Coveberry Limited

Uplands Independent Hospital

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

Uplands Independent Hospital provides long stay and rehabilitation mental health service to people aged over 18.

Our rating of this location went down. We rated it as inadequate because:

The Care Quality Commission conducted an unannounced inspection of Uplands Independent Hospital on 11 -12 January 2022 following a number of concerns, being brought to our attention by staff at the hospital and from information that we had gathered during our routine monitoring of the hospital, about the safety and quality of care being provided.

Following the inspection, we sent the provider a Section 31 Letter of Intent (which requires the provider to give us assurance that it will make immediate improvements) as we found that significant improvement was needed to ensure patients received safe care. It requires the provider to give us assurance that it will make immediate improvements. Although the provider sent us an action plan describing the improvements it intended to make, we were not assured that urgent improvements would be made in a timely manner, so we served the provider with a Warning Notice.

The Warning Notice required the provider to make immediate improvements to ensure it met the legal requirements set out in the Health and Social Care Act:

In order to meet those requirements, the provider must:

Ensure robust risk assessments are completed that clearly identify how risks will be minimised; ensure care plans are person centred and clearly identify patient's needs; ensure there is a focus on delivering recovery focused rehabilitation so that patients are supported to live independent lives and to prevent excessively long lengths of stay; ensure appropriate and timely physical health care for all patients, particularly for those with identified physical health problems. This includes ensuring medicines are administered as required, that there is a focus on monitoring patients who are on high doses of antipsychotic medicines and that medicines are stored and managed appropriately. The provider must ensure that environment and equipment is safe, clean and fit for purpose. In addition, the provider must ensure that there are enough, suitably qualified and competent staff on duty at all time and implement robust governance arrangements to ensure it is able to monitor incidents, the quality of care provided and make improvements in a timely manner.

As a result of our serious concerns about this service CQC's Chief Inspector of Hospitals has placed this service in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration. The service will be kept under review and, if needed, could be escalated to urgent enforcement action, including that described, at any time.

During the inspection we found:

Summary of findings

Wards were not clean, and staff did not understand their responsibilities in respect of infection control. Cleaning schedules had not been completed and wards were not being cleaned regularly. On the high dependency unit (HDU) there was a strong unpleasant smell. Electrical items had not been tested for safety.

The hospital did not have suitably qualified, skilled and experienced staff to deliver person-centred and recovery focused care safely to patients. The culture within the service was not focused on providing rehabilitation and recovery focused care to the patients.

Risk assessments were not robust and did not identify all the risks for patients and had not been robustly reviewed. This meant staff did not have a full understanding of how they might protect patients from avoidable harm. Staff had failed to plan care according to the individual needs of the patients and some staff were unaware of the risks for patients. This meant that patients did not always receive the best support from staff to meet their individual care needs.

There was little evidence of a rehabilitation and recovery model of care being implemented at the hospital. Patients said there were a lack of suitable things to do and we did not see any activities to help patients learn new skills to help them move on and live more independently. The culture of the hospital was not one that moved patients towards discharge and the staff culture was more like that of a care home that would be classed as a person's home for life.

The lack of focus on rehabilitation had led to significant lengths of stay for some patients. For example, the average length of stay for patients was about five years, which was significantly longer than you would expect in the setting. Senior managers confirmed that the service was not recovery-focused; they were unclear what a rehabilitation and recovery model should look like.

We reviewed four patient records on the complex care unit (CCU) and three on the high dependency unit (HDU). Physical health plans lacked detail so staff were unsure what they needed to do to monitor patient's physical health care and meet their needs. For example, staff could not demonstrate that they had completed physical health checks such as lithium bloods or heart tracing electrocardiograms (ECGs) for patients who required these.

Staff had not considered the impact of the medicines on patients' physical health and had not initiated high dose antipsychotic monitoring for patients. They were unsure of who was on a high dose of antipsychotics and as such were not taking steps to protect patients from avoidable harm.

Care plans were generally not recovery focused and did not detail how staff were to support patients with regaining the skills and confidence to live successfully in the community. For example, independent living skills such as cooking and budgeting. Care records lacked information about how the hospital was working with other agencies to support recovery and social inclusion in the community

None of the care plans that we reviewed had a discharge plan and there was no evidence of discussion with patients around their discharge. Some patients said that they were not included in planning their care. This meant patients were delayed from moving on from the hospital to an appropriate placement.

Although positive behaviour support (PBS) plans were in place for two patients (out of four records we reviewed) not all staff had received training in how to use the plans and staff were not following the plans

Staff did not always manage medicines effectively and safely. In the HDU clinic room there were several out of date medicines. Some medicine charts were not fully completed with reasons for missed doses of medicines.

Summary of findings

Patients we spoke with said they did not always feel safe at the hospital and some staff were not responsive to their needs. Some patients said some staff did not always speak kindly to them and this impacted on their mental health. Some patients said staff did not always listen to their concerns and they did not always feel staff were acting in their best interests.

There senior leadership at the hospital did not have robust governance arrangements in place to monitor the safety of care and ensure any necessary improvements to protect patients from avoidable harm were made in a timely manner.

There was insufficient oversight to ensure incidents were appropriately reported and staff said there were problems with the current reporting process. This meant there was a risk some incidents were not being reported and investigated appropriately.

Staff acknowledged arrangements were not in place to regularly review care records, as such out of date care plans and risk assessments were not picked up. Senior managers at the hospital told us they were unclear who had written care plans and risk assessments and were not assured these were updated following decisions and discussions at multidisciplinary team meetings (MDT).

There were some blanket restrictions in place including staff keeping all patients smoking/vaping materials on HDU and limiting times when patients could smoke or vape.

Senior managers did not have a system to review staffing to ensure they had the right staff with the right skills to meet the needs of patients on all shifts.

However:

Many of the issues within the hospital had already been identified by the hospital director. The hospital director had developed a site improvement plan which detailed how they intended to make improvements at the hospital. The site improvement plan was an active document that helped the team focus on required improvements essential to patient care.

Staff spoke fondly about patients and said they had built good relationships with them over a period of time.

Patients had some access to psychological therapies and occupational therapy. The psychologist and occupational therapist had met with all patients on the ward and there was a psychology assistant who helped provide therapies identified by the psychologist including acceptance commitment therapy (ACT) and dialectical behavioural therapy (DBT).

The therapy team were keen to implement training for all staff about relevant issues including positive behaviour support (PBS) plans.

The service had access to a range of specialists to help meet the needs of the patients on the ward. A number of new staff were being recruited at the time of inspection.

Staff mitigated risks in the environment by use of mirrors and observations and were aware of ligature risk points.

Care records were kept securely. Staff had access to the care records and made daily notes about patients.

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	Inadequate 	

Summary of findings

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Summary of this inspection

Background to Uplands Independent Hospital

Uplands Independent Hospital provides care and treatment to people aged over 18 who may be informal or detained under the Mental Health Act 1983. It offers assessment, treatment and continuing care for up to 30 people. At the time of the inspection there were 19 inpatients; 17 were detained under the Mental Health Act and two were informal. The hospital provides treatment for patients who require long stay and rehabilitation services. The hospital takes referrals from acute and low secure inpatient wards.

Uplands Independent Hospital is registered to provide the following regulated activities:

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

• Diagnostic and screening procedures.

• Treatment of disease, disorder or injury.

Uplands Independent Hospital is based in a historic manor house on the outskirts of Fareham. It is set within its own grounds. When originally established, the service was set up to provide for patients who had long term mental health issues and was considered a placement for life.

As national guidance and best practice for patients with a long-term mental illness changed to encompass a recovery focus to support patients to live more independently in the community the hospital began to accept patients with more complex mental health issues.

However, the model of care has not yet changed as would be expected.

The hospital director and manager is in place but is not yet registered with the CQC.

The service was last inspected in December 2018.

What people who use the service say

We spoke with four patients on the Complex Care Unit.

Three out of four said they did not feel safe on the ward and had experienced problems with staff. For example, staff not responding to their requests in a timely way and providing no explanation when they failed to respond.

Some patients described how they felt when staff did not speak kindly to them. This had caused patients distress and negatively impacted their mental health.

Some patients said staff did not take them seriously or listen to their concerns. This had the impact of patients not always feeling able to approach staff with any concerns or to make a complaint.

Some patients described negative incidents over a period and the impact this had on their mental health.

Summary of this inspection

Some patients did not feel confident that staff were always acting in their best interests.

Some patients did not feel involved in their care planning and none we spoke with had been involved in recovery goals or discharge planning process. This meant patients views were not heard and they were not moving on in their own recovery, leading to lengthy stays at the hospital.

Some patients said they were bored and there was a lack of suitable activities on the wards.

How we carried out this inspection

During the inspection:

- We spoke with four patients.
- We interviewed 13 members of staff. This included the hospital director, clinical nurse manager and three bank and agency RMNs.
- We spoke with the following staff:
- Speciality doctor, occupational therapist (OT) and psychologist
- One team leader, one recovery support worker (RSW), one kitchen assistant.
- One OT assistant, one activities coordinator

We reviewed the following documents

- Seven patient care records and 11 medicine charts
- Handover notes for eight patients on CCU
- Cleaning schedule for CCU ward
- In CCU we reviewed the S132 Rights folder and the physical health monitoring folder
- We reviewed the infection control policy
- We attended two handover meetings

The inspection team comprised of one inspection manager, one lead inspector, one team inspector, one specialist adviser nurse, one pharmacist and one expert by experience.

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

Areas for improvement

- The provider must ensure that staff develop person–centred, holistic, recovery-oriented care plans, that patients are involved in their development and that they are informed by a comprehensive assessment of individual patient's needs. Regulation 9 (1)
- The provider must ensure medicines are managed safely and effectively. Regulation 12(1) 12(3)
- The service must ensure the staff providing care and treatment have the qualifications, competence, skills and experience to do so safely and that there are enough staff on each shift to meet patients' needs. Regulation 12 (c)
- The provider must ensure the hospital is cleaned to maintain standards in accordance with infection prevention and control guidance. Regulation 12(1) 12(3)
- The provider must ensure that equipment is safe, clean, maintained and stored appropriately. Regulation 15(1)

Summary of this inspection

- The provider must ensure robust risk assessments are completed and regularly reviewed to mitigate risks. Regulation 12
- The provider must ensure the physical health of patients is assessed and monitored effectively. Regulation 12(2)
- The provider must ensure patients on high dose antipsychotic therapy (HDAT) have their physical health monitored appropriately. Regulation 12(2)
- The provider must ensure that robust governance processes are put in place to provide effective oversight of risks and that timely action is taken to minimise risks and to monitor the quality of care delivered at the hospital. Regulation 17(1) 17(3)
- The provider must ensure patients are treated with compassion and respect. Regulation 10
- The provider must ensure staff complete mandatory training and receive regular supervision. Regulation 18(1)
- The provider must ensure Mental Health Act 1983 T2 and T3 forms are up to date and a process is in place to monitor this. Regulation 9 (3) (c)
- The provider must ensure Mental Health Act 1983 S132 rights are explained to patients regularly and a process is in place to monitor this. Regulation 9 (3)(c)
- The provider must ensure a recovery focused rehabilitation model is developed to support patients in their pathway to discharge. Regulation 9

Action the provider SHOULD take to improve

- The provider should ensure they provide a range of activities and interventions suitable to the needs of patients cared for in a mental health rehabilitation service and in line with national best practice guidance.
- The provider should ensure the women's lounge in HDU is open and accessible to female patients.
- The provider should ensure staff are competent and confident in making safeguarding referrals.
- The provider should ensure there are no unnecessary blanket restrictions put in place and those that are in place should be reviewed regularly.

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	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Inadequate
Caring	Inadequate
Responsive	Inadequate
Well-led	Inadequate

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

Inadequate

Our rating of safe went down. We rated it as inadequate

Wards were not always safe, clean well equipped, well furnished, well maintained or fit for purpose.

Safety of the ward layout

The layout of the ward did not enable staff to observe patients in all areas. Uplands Independent Hospital was set within an old listed manor house, as a result there were some blind spots and narrow corridors. Where there were blind spots the ward used mirrors to mitigate this.

Senior managers had conducted a ligature assessment to review the hospital for potential ligature risks. A ligature point is a fixed point that someone could use to hang material off for the purpose of self-strangulation or hanging. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe by use of mirrors and staff observation.

Staff had access to alarms and patients had access to nurse call systems. However, some of these in the High Dependency Unit (HDU) bedrooms were missing from the walls. We asked the senior managers about this and they assured us they would be replaced before the bedrooms were used again.

Maintenance, cleanliness and infection control

Ward areas were not clean, well maintained, well-furnished or fit for purpose.

Wards were not clean, well maintained or fit for purpose and staff did not practice good infection, prevention and control.

We toured both wards and found that furniture and bathrooms were dirty and had not been cleaned.

On the High Dependency Unit (HDU) there was a strong unpleasant smell and the ward was generally not cleaned well. Staff told us that they were aware of the problem and they would ensure cleaning was completed.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

On the HDU we found surfaces were not clean, the patient call bell had a thick layer of dust on it and there were flies around the bin. The blood pressure machine (sphygmomanometer) and weighing scales were in the kitchen. There was also out of date food kept in the fridges including cheese that was more than one month past its expiry date.

On the HDU we found that four unused bedrooms had not been cleaned after patient discharge. Although they were unused at the time of inspection, they included broken furniture, dirty clothes from previous patients, marked walls and unclean drains and toilets.

The female only lounge on the HDU was locked and full of patient belongings and was not able to be used by patients.

Cleaning records were not up-to-date, and leaders had no oversight of infection, prevention and control of the environment.

Staff had not followed infection control policy. For example, in HDU there were open topped bins containing used dirty PPE materials including aprons and masks. The infection, prevention and control practices were not adequate to ensure patients were kept safe from the spread of infection This was escalated to senior managers on first day of inspection and changes were implemented immediately and bins replaced.

We reviewed the cleaning schedule for 13 rooms in the complex care unit (CCU). There was no record of cleaning in eight bedrooms. There was no record of when bed sheets were changed. Cleaning schedules did not show how the leaders monitored the cleanliness of the environment. Night staff duties included cleaning the communal areas and the kitchen. There was a template dated January 2022 and signed to say tasks had been completed. However, we saw the kitchens were still dirty despite night staff cleaning them. Staff we spoke with highlighted that cleaning was an ongoing issue within the service. Senior managers said recruitment of housekeeping staff was taking place.

The provider had not ensured all electrical appliances had been tested for their safety (PAT testing). As a result, staff could not be assured that all electrical items within the service were safe to use.

Inspection staff raised concerns around the cleanliness with the Hospital Director on the day of the inspection and some immediate remedial action was taken including cleaning on the HDU and in bedrooms.

Clinic room and equipment

Whilst clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly we found that oxygen masks were tangled up together on HDU and stored at the back of a cupboard with lots of clutter.

Both clinic rooms were cluttered, unclean and untidy. There were out of date medicines in the High Dependency Unit (HDU) clinic room. These included Clozapine in the drug trolley, Frusemide and Risperidone which were past their expiry dates. This was escalated to senior managers who assured us it would be removed.

There was an accumulation of some medicines in both clinic rooms. For example, there were several bottles of Sodium Valproate. This was a risk because of multiple expiry dates on medicine and need for stock monitoring by staff.

There were out of date items in the first aid box. For example, a mask and sodium chloride for cleaning wounds.

Staff had not checked, maintained, and cleaned some equipment. There was no information recorded about calibration or maintenance of medical equipment.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe staffing

The service did not always have enough nursing staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had significant issues recruiting registered nurses. There were two part time substantive nurses employed at the hospital and over seven FTE trained nurse vacancies. These vacancies were being filled by agency and bank nurses. During the inspection period the registered mental nurses (RMNs) on duty were agency and bank nurses. For example, on 11 January HDU were short staffed due to staff sickness and an agency nurse not showing up for their shift. However, the recent recruitment of recovery support workers (RSW) had been effective.

The staffing levels were set at one RMN and three recovery support workers (RSW) on each ward each shift. There was no process in place for checking shift fill rates and the leadership team were unable to check if staff had turned up for shifts or not. Staff said they often worked on shifts that were below staffing numbers required and that there was total acceptance that shifts were short. On several occasions, the hospital director and clinical nurse manager had to cover as there was no RMN on a night shift. The contingency plan was for one RMN to cover both wards if they were not able to staff with two RMNs. Staff told us this had happened regularly, however, the managers were not able to easily review staffing to identify how much of a problem this was.

Medical staff

Across the two wards a speciality junior doctor worked two days per week and a consultant psychiatrist worked two days per week.

All patients were registered with a local GP practice. The local GP practice had a contractual agreement to provide all physical healthcare and monitoring for patients.

A district nurse attended the service weekly to take patients' blood tests when needed.

Mandatory training

We reviewed the staff training matrix and found not all staff had completed their mandatory training to ensure they had the skills to carry out their roles to meet the needs of patients.

There were considerable gaps in the completion rates for mandatory training across a range of required training.

We found variations in the staff compliance with mandatory training. We found more staff had complete Fire Safety at Work training and infection control training. However, safeguarding adults training numbers were low and only 58% of staff had completed Mental Capacity Act training. There were low numbers of completion with only 50% of staff having completed Emergency First aid and basic life support and only 20% had completed face to face conflict management and use of restraint training.

The mandatory training programme was not comprehensive and did not adequately prepare staff to provide the care required by the patients. For example, staff had not completed training on developing or implementing positive behaviour support (PBS) plans for patients although these were in place for some patients. However, there was a plan in place to provide specialist training to the staff and to 're-induct' all staff to ensure that they had the training to provide the right care.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Assessing and managing risk to patients and staff

Staff did not always assess and manage risks to patients and themselves well.

Assessment of patient risk

Risks to patients were not always fully identified and staff were not responding to changing risks. Staff did not complete risk assessments for each patient on admission and did not review this regularly, including after any incident. For example, recent patient on patient assaults where risks had not been reviewed to include de-escalation techniques or to identify warning signs enabling staff to manage distressed and challenging behaviours.

Management of patient risk

Staff did not always know about any risks to each patient and acted to prevent or reduce risks and physical health risk assessments were not completed for some patients with health problems.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. This included the latest information about risks discussed at MDT not being shared in a timely way with staff. Staff told us that new risk information identified in the MDT was not always translated into a change in patient care.

Use of restrictive interventions

There were some blanket restrictions in place including staff keeping all patients smoking/vaping materials on HDU and limiting smoking times. The staff said it was to help people manage their quantity of cigarettes. However, staff had not assessed patient's ability to manage their own cigarettes. This meant patients were not given a choice of their preference.

Safeguarding

The provider had training available for staff on how to recognise and report abuse. However, only 61% of staff had completed safeguarding training. The service was in discussion with local commissioners about reporting incidents, including safeguarding and there was a conversation about thresholds for reporting incidents formally.

Staff could not give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics.

Staff did not know how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff did not know how to make a safeguarding referral and who to inform if they had concerns.

Staff access to essential information

Care records were in paper format and kept securely. Staff had access to the care records and made daily notes about patients. However, information from multi-disciplinary team (MDT) meetings was not always shared in patients care records. The document produced at MDT meetings was not embedded into patients notes or care plans.

Whilst staff had access to clinical information about patients, we found that there were significant inconsistencies and contradictions in the information recorded. For example, one patient's care records had contradictory comments made about their road safety.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Care plans were inconsistent with each other and with other associated care plans. Care notes for one patient stated that the patient accepted their prescribed medication. However, the patient's treatment charts and comments made by their consultant psychiatrist stated that they were non-compliant with their medication.

Medicines management

The service did not use systems and processes to safely prescribe, administer, record and store medicines. Staff did not regularly review the effects of medications on each patient's mental and physical health.

Staff did not always follow systems and processes to prescribe and administer medicines safely. We found medicines that were opened had date labels on that had not been filled in and it was unclear how old that medicine was. Additionally, a bottle of liquid Diazepam that was opened on 29 September 2021 had been dated to expire 28 October 2021 was still in use, but staff had not noticed the disposal date had long since expired.

Staff did not always complete medicines records accurately and keep them up to date. We reviewed 11 medicines charts and, two patients had missed doses of antipsychotic medicine and medicine charts had blank boxes where doses were missed and there was no explanation why they were missed in the relevant part of the medicines chart.

The provider had contracted a pharmacy service and the pharmacist had made some comments about patient's medication including high dose antipsychotic treatment (HDAT) monitoring. However, staff had not considered the impact of the medicines on patient's physical health and had not initiated the monitoring for patients as recommended by national guidance. Staff did not know which patients were on high dose antipsychotics and therefore were not taking appropriate steps to protect patients from harm. High doses of antipsychotic medicines can cause cardiometabolic side effects and these need to be monitored carefully to protect patients from harm. This was escalated to the senior leaders who identified a further two patients who were at risk from the prescribing of high doses of antipsychotic medication.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. We did not see any evidence that staff had completed safety checks such as lithium bloods or heart tracing electrocardiograms (ECGs) for patients or that they used best practice tools to assess cardiometabolic health that is a risk within this patient group. For example, patients taking the antipsychotic drug Clozapine.

One patient had not had their physical health risks assessed and mitigated effectively despite potential physical health risks being identified. Waterlow pressure injury risk assessments or moving and handling risk assessments were not completed although the patient had mobility issues. Staff needed to complete moving and handling risk assessments to assess the capabilities of the patient, the assistance from staff and the environment.

Staff told us they offered regular physical health screening such as blood pressure monitoring, but staff often recorded that patients refused. In November 2021 we noted that eight out of 10 patients' records reviewed in CCU had recording that identified that patients had refused to have physical health checks completed. There were no records of physical health checks being offered to patients or declined in December 2021.

Reporting incidents and learning from when things go wrong

Staff did not always recognise incidents and report them appropriately.

Staff said that the current incident reporting process online was not fit for purpose and recording incidents was 'difficult'.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff used an online system called Acoura to record incidents which were then investigated by senior managers. Staff also said a new Datix incident reporting system was due to be implemented in the week following the inspection

Staff told us that they did not think all incidents were being reported appropriately. For example, they told us about an incident when one patient assaulted another. We asked if this had been reported as an incident and were informed it had not. We discussed incident reporting with hospital managers, and they felt that not all incidents were being reported and that there was work to be done to ensure staff understood and recognised an incident. As a result, it was unclear how the service was going to go forward learning from the incidents that occurred.

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

Inadequate

Our rating of effective went down. We rated it as inadequate

Assessment of needs and planning of care

Uplands purpose was to provide rehabilitation and recovery to people with mental health problems. However, the model of care was not clear and there was no consensus from managers or staff about how long patients were expected to stay within the service and what the recovery care would look like. Staff did not always develop a comprehensive care plan for patients that met their mental and physical health needs. Staff did not always regularly review and update care plans when patients' needs changed.

The care provided did not provide patients with the skills needed to be discharged from the hospital in a timely and responsive way. This had a significant impact on the rights of the patients to receive effective recovery focussed care, a timely discharge to ensure they could have a life outside of the hospital.

Patients care and treatment care records were not always personalised and there was little documented information on how their needs would be met. We looked at seven care plans across the hospital and found care plans were not based on all areas of needs and lacked patients voice regarding their involvement in the planning of their care. Staff told us and documented that they offered patients a copy of their care plan, but they sometimes refused, however, some of the patients we spoke with said they had not been involved with their own care planning

In the care records we reviewed there was no evidence of discharge and recovery planning and staff were unsure whether the care being given was recovery or rehabilitation focussed. It was therefore unclear how staff were working with patients towards a meaningful recovery and discharge into the community

The care plans we reviewed did not always identify how they would support patients to regain the skills and confidence to live successfully following their discharge in the community. For example, they didn’t include details about the development of independent living skills such as cooking and budgeting. Care records didn’t identity how staff were working with other agencies to support recovery and social inclusion in the community.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Best practice in treatment and care

Patients had access to psychological therapies and occupational therapy. The psychologist and occupational therapist met with all patients on the ward and there was a psychology assistant who helped provide therapies identified by the psychologist including acceptance commitment therapy (ACT) and dialectical behavioural therapy (DBT). The psychologist told us that they did a formulation for all patients on the ward and had begun positive behavioural support (PBS) plans for the patients.

Positive Behaviour Support (PBS) plans were in place in two of the patients records we reviewed. PBS plans were sectioned into strategies which detailed the actions from staff to reduce the levels of behaviours that placed them and others at risk of harm. However, records showed that ward staff were not following the plans. For example, the PBS plan for one patient stated that staff should not keep the patient waiting in order to keep them engaged and relaxed. But it was documented that staff used the threat of refusing ground leave to manage a situation where the patient became frustrated at having to wait.

The therapies team had identified and created specific training on PBS that they planned to deliver to staff. However, the planned date for delivery of the training had been delayed due to the Covid-19 pandemic. PBS is a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge.

Although national early warning score (NEWS2) assessment tool were used to identify signs and symptoms of deteriorating ill health other recognised risk assessment tools were not used to identify pressure injury (Waterlow) and malnutrition universal screening tool (MUST).

Staff did not always meet patients' dietary needs and did not always assess those needing specialist care for nutrition and hydration. We saw that malnutrition MUST assessments were not completed for all patients at risk.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcome. For example, health of nation outcome score (HONOS).

The therapy team provided therapies and had access to assessment tools including the occupational therapy assessment (MOHO), acceptance and commitment therapy (ACT), cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT)

Staff did not take part in clinical audits, benchmarking and quality improvement initiatives. The hospital manager had identified the need for auditing in the site improvement plan actions identified in the plan had not been implemented and embedded into practice at the time of the inspection.

Skilled staff to deliver care

The service had access to a range of specialists to help meet the needs of the patients on the ward. For example, psychology, occupational therapy, medical and nursing staff. However, some staff were new to the hospital and had not yet been able to implement the therapeutic care they wanted to into practice yet. There was a plan in place to provide more specialist training to upskill the staff in rehabilitation and recovery, but this had been put on hold due to the coivd-19 pandemic. We spoke to the occupational therapist, psychologist and hospital director and discussed the plan to upskill staff and were told that it would be completed over the coming weeks as they were no longer in a lockdown situation.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers did not ensure all registered nurses and support workers had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. All staff were offered training, but the uptake and completion was below the levels the provider expected.

Staff we spoke with had told us that they did not receive regular formal supervision from a senior member of the team. The leadership team did not monitor supervision of staff so were not able to provide a guarantee that staff working on the wards received regular constructive support to perform their role as expected.

Managers made sure staff attended regular team meetings and gave information from these meetings to those that could not attend.

Whilst some training sessions were planned for staff, they did not meet the training needs of all staff and some staff said they would benefit from further training around specific mental health problems and supporting patients.

Multi-disciplinary and interagency teamwork

Staff had effective working relationships with staff from services providing care following a patient's discharge but did not engage with them early on in the patient's admission to plan discharge.

Staff held regular multidisciplinary team (MDT) meetings led by the consultant psychiatrist to discuss patients and improve their care, however it was not effective in moving patient's recovery forward. Staff we spoke with within the MDT felt that it was a strong effective team, however, they acknowledged the outcomes of these meetings were not reflected in patients care records. As a result, decisions made within the MDT did not always follow through to changes or improvements in their care. Senior managers said they were working on embedding the actions from the MDT, but this was a work in progress and the word document was not embedded in the actions to improve care. There was no standard process for updating care plans or risk assessments following decisions made within the MDT.

Staff did not ensure they shared clear information about patients and any changes in their care, including during handover meetings. We observed handover meetings and they did not give an overview of the risks of the patients and address their specific needs.

Ward teams had effective working relationships with external teams and organisations including commissioners.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff did not always keep up to date with mandatory training on the Mental Health Act and the Mental Health Act Code of Practice and only 58% of staff had completed this training.

However, staff had access to support and advice on implementing the Mental Health Act and its Code of Practice and a Mental Health Act administrator was in post full time.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff said Independent Mental Health Advocates (IMHAs) regularly visited the wards. However, some patients said they had not seen them for some time.

A Section 132 Mental Health Act Rights folder was in place at the service. Individual templates detailed the guidance for when patients' rights were to be explained to them, and dates of when staff had explained their rights under the Mental

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Inadequate

Health Act. The guidance was for staff to orally explain to patients their rights on admission, three monthly from then or following a review of their section. However, we found that staff did not explain to each patient their rights under the Mental Health Act in a way that they could understand, did not repeat as necessary and did not record it clearly in the patient's notes each time. Patients S132 rights had not been explained in 16 weeks and were due to be explained for the eight patients in December 2021. There was no evidence the patients had been provided explanation of their rights in December.

Care records listed the legal status of patients. The rights for Section 17 leave were documented and daily notes showed patients were aware of their prescribed leave.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

All of the 11 medication records reviewed had a consent to treatment form T2 or T3 in place. However, some of these were several years old and had address of a service where the patient was previously.

Informal patients did not know that they could leave the ward freely and the service did not display posters to tell them this. For example, there were no signs near the main locked door to the hospital.

Good practice in applying the Mental Capacity Act

All of the 11 medication records reviewed had mental capacity assessments recorded.

Patients mental capacity for treatment was assessed by the doctor. We reviewed the records for three patients and "Competency Test" templates were in place. These patients were assessed as lacking capacity due to them not being able "to weigh" information. However, the document lacked detail on how the decision was reached.

There was evidence that patient's capacity for medical procedures was assessed and there was clearly documented evidence on how external agencies reached the decision including for vaccination and surgery

Some staff kept up to date with mandatory training in the Mental Capacity Act and had a good understanding of at least the five principles. However not all staff had attended and 58% of staff had completed this training.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Inadequate

Our rating of caring went down. We rated it as inadequate.

Kindness, privacy, dignity, respect, compassion and support

We observed some caring interactions between staff and patients and staff spoke fondly of their relationships with the patients. However, staff were not always discreet or respectful when caring for patients. Some patients said some staff laughed at them and did not respond to their requests for help.

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Inadequate

Patients told us that staff did not always give them help, emotional support and advice when they needed it or support them to manage their own condition.

Three of the four patients we spoke with said they did not feel safe on the ward and some expressed concerns about the staff and how they were treated.

Some patients told us that staff did not always treat them well and behave kindly. For example, staff had been threatening and dictating to patients.

Staff did not always understand and respect the individual needs of each patient. Some patients said staff did not understand their condition and were not treating them properly.

During our inspection we observed staff sitting talking together in the lounge whilst two patients sat apart, and no attempts were made by staff to engage with them or involve the patients in any activities.

Patients described feeling bored and said that suitable activities were not available for them.

Involvement of patients

Staff had not documented whether patients had been involved in planning their care in the seven care records we examined. Some patients told us that they had need been involved in the planning of their care.

Staff did not involve patients in decisions about the service and patient community meetings had not been taking place recently. Managers stated that community meetings were not taking place due to the Covid-19 pandemic and social distancing requirements.

Patients could give feedback on the service and their treatment and staff supported them to do this. The new hospital director had sought feedback from the wards through individual feedback cards, however this had only recently been embedded so had not provided any meaningful feedback.

Staff did not always keep families and carers informed of what was happening with their loved one and there was little evidence detailed in the care plans we reviewed of family involvement in care. Some patients said they had family they wanted to get in touch with and they wished to make phone calls to relatives but had not been able to do so.

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

Inadequate

Our rating of responsive went down We rated it as inadequate .

Access and discharge

Patients were referred to the service from acute mental health units or secure services. The hospital had an admission criterion and was aiming to take more people from secure services in the future. The hospital director had decided to do face to face assessments for future patients coming into the service as a result of the referrals coming from secure services.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Many patients at the hospital had been there for long periods of time and many patients had their discharge delayed. The range of length of patient stay was between seven months and 22 years (some patients had stayed at the hospital when it had changed from a care home to a hospital).The average length of stay was five years which is considerably longer than expected of a service of this type. Patients stayed a long time due to the lack of a recovery and rehabilitation focussed care that did not adequately equip patients with the skills to move on from the hospital.

Managers did not regularly review length of stay for patients to ensure they did not stay longer than they needed to. However, the leadership team had begun to review the patients on the ward to find out what their plans were and hopes for moving from hospital. Staff were working with commissioners to identify appropriate placements for patients outside the hospital.

Some staff told us that they felt some patients in the CCU needed long term care and therefore they felt that rehabilitation was not appropriate. They felt some patients needed long term nursing home care.

Staff said patient's discharges were delayed due to lack of suitable follow on facilities identified by commissioners.

Staff did not always carefully plan patients discharge and did not work effectively with care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom, which they could personalise.

Patients on the HDU did not always have a lockable space to store personal possessions and we saw some broken lockable drawers in female bedrooms.

The female HDU bedrooms had security windows for observation but these could not be controlled by the patient from the inside and their dignity and privacy was not protected.

The female only HDU lounge was out of use and used to store patients' belongings and a hoist.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private. However, patients said that they had to continually ask staff to make a phone call and they were not always able to.

The service had an outside space that patients could access easily. However, access to this space on HDU was limited for e-cigarette breaks and set times were in place.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service did not offer a variety of good quality food and meal choices were limited. There was only one menu option for each main meal and some patients said the quality of food was poor.

Some patients were wandering around the CCU ward looking unkempt and with missing clothing. This impacted upon their dignity and comfort on the ward.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Patients' engagement with the wider community

Staff did not support patients with activities outside the service, such as work, education and family relationships. However, an activities coordinator had recently been appointed to the service and they were making plans for a range of activities with patients.

Staff did not make sure patients had access to opportunities for education and work, and supported patients. For example, none of the seven care plans identified any opportunities or goals for education or employment.

Meeting the needs of all people who use the service

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Patients had access to spiritual, religious and cultural support. For example, staff had planned for the future to work with a local church to do projects for the benefit of the patients and the community.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns.

Listening to you forms were available on the wards to capture feedback. However senior managers said patients needed to be encouraged and supported to use them, aimed at increasing the number of complaints. This feedback could be anonymous.

Some patients said they had made complaints but did not feel listened to by staff and no action was taken.

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

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

The hospital director had been brought into the hospital seven months prior to the inspection to lead the change required. They felt the service was transitioning from a care home and that the culture and systems were inadequate and remained incomplete. The hospital director had a good understanding of how to run a service but had struggled to implement effective change necessary for this setting. The leadership team stated that the service was not recovery-focused, and they were unclear on what the rehabilitation and recovery model for the service was.

The provider had identified the need to embed a recovery-focussed model to the service and this was documented in their Service Improvement Plan. For example, some of the therapy team were newly recruited and had plans for the service and rehabilitation models but these had not yet been embedded.

Vision and strategy

The leadership team had identified risks within the service and developed a comprehensive site improvement plan to help staff make change and provide better care. This was owned by the hospital director who had overall oversight of the implementation of the plan. The hospital director had employed a clinical nurse manager to help implement the

plan and free them up to work on the strategic side of the hospital to get more appropriate patients in. The improvement plan had helped the team focus on specific aspects of patient care and safety within the hospital, however there remained a significant number of issues within the service and therefore patients were not getting some of their basic needs met.

The service was not providing the patient centred recovery orientated care that it was commissioned to provide.

Culture

The culture within the service was not focused on providing rehabilitation and recovery focused care to the patients. The hospital director and therapy team said that the nursing culture was one of a care home mindset, and that the biggest piece of work for the hospital was to change this. The hospital director had a plan to introduce a key worker system to help cultural change so that identified staff would be in charge of an identified patient's recovery. The staff had pushed back on this, however, and as such it had not yet been implemented. The hospital director felt the service was working as a care home and that the culture and systems were inadequate.

Staff did not always feel respected, supported and valued and there was a closed culture which included a lack of staff confidence in raising concerns. Some staff said at times they did not feel safe at work and having a lot of temporary agency staff was unsettling for the patients and staff. Some staff said they felt overlooked and that their contribution to the service was not recognised.

Some staff felt they could raise concerns to the hospital management team while others felt unable to. Some told us that they did not feel hospital director and clinical manager were approachable. Some staff did not always feel that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Some staff told us that some staff used derogatory language about patients which they had not felt able to report. This was fed back to the team during the inspection.

Some staff told us that some patients had been at the hospital when it changed from being a care home to a hospital and therefore saw the hospital as their home – this needed to be taken into account in their care and appropriate placements were needed.

The hospital director and clinical nurse manager said the view of several of the staff was that this is the patients' home and that there were training needs for staff to implement rehabilitation work**.** The senior therapy staff were committed to working in an outcome focused recovery model however, this was not widely implemented or shared throughout the team.

Governance

The service did not have systems in place to improve service quality systematically and safeguard high standards of care by creating an environment for excellent clinical care to flourish. There was a lack of robust governance systems and processes in place with a lack of clarity about how these should operate and how they provided assurance.

The lack of governance arrangements meant that risks within the service were not identified and acted upon in in a timely way. This included an omission of reviewing incidents, care records and staffing, audits or how clinically effective the hospital was being. The hospital directors and the organisation did not have a governance meeting essential to the oversight of providing rehabilitative care.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We spoke with senior managers who acknowledged that there was a gap in the governance arrangements within the service and there was no system in place for shared learning across the organisation. The HD acknowledged that there was limited shared learning taking place across the organisation and that clinical governance needed strengthening. However, they found many more pressing issues around safety that took a priority and were added to the site improvement plan.

The hospital director had outlined, in the improvement plan, that a series of audit were planned but these had not been implemented at the time of the inspection.

Management of risk, issues and performance

The service did not use systems to manage performance effectively. They did not effectively identify and escalate relevant risks and issues and identify actions to reduce their impact.

The hospital director and clinical nurse manager acknowledged that there was no process to look at care records to check on quality and to check to see if records were up to date and current with new risks well documented and alerted to the team. They said it was also unclear who had written the care plans or the risk assessments and that there was no updating following decisions and discussions at multi-disciplinary team meetings. The managers and therapy staff of the hospital said that immediate risks were managed but that decisions made in the MDT did not translate into patient care. As a result, patients did receive the updated care approach they required.

Risk assessments were not up to date or regularly reviewed. For example, we found one care plan with a risk assessment that was completed in 2018 and had not been updated. In the three care records examined in HDU one had a recent risk assessment.

Staffing was not adequately reviewed to ensure there were suitably skilled and experienced staff to deliver person-centred and recovery focused care safely to service users. The hospital did not have the right staff with the right skills to develop an effective recovery plan for the patients and this was a risk because patients were not moving on in their recovery.

There was a lack of oversight and poor risk management of medicines. For example, on ensuring that the clinic rooms were clean, tidy and fit for purpose and that patients were assessed to safely receive the prescribed medicines. The was an absence of a safe process to ensure safe medicines storage and management at the time of the inspection.

Information management

There was a system in place to store records essential to patient care. The care records were in paper form and difficult to navigate. There as a plan in place to change to electronic records but this was early in its development. The incident recording system was inadequate, but the service was changing to a new one after the inspection.

A programme of audit and data collection was outlined in a service improvement plan from May 2021, but this had not translated into improvements in quality of care at the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients were not treated with compassion and respect. Regulation 10

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Staff had not completed mandatory training or received regular supervision. Regulation 18(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Robust risk assessments were not completed and regularly reviewed to mitigate risks. Regulation 12 Patients physical health was not assessed and monitored effectively. Regulation 12(2) Medicines were not safely managed or effective. Regulation 12(1) 12(3) The physical health of patients on high dose antipsychotic therapy (HDAT) was not appropriately monitored. Regulation 12(2) The staff providing care and treatment were not qualifications, competent or skilled and experienced. There were insufficient numbers of staff on each shift to meet patients' needs. Regulation 12 (c)

This section is primarily information for the provider

Requirement notices

	The hospital was not maintained in accordance with infection prevention and control guidance. Regulation 12(1) 12(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Robust governance processes were not in place to provide effective oversight of risks to then take timely action and minimise risks and monitor the quality of care delivered at the hospital. Regulation 17(1) 17(3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care A recovery focused rehabilitation model had not been to support patients in their pathway to discharge. Regulation 9 Care plans, that were person–centred, holistic and recovery-oriented were not developed or informed by a comprehensive assessment of individual patient's needs. Patients were not involved in the planning of their care and that they . Regulation 9 (1) Mental Health Act 1983 T2 and T3 forms were not up to date and a process was not in place to monitor this. Regulation 9 (3) (c) Mental Health Act 1983 S132 rights were not explained to patients regularly and a process was not in place to monitor this. Regulation 9 (3)(c)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Diagnostic and screening procedures	Equipment used for and by patients were not safely maintained clean or stored appropriately. Regulation 15(1)
Treatment of disease, disorder or injury	

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.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Section 31 HSCA Urgent procedure for suspension, variation etc. Letter of Intent (which requires the provider to give us assurance that it will make immediate improvements) Significant improvement was needed to ensure patients received safe care. It requires the provider to give us assurance that it will make immediate improvements

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	S29 Warning Notice Robust risk assessments were not completed that clearly identify how risks will be minimised; Medicine systems were not managed safely Appropriate and timely physical health care for all patients were not taking place, particularly for those with identified physical health problems. This includes ensuring medicines were administered as required and physical health monitoring for patients on high doses of antipsychotic medicines. The environment and equipment was not safe for patients and staff, clean and fit for purpose. There were not enough, suitably qualified and competent staff on duty at all time Care plans were not person centred or clearly identify patient's need, focussed on delivering recovery focused rehabilitation to support patients to live independent lives and to prevent excessively long lengths of stay;

This section is primarily information for the provider

Enforcement actions

Robust governance arrangements to ensure it is able to monitor incidents, the quality of care provided and make improvements in a timely manner were not in place