

Baldock Manor

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Requires improvement



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

We rated Baldock Manor as requires improvement because:

- Male patients were permitted to spend periods of time on Oakley female wards. There was no evidence of risk assessment or care planning to safeguard those patients.
- Risk assessments did not always capture recent changes in risk following update.
- The service had 27 staff vacancies and staff turnover was at 33%.
- Qualified staff were not visible on all wards and some worked across two or three wards.
- There was little evidence that patients were having 1:1 time with their named nurse.
- Not all patients were being offered regular Section 17 leave. Not all patients were having regular access to outside spaces for fresh air.
- Checks of physical health equipment including emergency equipment were not taking place.
- Incident reports were not always fully completed.
- Confidential information was not always stored securely on all wards.
- Care plans were not always personalised or person centred.
- There was a lack of psychological therapies in place across the service.
- Mental Capacity assessments were not robustly completed.
- We were not assured that patient's dignity was maintained on Oakley female ward.
- There was little evidence of therapeutic activities on the wards.

- Most ward based staff were not aware of lessons learnt following investigation and complaints.
- Managers did not provide staff with regular supervision and annual appraisals.
- There was a high dependency of bank and agency staff.
- Ward based staff were not aware of the organisations visions and values.

However:

- Managers completed regular ligature audits.
- All ward environments were clean and tidy and well maintained with adequate equipment to support treatment and care of patients.
- Staff compliance with mandatory training was at 94%. Overall, 96% of staff had received training in the Mental Capacity Act and 91% of staff had received training in the Mental Health Act.
- We observed staff interact with patients in a caring and respectful manner. Staff understood patient's individual care and treatment needs.
- There was access to an advocacy service.
- We saw evidence of a variety of meal options provided by the kitchen.
- Information was available to patients on treatment, advocacy and their rights.
- Patients could personalise their bedrooms should they wish to.
- Overall sickness was at 3.7 %.
- There were no reported cases of bullying or harassment.
- Staff generally felt listened to and supported.
- Senior managers were visible and available to staff.

Summary of findings

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Requires improvement 

Baldock Manor

Services we looked at

Long stay/rehabilitation mental health wards for adults

Summary of this inspection

Background to Baldock Manor

Baldock Manor is a private hospital that provides a rehabilitation service to people who have needs related to their mental health and who are detained under the Mental Health Act 1983, Mental Capacity Act 2005, or are voluntarily staying at the hospital.

There were five wards:

- Radley ward – learning disability, male ward with 10 beds
- Mulberry ward – mental health, male ward with 15 beds
- Burberry ward – mental health, female ward with 9 beds
- Oakley ward (male) – mental health older persons, male ward with 7 beds
- Oakley ward (female) – mental health older persons, female ward with 10 beds.

At the time of inspection, there were 32 patients at Baldock Manor.

The Care Quality Commission (CQC) inspected Baldock Manor in November 2015. The provider had breached regulation 12, 14 and 17 of the Health and Social Care Act and was given an overall rating of inadequate. A focused inspection took place in May 2016 in order to check compliance against warning notices. We concluded that Baldock Manor was no longer in breach of regulation 14 but remained in breach of regulation 12 and regulation 17.

At the time of inspection there was a registered manager in post.

Baldock manor is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Treatment of disease, disorder or injury.
- Personal care.

Our inspection team

Team leader: Deborah Holder

The team that inspected Baldock Manor consisted of an inspection manager, four inspectors and a specialist professional advisor.

The team would like to thank all those who met and spoke to inspectors during the inspection.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

The last comprehensive inspection was carried out in November 2015, where we rated the service as inadequate. Requirement notices were issued and a focused inspection was completed in May 2016 to check compliance with requirement notices. These related to the following regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12 Safe care and treatment
- Regulation 14 Meeting nutritional and hydration needs

- Regulation 17 Good governance
- Regulation 18 Staffing

During this inspection we found that the provider had made improvements in most areas identified in November 2015 and May 2016 inspections. Further improvements are required in the reviewing and updating of risk assessments, the documentation of restrictive interventions, the maintenance and review of equipment to monitor physical health, supervision and appraisal rates and documentation and lesson learnt following serious incidents.

Summary of this inspection

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 a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients

- spoke with 10 patients who were using the service and three carers
- interviewed the registered manager and managers for each of the wards
- spoke with 35 other staff members; including doctors, nurses, and pharmacist
- interviewed an independent advocate
- collected feedback from 6 patients using comment cards
- looked at 20 care and treatment records of patients
- reviewed 16 incident reports
- carried out a specific check of the medication management on all wards and reviewed 27 medication records
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- We spoke with 10 patients that used the service.
- Patients were positive about the care and treatment they received and told us that staff were kind.
- Patients reported the use of agency was high and that they did not always know the staff. They felt that the wards would benefit from additional qualified staff.
- Patients did not feel involved in their care plans and stated that 1:1 sessions with their named nurse were not taking place.
- Patients knew how to complain and stated that managers were available to talk to.
- Three patients reported that leave was sometimes cancelled or postponed due to staffing issues. They reported a lack of therapy and activities.

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?

We rated safe as requires improvement because:

- The provider's policy on restrictive interventions was not in line with the Mental Health Act Codes of Practice.
- We saw that male patients spent time on Oakley female ward for activities and unstructured time. There was no evidence of risk assessment or care planning to safeguard those patients.
- Updated risk assessments did not always capture changes in risk.
- The service had 27 staff vacancies, which meant that they relied on bank and agency staff.
- Staff turnover for the last 12 months was at 33%.
- Qualified staff were not visible on all wards and some worked across two or three wards.
- Regular checks and calibration of physical health equipment was not taking place.
- Emergency medical equipment was not routinely checked/ assembled and ready for immediate use.
- Six out of 16 serious incident reports were fully completed. The other 10 were incomplete and lacked detail.
- Staff left office doors unlocked and bags unattended on Oakley female ward and Burberry ward.

However:

- Managers completed regular ligature audits.
- The wards complied with the Department of Health guidance on eliminating mixed sex accommodation; there were separate wards for male and female patients.
- Clinic rooms were fully equipped.
- All ward environments were clean, tidy and well maintained.
- Staff compliance with mandatory training was at 94%.

Requires improvement



Are services effective?

We rated effective as requires improvement because:

- Care plans did not always contain up to date information following review.
- Not all care plans were not personalised or person centred. Carers told us that not all staff were aware of the patients history.
- There was little evidence of patient and family involvement in care planning.

Requires improvement



Summary of this inspection

- There were no psychological therapies in place across the service. Carers did not feel that the therapies needed to support rehabilitation were available.
- Mental Capacity assessments lacked detail and rationale for decision making. There was little evidence of family or advocacy involvement and patient's wishes were not captured within the assessment process.

However:

- All patients had assessments in place after admission.
- Most patients had physical health examinations upon admission and there was on-going monitoring in place.
- Overall, 96% of staff had received training the Mental Capacity Act.
- Overall, 91% of staff had received training on the Mental Health Act.

Are services caring?

We rated caring as requires improvement because:

- Patient's dignity was not maintained on Oakley female ward.
- Patients on Oakley female were not receiving regular baths or showers.
- Patients were not involved in developing their care plans. Carers confirmed this.
- Carers told us that they were not involved in care plans. They had not seen care plans and had not been provided the opportunity to contribute to their relatives care and treatment.
- Patients were not provided with a copy of their care plans.

However:

- We observed staff interact with patients in a caring and respectful manner.
- Staff understood patient's individual care and treatment needs.
- There was access to an advocacy service.

Requires improvement



Are services responsive?

We rated responsive as requires improvement because:

- Not all patients were having regular access to outside spaces.
- We saw little evidence of therapeutic activities on the wards.
- The en-suite bathrooms did not provide adequate space for those using wheelchairs.
- Ward based staff were not aware of lessons learnt following investigation and complaints.

However:

Requires improvement



Summary of this inspection

- Wards were comfortable with adequate equipment available to support treatment and care of patients.
- We saw evidence of a variety of meal options provided by the kitchen.
- Information was available to patients on treatment, advocacy and their rights.
- Some patients had personalised their bedrooms.

Are services well-led?

We rated well-led as requires improvement because:

- Managers did not provide staff with regular supervision.
- Managers did not ensure that staff received annual appraisals.
- There was a high dependency of bank and agency staff.
- Ward based staff were not aware of the organisations visions and values.
- Regular team meetings were not taking place.

However:

- Overall sickness was low at 3.7 %.
- There were no reported cases of bullying or harassment.
- Staff generally felt supported and listened to.
- Senior managers were visible and available to staff.
- Compliance with mandatory training was at 94%.
- The provider had made improvements in monitoring the quality of the service and governance structures in place had improved.

Requires improvement



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.

- Overall 91% of staff had received training on the Mental Health Act.
- The provider had a Mental Health Act policy in place which staff could refer to if needed.
- Staff on the wards informed patients of their rights, we saw copies of paperwork and documentation in case records. There was evidence of section 132 rights read on detention and at appropriate intervals thereafter.
- Doctors granted patients Section 17 leave following assessment of risk. We saw that that forms were generally signed and in date. It was not evident if patients had a copy of the form. Staff had not recorded and patients did not sign to say they had received a copy.
- Staff completed consent to treatment forms. Staff attached copies of paperwork to medication charts.
- Information on the rights of detained patient was available across the wards.
- Independent mental health advocacy services were available to support patients. Staff knew how to access and support patients to engaged with the advocate. Staff reported weekly ward visit from the advocate and patients confirmed this.
- The service carried out regular audits to ensure that the MHA was correctly applied and we saw evidence of follow up and correction when issues were identified.
- There was a Mental Health Act administrator and staff knew how to contact them for advice.

Mental Capacity Act and Deprivation of Liberty Safeguards






- Overall, 96 % of staff had completed Mental Capacity Act and Deprivation of Liberty Safeguards training.
- We interviewed staff and asked them about their knowledge of the Mental Capacity Act. They were able to describe an understanding of the practical application of the Mental Capacity Act and could provide basic examples of how they would transfer this knowledge to their practice on the wards.
- Mental capacity assessments were present where required however were not always documented in detail and lacked evidence of family or Independent Mental Capacity Act Advocate involvement. Where a patient was deemed to lack capacity there was evidence that the best interest decision-making process was applied in some cases.
- There were five patients cared for under a Deprivation of Liberty authorisation at the time of inspection.
- The service had a Mental Capacity Act policy in place that staff were aware of and could refer to.

Overview of ratings

Our ratings for this location are:

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

Long stay/rehabilitation mental health wards for adults

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

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

Requires improvement 

Safe and clean environment

- The layout of the building meant that all wards had blind spots. Blind spots had been identified and mirrors and closed circuit television had been installed to improve observation across the wards.
- Managers had identified ligature points throughout the wards and gardens and completed annual audits. A ligature is a place to which patients intent on self-harm could tie something to harm themselves. Staff managed risk with nursing observations and risk assessment.
- The wards complied with the Department of Health guidance on eliminating mixed sex accommodation; there were separate wards for male and female patients. However, we saw that male patients would spend time on Oakley female ward for organised activities such as music events. Staff told us that some patients from Oakley male ward would spend regular periods of time on Oakley female ward as they liked sitting with the female patients. On one occasion we saw a male patient left unsupervised in the day area with female patients. We were not assured that male patients who regularly accessed the female ward had been appropriately risk assessed or care planned.
- Clinic rooms were equipped and stored emergency drugs. Emergency response equipment was shared across the service. One bag was stored on Oakley female ward the second bag on Mulberry ward, the third on Burberry ward. The emergency response bag on Mulberry ward had two face masks; both were brittle and discoloured, the suction pump had not been assembled so was not ready for use if needed. The defibrillator had no battery fitted and no pads were in place so was not ready for use if required. The portable oximeter contained no batteries however batteries were available, a blood pressure monitoring machine was available but contained no batteries. There was no evidence that physical health equipment had been checked or calibrated.
- Burberry and Oakley male ward shared a clinic. A range of equipment was available to support treatment and care of patients.
- All ward environments were clean and well maintained and furniture was in good condition.
- On Radley ward the bathroom had no call bell for use in emergencies. The qualified nurse struggled to find the key to the clinic room fridge due to the amount of keys. The nurse in charge confirmed that they were looking to simplify the bunch of keys to prevent delays. The kitchen was open and could be accessed by patients up until midnight. Patients could use the kitchen for cooking meals following risk assessment. Patients had access to a ground floor garden.
- On Oakley female ward there were five patients on covert medication plans. Plans were in place but were not detailed and did not identify if medication had been accepted or given covertly.
- On Oakley female ward, the bathroom was just off the ward in a non-clinical area. This bathroom was used by other wards including male patients. The toilet had not been adapted for those with mobility issues. The bath had been appropriately adapted. Patients were supervised in this area. There was a delayed response

Long stay/rehabilitation mental health wards for adults

from staff to this alarm during inspection. This was fed back to the manager who responded promptly with an action plan for regular drills for this area of the service to improve response time.

- Staff told us that the en-suite bathrooms on Oakley female ward were too small for patients using wheelchairs. We observed that the observation panels for some bedrooms were open; staff did not have the keys to close them. The office door was consistently left open and was unstaffed at times, leaving confidential information accessible. The medication charts were left in the day area unattended. One member of staff kept their bags with them in the main ward area; at times this bag was left unsupervised.
- On Oakley male ward, staff told us that there was no nurse call system. The ward manager was unsure of the ligature points across the ward. A disabled toilet and bathroom was not available on the ward but patients could use the adapted bathroom on Radley ward.
- On Burberry ward the patients quiet lounge was also used as a staff room. We observed that staff left their bags and personal belonging in this room and this room was unlocked. Patients had access to the kitchen across the day where they could make themselves drinks and snacks.
- On Mulberry ward both sharps bins in the clinic were full. Physical health equipment was present but had not been calibrated and regular checks of equipment had not taken place.
- Mulberry Ward has several rooms for patients to spend time including a quiet room. Patients could access the ward kitchen following risk assessment. The fridge in clinic was visibly dirty. A garden area was available on the ground floor.

Safe staffing

- Managers used the Royal College of Nursing guidance to calculate staffing levels. Staffing requirement was based upon occupancy levels. There were 12 qualified and 15 support worker posts vacant at the time of inspection. Staff on Oakley female felt that the established staffing numbers were sufficient to provide care needs but not to facilitate additional activities due to the nature of the patient group and their dependency on staff to meet their personal needs.

- Two qualified staff worked across the five wards at night time. Staff reported that this was not sufficient to ensure that all patients' needs were met. Management had responded by agreeing to increase qualified establishment at nights.
- There was adequate staff on shift during the inspection period.
- The service used bank and agency staff across all wards to maintain safe staffing numbers. Between August and November 2016, 1162 shifts were filled by bank or agency staff to cover sickness, absence or vacancies. The highest use of bank and agency staff was on Mulberry ward which accounted for 41%. Staff confirmed a high dependency on agency and bank staff.
- Staff turnover for the last 12 months was at 33%. Managers had active recruitment in place to fill the gaps in staffing.
- Managers reported that they preferred to use staff that were familiar with the wards and would block book agency staff to provide some consistency in staffing. The service had a pool of bank staff that they could also use. We noted a higher dependency of agency to cover nights and when enhanced observation was required.
- Managers could adjust staffing levels to take account of patient mix, presentation and level of observation. We observed patients being cared for on enhanced observation during inspection.
- Qualified staff were not present in communal areas of all wards. Qualified staff worked across the wards. On Oakley female ward there were no staff present in communal areas on two occasions. Patients on Radley ward told us that staff were not always present in the day area or corridor.
- There was little evidence in care records that patients were having regular 1:1 time with their named nurses. Staff on Oakley male, Oakley female and Burberry ward confirmed this. Qualified staff that worked across two wards told us that they spend very little time with patients.
- Most staff told us that leave and activities were not usually cancelled due to lack of staff. Some staff reported that leave was occasionally cancelled or postponed. However, we saw that some patients on Oakley female and Oakley male wards were not offered regular leave.
- Physical observations were taking place across the wards and physical health care was overseen by a doctor within the service.

Long stay/rehabilitation mental health wards for adults

- There was adequate medical cover day and night. Staff confirmed that medical cover was provided by the Doctors via a rota system.
- Overall, compliance with mandatory training was at 94%. Staff reported access to training appropriate to their needs.

Assessing and managing risk to patients and staff

- There were no seclusions reported and the service had no seclusion rooms.
- There was a policy in place for the use of restrictive interventions however this policy was not in line with the Mental Health Act code of practice and did not cover long-term segregation or the monitoring and documentation under this arrangement. The service did not report any incidents of long-term segregation prior to the inspection visit. On inspection staff told us two bedrooms off Oakley female had recently been used to nurse a male patient.
- During the inspection it was agreed that there was an inaccurate reflection of segregation within the providers policy, although we were satisfied that the patient in question was being cared for appropriately. The provider referred to this as long term isolation. Long term segregation was not referenced in the policy and did not follow the Mental Health Act code of practice.
- There were 13 incidents of restraint between June 2016 and December 2016 involving six patients. None of these restraints were in the prone position (face down).
- We reviewed 20 care and treatment records. All had risk assessments in place. Generally risk assessments had been updated however not all risk assessments reflected recent changes in risk. On Radley ward one risk assessment was five months overdue for review, this related to a patient with a significant risk history.
- Staff used the company's risk assessment tool and also HCR20 where appropriate to assess patient risk upon admission and then at regular intervals.
- Staff told us that informal patients could leave at will. We saw information on wards informing informal patients of their rights.
- Policies and procedures were in place for the use of observation and searching patients. We observed one occasion where patients on Oakley female ward were left with no staff observation whilst there was a male patient visiting from another ward.

- Restraint was used only after de-escalation had failed and the correct techniques were applied.
- The use of rapid tranquilisation followed National Institute for Care and Health Excellence guidance.
- Overall, 93% of staff were trained in safeguarding adults. Staff we spoke with could explain what a safeguarding incident was and how to raise an alert.
- Clinics across the service were well maintained. There were photos attached to medication charts where patients consent and allergies were recorded. There was evidence of regular audit of prescription charts conducted by the pharmacy service.
- On Burberry ward we found incomplete physical health documentation for one patient on antipsychotic medication. We found seven different medications that were out of date and other equipment passed it's used by date. This was immediately rectified by staff when the issue was brought to their attention.
- Staff were aware of prevention of pressure ulcers and we saw care plans in place to support those at risk. Food and fluid charts were in place.
- There were procedures in place for children to visit the service. There was no dedicated visiting room however a meeting room off the ward could be used for child visits.

Track record on safety

- The service had 66 serious incidents requiring investigation between December 2015 and December 2016.
- The services had a low threshold for reporting and recording of serious incidents. Types of incidents reported included aggression between patients, inappropriate behaviour such as aggression towards property, and spitting out medication.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew what incidents needed reporting and how to report via the electronic incident system.
- Most incidents that should be reported to the Care Quality Commission were reported. However, staff were not always completing safeguarding notifications following a serious incident.

Long stay/rehabilitation mental health wards for adults

- Staff were open and transparent and explained to patients when things went wrong. In care records we saw letters from the registered manager including letters of duty of candour in response to complaints.
- Managers told us that they received feedback from investigation following incidents and we saw evidence of this. However this feedback did not always reach the ward based staff. Staff told us that they did not always receive feedback after reporting an incident. Ward based staff often found out about incidents via word of mouth rather than a formal feedback process.
- Monthly clinical governance meetings discussed risk incidents. We reviewed the minutes of these meetings and found that they were detailed and looked at improving safety across the service.
- Team meetings were not always taking place on the wards and there was little evidence that staff teams met formally to discuss feedback from incidents. There was some evidence of recent team meetings taking place on Radley ward however records were inaccurate. We found dates recorded in team meeting minutes had been changed.
- Some staff reported debrief following a serious incident and receiving support from the manager. Staff on Oakley male ward were not aware of feedback from complaints or lessons learnt from serious incidents.
- We reviewed 16 incident reports. Six were complete with lessons learnt identified, the others were incomplete

Are long stay/rehabilitation mental health wards for adults effective?
(for example, treatment is effective)

Requires improvement 

Assessment of needs and planning of care

- We reviewed 20 care and treatment records. All patients had assessments completed after admissions.
- Care records showed that a physical examination was usually undertaken on admission by a doctor and there was evidence on-going monitoring of physical health problems. We found one patient on Oakley male who waited two months for his physical health assessment to be completed. A second patient missed a planned appointment at the general hospital, the manager

reported that the patient was unsettled at the time however the care records did not support this viewpoint. One patient on Mulberry ward did not have a medical assessment completed by a doctor upon admission but was seen by a nurse. Day to day physical healthcare needs were overseen by a Doctor within the service.

- Care records had been reviewed and there was evidence that previous reviews had taken place for some patients. The quality of care plans varied as did patient participation in care planning. We found some care plans contained direct quotes from patients and were signed but in others there was no evidence of patient involvement or that patients had been provided with a copy. Some physical health care plans had been recently reviewed but did not contain up to date information.
- Some care plans remained in place that were no longer required. Care records for one patient nursed separately lacked detail or evidence of robust reviews. Covert medication care plans lacked detail and made reference to follow pharmacist directions. However, no directions were available. There was little evidence of family involvement in care plans.
- Some of the care plans were personalised and recovery focused. Some care plans on Radley ward were complex for patients with learning disability; others had been simplified and were in large print. We found that some patients lacked capacity to participate in their care planning but had care plans written in the first person. There was no care plan for one patient on Oakley female ward for choking although this was an identified risk.
- Information needed to deliver care and treatment was stored in the locked nursing office on three wards. On Oakley female ward the office was open and unattended and the medication charts were left unattended in the day area. Burberry ward office door was kept unlocked. We could not be reassured that all information was secure and confidentiality was maintained. We found information relating to Oakley male patients on Oakley female ward.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication.
- Psychological therapies were not in place at the time of inspection. The psychologist had recently left the service. The service was actively recruiting to this post.

Long stay/rehabilitation mental health wards for adults

We saw some evidence of previous psychology being offered to some patients. On Oakley female ward there was no evidence of psychological interventions taking place in patient records. Staff confirmed there was no regular psychology provision. Carers told us that they did not believe that therapies to support rehabilitation were available.

- There was access to physical healthcare including access to specialist healthcare services. Staff told us that Speech and Language Therapy and a Dietitian were available via referral to the local hospital. Patients were not registered at a local GP surgery. GP provision was provided by one of the doctors on site and supported by a medical practitioner.
- Patient nutritional and hydration needs were generally assessed and met. Staff told us that all patients on Oakley female ward were on food and fluid charts.
- The service used Health of the Nation Outcome Scales to monitor outcomes for patients.
- Clinical staff participated in a variety of clinical audits to monitor effectiveness of the service; we saw some evidence of improvements and changes following audits.

Skilled staff to deliver care

- The multidisciplinary team consisted of nurses, doctors, support workers and a social worker. There was an occupational therapist that worked across the service, supported by three occupational therapy assistants. Outside agencies carried out specialist assessments such as physiotherapy and speech and language therapy when required.
- There were experienced and qualified staff in post however there was a high number of new staff due to recent recruitment. Some qualified staff and managers worked across several wards.
- Senior managers told us staff completed an induction before starting work on the ward. Some but not all staff confirmed this. We saw evidence of a new induction programme planned to begin in April 2017.
- The provider's supervision policy stated that staff should to attend supervision bi-monthly. Overall, 49% of staff had received supervision between January and December 2016. In January 2017 35% of staff, excluding ward managers, had received individual supervision.

Compliance for group supervision was 54%. Staff we spoke with confirmed that supervision was not taking place. Team meetings were not taking place consistently across the wards.

- Data showed that 40% of staff had received an appraisal. There was a plan in place to ensure that all staff entitled to an appraisal would receive one in 2017.
- The service offered specialist training for staff. There was a detailed database that outlined the training needs of all staff.
- There was evidence that poor staff performance was addressed promptly and effectively by senior management. Seven staff had been suspended pending investigation.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings were taking place on all wards and we saw evidence of this in care records.
- Shift to shift handovers took place within the wards. Staff discussed each patient and handed over relevant information. Staff documented handovers so that they could refer to the information if needed. Communication books were used on wards to share information across the nursing shifts.
- Staff told us that community professionals were invited to care planning reviews.
- The pharmacist visited the service weekly and completed regular audits.

Adherence to the MHA and the MHA Code of Practice

- We looked at Mental Health Act documentation across the service and found them to be in order.
- The mental health act administrator provided support and advice to staff in relation to the Act. Staff knew how to contact them for advice.
- Doctors granted some patients Section 17 leave. We saw that forms were generally signed and in date. It was not evident if patients had a copy of their leave forms. Staff had not recorded when copies had been given and patients did not sign to say they had received a copy.
- Overall, 91% of staff had received training on the Mental Health Act.
- Staff generally understood the MHA and their responsibilities and under the Act and the Code of Practice.
- Staff completed appropriate Mental Health Act paperwork upon admission. Staff completed consent to

Long stay/rehabilitation mental health wards for adults

treatment forms and attached copies to medication charts. We saw that doctors discussed consent to treatment for medication with patients and recorded these in care records.

- Staff on the wards informed patients of their rights, we saw copies of paperwork and documentation in care records. There was evidence of section 132 rights read on detention and routinely thereafter.
- The service had carried out regular audits to ensure that the MHA was correctly applied and we saw evidence of follow up and correction when issues were identified.
- Patients had access to Independent Mental Health Act Advocate service. Staff and patients knew how to access this service. We saw posters across the ward advertising the service and patients confirmed that they visited weekly.

Good practice in applying the MCA

- Overall, 96% of staff had received training in the Mental Capacity Act.
- There were five applications under the Deprivation of Liberty Safeguards at the time of inspection.
- Most staff we spoke with demonstrated knowledge of the Mental Capacity Act and the assessment process.
- There was a Mental Capacity Act policy in place that staff were aware of and could refer to for guidance.
- Capacity assessments were in place where required however they were not always detailed. Staff documented patients did not have capacity but did not give a rationale as to why they had made this decision nor document discussions. There was limited documentation of family or Independent Mental Capacity Act advocate involvement in most assessments.
- Where a patient was deemed to lack capacity there was limited evidence that the best interest decision-making process was applied. We saw little evidence of involving family in best interest decision making. There was little documentation of the person's wishes, feelings, culture, or history. We found that some patients had signed consent to treatment forms when assessed as lacking capacity to consent.
- Staff told us that they would contact the Mental Health Act administrator if they needed any specific guidance.
- Deprivations of Liberty Safeguards applications were usually made when required and there was evidence of follow up where they had been a delay in assessment

from the local authority. We found one delay of in applying for a Deprivation of Liberties Authorisation on Oakley female ward following the mental health section being lifted at tribunal.

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

Requires improvement 

Kindness, dignity, respect and support

- Generally we observed staff interactions with patients as kind and caring across the service. Staff demonstrated good understanding of the patients' individual needs and their care plans. We saw staff attend to patients' needs in a caring and supportive manner on Burberry and Oakley male ward. Carers confirmed that staff were caring in their interactions.
- Oakley female ward staff provided support to some patients during meal times. This was not always in a respectful manner. We observed staff standing over patients whilst they assisted with meals, there was little interaction with the patients and they were talking to other staff. Some staff were very loud in their interactions which impacted on privacy and dignity.
- Patients across the service reported that staff were caring and supportive. Patient told us that there were high numbers of agency staff on the wards that they did not know well.
- We observed on Oakley female ward the bedroom observation panels were open and staff did not have the key to close them. Staff were not always discreet when patients needed support with personal care. We observed both non clinical staff and clinical staff not working on the ward utilise the kitchen across the inspection. We were not reassured that patient's dignity was maintained at all times.
- There was little evidence to support that patients on Oakley female ward were receiving regular showers and baths. En-suite bathrooms were not big enough for those dependent on wheelchairs. In records we saw evidence of bed baths and occasional showers. Staff confirmed that the bathroom is used monthly. One patient was unable to flush their toilet due to mobility issues.

Long stay/rehabilitation mental health wards for adults

The involvement of people in the care they receive

- Staff told us that when patients were admitted to the ward they were shown around and supported.
- Patients told us they were not aware of their care plans, they did not have copies and most had not participated meaningfully in developing them.
- There was little evidence of involving carers in care plans.
- There was access to advocacy service and posters were displayed on all wards providing information for patients. Patients confirmed regular visits took place.
- There were advance decisions in place for some patients that documented family involvement.

Are long stay/rehabilitation mental health wards for adults responsive to people's needs?

(for example, to feedback?)

Requires improvement 

Access and discharge

- At the time of inspection there were 32 patients receiving care. The provider had capacity to provide care for up to 51 patients.
- Managers transferred patients between wards only where they identified a clinical need that this should happen.
- We reviewed 20 care records, most had discharge plans in place. Some patients had been identified as ready for discharge and were waiting for an appropriate placement to move on to.

The facilities promote recovery, comfort, dignity and confidentiality

- Wards had meeting rooms for patients to meet visitors or staff. We observed some visits taking place in the ward area.
- There were phones available to patients upon request. Some patients had their own personal mobiles that had been made safe to have on the wards.
- Three wards had no direct access to a garden area and most patients had to be escorted at all times. Patients had to wait for staff to be available to obtain access to

fresh air. On Oakley female ward there was designated space at the front of the grounds; patient had to be escorted by staff to access this area. We were not reassured that all patients were offered regular access. Patients from Radley and Mulberry ward were escorted to outside space on the ground floor for fresh air.

- Staff documented leave on Section 17 paperwork for detained patients but no process was in place for recording leave for informal patients. Some patients were only offered leave for physical health appointments. Staff did not routinely document leave offered but declined by the patient. We were not reassured that all patients were routinely offered leave.
- We saw evidence of a choice of meals and patients were generally happy with the quality and quantity of food offered. We saw some patients ask for food different to what they ordered and this was provided.
- We saw that drinks and snacks were available across the day on all wards. On some wards patients could access the kitchen independently to make their own drinks.
- Some patients had personalised their bedrooms with posters, bedding and furniture.
- A timetable of activities was displayed on all the wards. During inspection we saw little activity taking place on the wards. Staff on Oakley female told us that there were limited activities offered to patients and this was confirmed in care records.
- Observation panels on bedroom doors were open on Oakley female ward however staff did not have the key to close them.
- On Radley ward the office computer screen was visible from the day area. One patient told us that they were able to read the screen from the day area.
- Some staff told us that they are unable to facilitate the amount of leave that patients required due to staffing numbers.

Meeting the needs of all people who use the service

- The service provided disabled access and had lifts on site to ensure access to both floors.
- The en-suite bathrooms were too small to accommodate those in wheel chairs comfortably. Staff confirmed this.
- Information leaflets on treatment, advocacy, patients' rights and how to complain were available on the wards. We saw feedback to service users on the wards in the form of "you said, we did".

Long stay/rehabilitation mental health wards for adults

- A choice of food to meet dietary requirements was available upon request. We observed patients being supported to eat at meal times.
- Staff reported that there was access to specific spiritual support in the community. Patients confirmed that their spiritual needs were being met.

Listening to and learning from concerns and complaints

- We reviewed the service complaints folder and saw that response to complaints had improved. Between May 2016 and January 2017 the service received 40 complaints. Mulberry ward received 55% of the complaints. Themes of complaints included interpersonal issues between patients.
- Staff and managers told us that they responded to any concerns raised quickly.
- The majority of patients knew how to complain or raise concerns. Most patients were confident that they would be listened to and the matter dealt with.
- Managers were aware of feedback on the outcome of investigations of complaints. However this information was not reaching ward based staff.

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

Requires improvement 

- Overall, compliance with mandatory training was at 94%. Staff reported access to training appropriate to their needs. A robust database was in place to monitor all training needs.
- Staff were not receiving supervision in line with the provider's policy. Annual appraisals were not taking place for all staff. However the provider had plans in place to improve on these areas.
- Shifts were covered by a sufficient number of staff. However, there was a high dependency upon agency staff. Managers had requested additional qualified staff across nights and this had been agreed and recruitment was due to take place.
- Limited activities were observed during inspection, we saw staff support patients with personal needs, meals and observations. Qualified staff that worked across the ward told us they had little time to spend on direct patient activity.
- Staff participated in a large variety of clinical audits to monitor practice across the wards.
- Managers and qualified staff were aware of learning from incidents, complaints and service user feedback but unregistered staff were not.
- The provider used performance indicators to gauge the performance of the service and these were regularly reviewed in the monthly governance meetings.
- Ward managers told us they had sufficient authority and administration support to undertake their role.
- Staff had the ability to submit items to the providers risk register and raise concerns directly to the hospital manager. Staff told us they would be confident to do this.

Vision and values

- The provider had set visions and values; these were displayed in reception and on ward office notice boards. Managers and senior staff were aware of the visions and values but ward based staff were not.
- Ward teams did not have set objectives and many staff were still waiting for appraisals.
- Staff knew who the most senior managers in the organisation were and told us that managers were visible and visited the wards.

Good governance

Leadership, morale and staff engagement

- Sickness between January and December 2016 was low at 3.7%.
- There were no reported cases of bullying and harassment.
- Staff knew how to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. However, some staff were not confident that action would be taken.
- Staff reported improvements across the service in recent months due to changes in management. Morale varied across the wards, most staff were positive that the service would continue to improve. Some staff did

Long stay/rehabilitation mental health wards for adults

not feel that their hard work was recognised and did not always get breaks on their shifts. However, the provider told us of plans they had to improve staff rewards and plans for staff retention.

- Staff told us of opportunities for leadership development. Some qualified staff had obtained managers posts and there was current recruitment for ten senior support worker posts.
- Staff spoke positively about the ward teams they worked in and most said they were able to access support. Team meetings were not consistently taking place across all wards. Senior managers held a monthly meeting that was open for all staff to attend.
- We saw evidence in care records of staff being open and transparent and explain to patients if and when something went wrong.
- Some staff told us that they provided feedback about the service in December 2016, the results of this service was not yet available.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that all risk assessments are updated and reviewed regularly.
- The provider must ensure that restrictive interventions are recorded as outlined in the Mental Health Act Codes of Practice.
- The provider must ensure that they have systems and processes in place to ensure that equipment to monitor physical health is fit for purpose, maintained and monitored and ready to use.
- The provider must ensure all staff have regular supervision and an annual appraisal.
- The provider must ensure that all patient records are securely stored.
- The provider must ensure that all incidents that need reporting are reported.

- The provider must ensure that before male patients spend time on the female ward this activity is risk assessed and care planned. The provider must ensure that these patients are supervised at all times.
- The provider must ensure that all patients are treated with dignity and respect at all times.

Action the provider **SHOULD** take to improve

- The provider should ensure that lessons learnt and action plans from incidents and complaints are shared with staff.
- The provider should ensure that they have a system and process in place to review and check that all medication and equipment is in date.
- The provider should ensure that assessments under the Mental Capacity Act are robust and detailed and involve family or Independent Mental Capacity Act Advocate where appropriate.

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 Personal care Treatment of disease, disorder or injury | <p>Regulation 9 HSCA (RA) Regulations 2014 Person-centred care</p> <p>Regulation 9 HSCA (RA) Regulations 2014</p> <p>Person centred care</p> <ul style="list-style-type: none">• Staff did not ensure that all care plans were personalised or person centred, and that patients and families were involved in care planning.• There was inadequate space in some bedroom for patients in wheel chairs to use there toilet and showers. The adapted bathroom was off the ward as not easily accessible.• Patients preference for care and treatment was not recorded.• Staff did not record when patients were supported to use the shower or bath. <p>The is a breach of Regulation 9 (1) (b)(c)</p> |
| Regulated activity | Regulation |
| Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury | <p>Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect</p> <p>Regulation 10 HSCA (RA) Regulations 2014</p> <p>Dignity and respect</p> <ul style="list-style-type: none">• The provider did not ensure that all patients were treated with dignity and respect at all times. On Oakley female ward staff were not always discrete when meeting the personal care needs of patients.• Not all staff were respectful when assisting patients with meals and drinks. |

This section is primarily information for the provider

Requirement notices

The is a breach of Regulation 10 (1)

Regulated activity

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

Personal care

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 HSCA (RA) regulations 2014

Safe care and treatment

- The provider did not ensure that all risk assessments capture up to date and current risks following review.
- The provider did not ensure that all incidents that require reporting were reported.

This is a breach of Regulation 12 (1) (2) (a) (b)

Regulated activity

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

Personal care

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13 HSCA (RA) Regulations 2014

Safeguarding service users

- Male patients were left unsupervised on a female only ward. There was no evidence of care plan or risk assessment to mitigate this risk.
- The provider did not report all safeguarding incidents via the safeguarding process.

This is a breach of Regulation 13 (2) (3)

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

Personal care

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014

Good governance

- The provider did not ensure that all incident forms were fully completed and that incidents are fully investigated and learnt from.
- Staff used restrictive interventions but these were not recorded in line with the Code of Practice. Interventions and reviews were not robustly documented.
- The provider did not ensure that all patients' records were securely stored and kept confidential.
- The provider did not ensure that there were systems and processes in place to ensure medication and other equipment was in date.
- The provider did not ensure that there were systems and processes in place to monitor and maintain physical health equipment.

This is a breach of Regulation 17 (2) (c)