no informal patients at the time of inspection as the acute wards were empty.
- Information received from the provider told us there had been two incidents of use of seclusion since patients were first admitted in June 2018. At inspection, we saw evidence of a third occasion. However, this had been implemented appropriately and records documented the support offered to the patient. Where seclusion was used, it was for less than an hour and it had not been added to the log sheet by a member of staff. The failure was a staff member not adding it to the log sheet, not in its application. The two other incident records had not been signed, where a review by the ward manager or clinical director was required.
- The seclusion room did not meet all the specifications recommended in the Mental Health Act code of practice. There was no clock visible for the patient to orientate to time of day and staff could not tell us if there was one available. There was a blind spot in the toilet area which had not been mitigated against. The metal casing around the door frames had sharp edges. However, the temperature of the room could be regulated and there was two-way communication and a suitable mattress for use. The room was clean.
- The nurse had to swipe her card four times to release the seclusion room door. Not all staff were aware that only registered nurses could open the seclusion room. There was a concern this would cause a delay in responding in an emergency, putting the patient at risk.
- Between 12 June 2018 and 31 October 2018 there were 71 recorded incidents of restraint on two patients. There was no use of prone restraint.
- Staff only used physical intervention techniques as a last resort and there was a culture within the hospital that staff tried all other de-escalation techniques prior to using this intervention. Where it was necessary, these incidents were reported and staff and patients held a debrief. There was a lead staff member who reviewed restraints to determine any learning.
- Prior to inspection, the hospital reported there had not been an audit of rapid tranquilisation, although, during inspection we saw that there was some review of this. We noted that staff were not consistently attempting to carry out physical observations following administration of rapid tranquilisation. The hospital had already recognised this, although it was not clear what the plan was to improve in this area.
- The hospital had a designated safeguarding lead. There were systems in place and there had been engagement with the local Norfolk safeguarding board who told us they were satisfied with the processes in place to report any concerns. There had been three referrals to the safeguarding board.
- One hundred per cent of staff had undertaken safeguarding adult training and those staff asked, understood what constituted abuse and how to report it.
- Staff followed good practice in medicines management following national guidance in the transportation, storage, administration and disposal of medication. There was a weekly medicines audit carried out and any issues identified were addressed. There was a monthly medication management committee in place, headed chaired by the medical director.

Track record on safety

There were no serious incident reports between 12 June 2018 and 28 November 2018.

Reporting incidents and learning from when things go wrong

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- Staff knew what incidents to report and how to report them. We reviewed incident reports and we could cross reference these to care records in most cases. However, staff did not always record the incident number in the care records when describing the incident and did not consistently document within the clinical records that they had raised an incident report. The hospital advised there was no guidance for this. Therefore, there was no system in place to confirm that an incident report had been raised within the clinical records.
- Staff understood the duty of candour. They were open and transparent, and would give patients explanations when things went wrong. There were no significant incidents recorded.
- There was some evidence of review of incidents at the monthly clinical governance team meetings and on a regular basis in the morning meetings. However, the minutes of these meetings lacked detail. It was unclear what action took place and how staff got to know about it and what they needed to do. However, there had not been any serious incidents since the hospital opened in June 2018. We saw that conversations did happen, but were not adequately captured.
- All staff and the patient spoken with confirmed that there had been a debrief following any incidents. The patient was enthusiastic about this happening.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We saw evidence that staff completed a mental health assessment prior to and after admission.
- A weekly multidisciplinary team meeting was held with the patient. Staff involved included ward nurses, an occupational therapist, doctors, the physical health nurse, consultant psychiatrist and clinical psychologist as appropriate. Staff at the meeting reviewed the patients progress, incidents from the previous week, medication and other treatment plans, physical health care, enhanced observations, issues related to the Mental Health Act and the patient views were documented and discussed as an integral part of the process. This information was well documented and covered some elements expected to be seen in a care plan.
- The patients did not receive a copy of their care plan and had no means to review the information discussed at the multidisciplinary meeting. We raised this concern with the hospital who assured the inspection team that this omission would be addressed. Within the patient records there were some care plans specific to a need – such as violence and aggression or self-harm. However, the care plans did not demonstrate all needs were personalised, holistic and recovery oriented and the patient was not routinely offered a copy. The national institute for clinical excellence (NICE) guidance quality standard 14/18 says 'people using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it'. The hospital staff failed to meet this standard.

Best practice in treatment and care

- The hospital employed a nurse who was dedicated to ensuring the physical health needs of the patients were met. The nurse had developed systems to ensure information was captured on admission and that identified actions were carried out. We saw specific care plans were written aimed at supporting the person to meet their physical health needs. This ranged from diabetes management to supporting a patient with injuries from acts of self-harm but a copy was not offered to the patient. There was evidence of the beginnings of health promotion and information was displayed on a notice board, and was refreshed monthly. Both patients and staff benefited from this information. Staff received training on induction to cover elements of physical health care and the nurse was available on-site to respond to queries.
- Clinical audit was beginning to be used within the hospital. This was in its early stages as the hospital had been open for five months at the time of inspection. Further work to embed this was needed.

Skilled staff to deliver care

- The hospital had access to a range of specialists required to meet the needs of the patients. This included doctors, nurses from all disciplines, occupational therapists, a clinical psychologist, and

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

consultant psychiatrist. The physical health nurse was responsible for ensuring that referrals would be arranged for additional services such as speech and language therapist and physiotherapist.
- The hospital employed a clinical psychologist for 30 hours a week. The role was still in development as there were difficulties in carrying through work when it was not known how long a patient would be in the hospital. Patients may be recalled closer to home at any time and this was not in the hospitals control. The clinical psychologist also provided reflective practice sessions to staff to help with their knowledge, development and learning. Appropriate supervision arrangements were in place as required for someone with this role.
- The hospital managers provided new staff with appropriate induction which met the care certificate standards requirements for healthcare assistants.
- Staff received supervision every two months. Information provided to us from the hospital indicated that supervision levels were 53% on the PICU at the time of submission. We found that this had significantly improved by the time of the inspection and that compliance was above the 85% target set by the hospital. Monitoring of this was undertaken by the hospital management team. In addition to supervision, staff also had access to reflective practice monthly which was led by the clinical psychologist.
- No staff had received an appraisal as the hospital had not been open for 12 months. We saw evidence of an appraisal system in place ready for completion.
- We saw staff received specialist training to carry out their role effectively. This included drug and alcohol, suicide, ligature and self-harm awareness, relational security and other courses relating to medication and physical health.

Multi-disciplinary and inter-agency team work

- Staff held regular and effective multidisciplinary meetings with patients at the centre of all discussions.
- We observed one ward handover. Information was shared with the team, however, there did not appear to be a system to ensure all information was captured in a timely and systematic way.
- We saw that some relationships were forming with external bodies such as the safeguarding board.
- A GP had recently begun to visit the hospital on a weekly basis with arrangements in place for patients to be seen outside of this time.

Adherence to the MHA and the MHA Code of Practice

- Eighty-six per cent of staff were trained in the Mental Health Act. Staff demonstrated knowledge of the Mental Health Act, the code of practice and guiding principles.
- The hospital employed a dedicated Mental Health Act administrator who was involved with and had knowledge of all detained patients. Legal papers were scrutinised and when an error was detected this was acted upon.
- An independent mental health advocate attended the hospital upon request and staff knew how to request this. However, there were no leaflets or posters on display on the PICU ward advising patients of the role of the independent mental health advocate.
- Staff explained to patients about their rights as a detained patient. However, we saw that one patient had not understood their rights. The rights were re-read weekly for three weeks and the patient continued not to understand their rights. A referral to the independent mental health advocate had not been made. We raised this with the hospital and action was taken immediately to address this.
- Section 17 leave was available and happened as planned.
- Patients did not have a leave care plan and the section 17 form was not shared with the patient. This meant the patient would have to ask staff about their leave arrangements and had nothing to refer to.
- We saw evidence of regular audit of paperwork and scrutiny from the Mental Health Act administrator. However, this did not identify all errors as outlined above in this section of the report.

Good practice in applying the MCA

- Ninety per cent of staff had completed training in the Mental Capacity Act 2005 and deprivation of Liberty safeguards.
- There had been no applications made for deprivation of liberty since the hospital admitted their first patients in June 2018.
- We saw that patients' capacity was assessed and documented appropriately.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

Good

Kindness, dignity, respect and support

- Staff attitude and behaviour towards the patients was kind and compassionate. We observed on PICU discussions with and about the patients which were patient centred and responsive to the patients' needs. We saw emotional support and advice was given.
- One patient spoken with, told us that this was the best place they had ever been to and that the staff really cared. Patients felt listened to and were confident they could approach any of the staff and receive support.
- There was a lack of evidence in patient records and care plans about meeting the cultural and social needs of the patients, although staff talked about meeting the cultural and social needs of the patients. There was a multi-faith room on site to facilitate religious needs also.
- Patients said the staff treated them appropriately.

The involvement of people in the care they receive

.

- Staff showed us admission information and demonstrated the processes in place to admit and orientate a patient to the wards. One patient on PICU told that they were shown around when she felt well enough.
- The multidisciplinary meeting minutes reflected that patients were involved with the planning of their care and their views were documented. A patient explained that they were listened to at the meeting. The patient told us they didn't have a care plan and had never been offered one.
- There was evidence of patients' community meetings in all wards, known locally as 'people's meetings'. These were held to enable patients to discuss ward issues, plans for the day and anything else they wanted to discuss. This included the wider staff team, including the housekeeper and chef as appropriate.
- The occupational therapists completed a form with the patient to help identify their interests and hobbies which couldcan then be supported when possible.
- During inspection, we saw, on PICU, a meeting was held with clinicians, a patient and a family member. The family member declined the opportunity to speak with an inspector.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- There have been 53 admissions and 50 discharges since the hospital opened in June 2018. At the time of inspection there were no beds in use on the acute ward. There were 24 acute beds available and five PICU beds. Three PICU beds were in use. The acute wards were empty.
- The hospital discouraged admission and discharge at night, however, the hospital responded to the commissioners needs and there were occasions this had been required to happen.
- The patients were admitted from anywhere in the country. Patients may be recalled closer to home at any time which may disrupt patient care, however, this was not in the hospitals control.
- There was one delayed discharge from the PICU. This was not in the hospitals control as it was due to the commissioner not having a bed available for the patient to return to.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms with ensuite facilities on both PICU and acute wards.
- There was secure space away from the bedroom for patients to put their belongings.
- There were sitting rooms and an activity room within the PICU and acute wards for patients to relax or carry out activities.
- There was a small clinic room for medication and other medical equipment to be stored. However, there was no facility for a patient to have a physical examination if required within the PICU.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- There was a room where visitors could see their relatives.
- There was access to outdoor space. The hospital did not operate a smoke free environment so patients could smoke outside. There was not a suitable area of the garden for non-smokers within PICU.
- Patients could access the onsite gym when risk assessed to do so. This was a large area that facilitated a range of physical activities. The hospital also commissioned a sports therapist to run a session weekly.
- Patients could make a phone call in private when risk assessed to be safe to do so.
- There was a beverage bay located just outside the ward on PICU. Only patients with Section 17 leave could utilise this. There was no facility for the patients on the ward to access fluids without approaching staff. There was access to drinks at all times on the acute wards.

Patients engagement with the wider community

- We saw patients with leave enjoyed access to the local community. This included trips to the local beach, shops and amenities.
- The hospital engaged with local groups and promoted the hospital locally with the aim of establishing warm relationships.

Meeting the needs of all people who use the service

- The hospital could make adjustments for disabled patients.
- Information was displayed on how to complain, and there was also some information regarding access to advocacy and patient rights. We did not see any information on mental health conditions and treatments.
- In the reception area, there was information regarding the local area and events displayed.
- Patients could help in the preparation of meals and snacks.
- There was a chef employed by the hospital who offered a wide and varied menu. The chef attended community meetings and responded to patient requests. Hot meals were offered daily, and could be adapted to meet the cultural, spiritual and religious needs of patients. Healthy options were offered and there were many compliments about the quality of the food. The physical health nurse worked with the chef when there was a dietary need relating to a patients' physical health.
- There was a multi-faith room and access to spiritual support.
- All staff received equality, diversity and human rights (EDHR) training.

Listening to and learning from concerns and complaints

- There was a system for reporting complaints or to raise concerns. Patients also felt able to do so.
- There was one formal complaint since the hospital first admitted patients in June 2018. This was investigated appropriately and resolved.
- Staff understood the complaint process and how to respond.
- We saw over 50 compliments about the service (both adult and acute wards) from former patients and their relatives. We also saw compliments from a care coordinator regarding the care the hospital provided. The comments were highly complementary.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- Staff could describe fundamental core values that described their commitment to providing person centred care. However, staff did not know the vision of the organisation. We received a variety of suggestions as to what it was.
- Southern Hill had been accepting patients for five months at the time of inspection. New ways of working were still being developed. Staff had a range of knowledge gained prior to joining the hospital. Managers were endeavouring to use this knowledge whilst creating a new culture to reflect their vision and values.
- Staff spoken with felt respected, supported and valued. They were proud to work at Southern Hill hospital.
- Staff spoken with felt able to raise concerns without fear of retribution and were aware of the whistleblowing process.

Acute wards for adults of working age and psychiatric intensive care units

Requires improvement

- Supervision arrangements improved each month and the latest statistics showed compliance of 100% across all wards.

Governance

- The hospital had a governance structure which demonstrated key roles, accountability and responsibility.
- There was a recruitment and retention process in place to attract staff to work within the hospital. Managers knew the key challenges - such as the rural location - and were working to recruit appropriately skilled staff. There were sufficient staff to meet the current demand due to the acute wards being empty. Further recruitment was planned for when the service was full.
- HR processes ensured that there were appropriate background checks undertaken of staff including checking the disclosure and barring system and right to work.
- Incidents were reviewed every day at the morning meeting. This included a review of individual patients, initial discussion of incidents in the previous 24 hrs and a review of patient observations. This information was not always transferred into individual clinical records. For instance, the hospital could not evidence that patients enhanced observations were reviewed daily within individual records, and this process did not include the patient voice.
- We saw a programme of audit in place and discussion held based on findings. These were discussed at clinical governance meetings.
- The actions from clinical governance meetings were not clearly evidenced as discussed at local team meetings, however, the hospital told us of the use of other methods to inform of actions such as handovers and ward diaries.
- Staff, including ward managers, were not aware of any key performance indicators that the hospital measured.
- The hospital managers responded immediately to concerns raised during inspection and developed plans to address those concerns.

Management of risk, issues and performance

- Frontline staff were unaware of the presence of a risk register, how issues could be added to it or what the key risks to the organisation were.
- Managers had written a business continuity plan. Most of the staff spoken with were not aware of this. One staff member said there were enough supplies on site to last two weeks. Staff were unaware of contingencies for loss of utilities such as water or electricity but believed there would be a plan.
- We saw a fire risk assessment was in place and actions identified to manage risks. There were named fire marshals on site and staff knew what to do in the event of a fire.
- The hospital did not have a clear process for ensuring the security of the PICU. Detail of which can be found in the safe domain. The hospital needed to formalise security arrangements and we raised this during inspection. The hospital assured us they would look into this concern.
- There had been an information management concern raised. Most of the clinical information was paper based. However, care plans were typed. The hospital reported an incident were a patient record could be overwritten and the previous version lost. Managers recognised this and spoke to the individual staff concerned, however there was no evidence of action being taken to prevent this occurring in the future. We raised this issue during inspection with the registered manager who agreed to address the concern.

Engagement

- The hospital captured patient views and ensured these were used for learning.
- There was a significant number of compliments logged and personal letters of thanks from patients to the teams.
- Staff attended team meetings monthly. The format of these meetings was regularly reviewed.

Learning, continuous improvement and innovation

- Staff were given the opportunity to access training and development. Ideas for improvement were listened to and discussed within the clinical governance framework.
- The hospital confirmed it planned to pursue accreditation schemes once the hospital had been open for a sufficient period.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are effective systems for ensuring the safety and security of the PICU ward.
- The provider must ensure the seclusion room is fit for purpose.
- The provider must ensure that patients have a care plan and are offered a copy.
- The provider must ensure that risk assessments are reviewed and all risks captured upon admission and following incidents.
- The provider must ensure that the enhanced observation sheets identify all risks.
- The provider must ensure that alarms can be heard by all staff to ensure a timely response to an emergency.

Action the provider SHOULD take to improve

- The provider should ensure there is an effective system where alarms can be heard by all wards to ensure there is an effective response to an incident.
- The provider should ensure that the patient is involved in the daily review of enhanced observations.
- The provider should ensure that patients can access drinks freely within the PICU.
- The provider should ensure that all electronic records are secure and cannot be overwritten in error.
- The provider should ensure staff know the organisations vision and values.

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 Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Person Centred Care • The provider had not ensured the patient had a clear care plan which included agreed goals, a review date and the patients voice in a way the patient understands This was a breach of regulation 9

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Regulation 12 (Regulated Activities) Regulations 2010 Safe care and treatment • The provider had not ensured that the seclusion room met the MHA code of practice. • The provider had not ensured that all risks were captured on admission and that incidents were documented within the risk assessment in a timely manner.

This section is primarily information for the provider

Requirement notices

- The provider had not ensured that the enhanced observation of patients' documentation recorded all relevant information.
- The provider had not ensured staff understood and adhered to control measures to ensure the environment was safe at all times.

This was a breach of Regulation 12