Jigsaw Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated Jigsaw independent hospital as good because:

- The service was clean and newly refurbished. Ligature risks were well managed.Staff had completed comprehensive risk assessments for patients and these were up to date and reviewed regularly. Practice in relation to moving and handling and falls assessment and management had improved. Moving and handling risk assessments were in place for all patients who needed these and included falls risk information and plans.
- Care records contained up to date, personalised, holistic care plans. Staff had created easy read or pictorial care plans for some patients who needed these. There was excellent psychology and occupational therapy provision. Physical healthcare needs were assessed and monitored, with care plans devised to capture this. A practice nurse had been appointed part time to assist staff with physical healthcare monitoring.
- We saw positive interactions between staff and patients during this inspection. Patients were positive about staff, describing them as kind, respectful, polite and caring. Two carers gave positive feedback about their relative's care.
- All admissions to the hospital were planned. A pre-admission assessment was completed by clinicians before placement was offered and this included a detailed breakdown of proposed interventions and treatment and a timescale for admission. The hospital managers and commissioning lead had been proactive in identifying the next steps for some patients and in liaising closely with commissioners to plan successful patient discharges.

However:

- The service had made progress in identifying and reviewing blanket restrictions but there were still some blanket restrictions in place. These were in relation to rooms and outside space; which patients were not able to access.
- Not all staff had their own confidential email address and each ward had a mailbox which all staff accessed.
- The service has not ensured ongoing arrangements for recruitment and training of hospital managers in relation to the Mental Health Act 1983.
- Most patients were involved in activities but patients mentioned a lack of activities at evenings and weekends. This had been highlighted in a recent patient survey.
- Some patients told us they did not use the complaints system as they felt it was not effective.

Summary of findings

Contents

Good

Jigsaw Independent Hospital

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to Jigsaw Independent Hospital

Jigsaw Independent Hospital provides care and treatment for up to 37 patients. At the time of the inspection there were 15 patients at the hospital, all of whom were detained under the Mental Health Act.

The provider was registered to provide the following regulated activities:

• Diagnostic and screening procedures

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

• Treatment of disease, disorder or injury

The wards we visited were:

Linden ward – male complex care and rehabilitation with 10 beds

Cavendish ward – female complex care and rehabilitation with 10 beds

Two other wards are currently closed. Montrose ward, an eight-bedded ward and Oriel ward, a nine bed ward.

The service had previously been comprehensively inspected in January 2017. At that inspection, there had been concerns about oversight of supervision, appraisals and training and ligature risk assessments being out of date. A requirement notice was served for a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the hospital as requires improvement overall. We rated safe and welled as requires improvement and effective, caring and responsive as good. An action plan was developed by the provider to address these issues.

At a follow-up inspection in January 2018 the requirement notice was found to be met but other issues were identified, resulting in requirement notices being issued for breaches of regulations 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found these requirement notices had been met.

The registered manager for the service had left earlier in the year. At the time of inspection, the service had an acting manager and a controlled drugs accountable officer.

Our inspection team

The team that inspected the service comprised three CQC inspectors, a medicines inspector, and two specialist advisors who were an occupational therapist and a physiotherapist. Specialist advisors had a background in learning disability and rehabilitation settings.

Why we carried out this inspection

This was a planned comprehensive inspection to inspect and rate the service and to follow up previous requirement notices.

Summary of this inspection

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the location including information discussed at provider engagement meetings. The service had also completed a provider information request after the inspection was announced.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with seven patients who were using the service;
- spoke with the acting manager;
- spoke with the clinical lead nurse;
- spoke with 20 other staff members; including support workers, doctors, nurses, occupational therapy staff, clinical psychologist, domestic staff and the cook;
- spoke with the advocate;
- attended and observed two morning meetings;
- attended one handover meeting;
- attended one multidisciplinary patient review meeting;
- collected feedback from nine patients and carers using comment cards;
- spoke to one carer;
- looked at eight care and treatment records of patients;
- received feedback about the service from five care co-ordinators or commissioners;
- carried out a specific check of the medication management on two wards; and
- 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 seven patients about their care. We offered to speak with all patients, but not everyone wanted to speak with us.

All patients told us the wards were clean and they were happy with their own bedrooms, which they could personalise. Patients were positive about staff, describing them as kind, respectful, polite and caring. Some patients noted high levels of agency staff and that staff changed frequently. Three patients described feeling unsafe, in two instances this was related to illness and in one instance due to a previous assault from peers. Most patients were involved in activities but three mentioned a lack of activities at the evenings and weekends. Four patients mentioned having to ask staff for drinks and drinks and snacks not being freely available. One patient was unhappy with the food choices, but all other patients were positive about food choices and quality of the meals provided. Most patients were aware of likely discharge plans and were involved in these.

One carer fed back in person and via a comment card positively about the care their relative received. They told us that their relative was well cared for and safe. Another carer had fed back by comment card with praise for the staff and care their relative was receiving.

Seven other comment cards were reviewed, with positive feedback regarding staff, community trips, activities and cleanliness although there were also comments regarding concerns about patient mix on wards and high numbers of temporary staff at times.

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?

Good

We rated safe as good because:

- Ward areas were clean, and following a recent refurbishment the furniture and fittings were all good quality and in good condition.
- Staff had completed comprehensive risk assessments for patients and these were up to date and reviewed regularly.
- Moving and handling risk assessments were in place for all patients who needed these and included falls risk information and plans.

However:

- The service had made progress in identifying and reviewing blanket restrictions but there were still some blanket restrictions in place in relation to rooms which patients were not able to access and access to outside space.
- Patients were monitored following rapid tranquilisation administration but this was not in line with the policy.

Are services effective?

Good

We rated effective as good because:

- Physical healthcare needs were assessed and monitored, with care plans devised to capture this. A practice nurse had been appointed part time to assist staff with physical healthcare monitoring.
- Care records contained up to date, personalised, holistic care plans. Staff had created easy read or pictorial care plans for patients who needed these.
- There was good psychology and occupational therapy provision.
- In terms of clinical audit, there was a structured audit schedule overseen by the company audit lead.
- There was positive feedback about multidisciplinary working from a range of external sources.
- Staff showed a good understanding of the Mental Capacity Act 2005 and the five statutory principles.

However

- There was an issue in that not all staff had their own email address and each ward had a mailbox which all staff accessed.

Summary of this inspection

- The service has not ensured ongoing arrangements for recruitment and training of hospital managers in relation to the Mental Health Act.

Are services caring?

Good

We rated caring as good because:

- We saw positive interactions between staff and patients during this inspection.
- Patients were positive about staff, describing them as kind, respectful, polite and caring.
- Two carers gave positive feedback about their relative's care.
- In records we reviewed, there were highly detailed, individualised care plans which showed patient involvement and included patients signing their plans and in some cases adding comments.
- The advocate chaired a patient forum every month for patients to attend.

However:

- There were mixed responses from patients about privacy and dignity from a provider led survey.

Are services responsive?

Good

We rated responsive as good because:

- All admissions to the hospital were planned. A pre-admission assessment was completed by clinicians before placement was offered and this included a detailed breakdown of proposed interventions and treatment and a timescale for admission.
- The hospital managers and commissioning lead had been proactive in identifying next steps for some patients, and in liaising closely with commissioners to plan successful patient discharges.
- A visitor's room was available adjacent to the main reception area and this was light and bright, with comfortable furniture.

However:

- Most patients were involved in activities but patients mentioned a lack of activities at the evenings and weekends and this was highlighted in a recent occupational therapy led survey.
- Patients could make drinks on the wards if they had access to the kitchens. Otherwise patients told us they would ask for drinks. Cold drinks were provided on Cavendish ward during this inspection but patients told us this did not happen every day and was dependent on certain staff.

Summary of this inspection

- Some patients told us they did not use the complaints system as they felt it was not effective.

Are services well-led?

Good

We rated well led as good because:

- Staff were aware of the vision and values of the service. Staff knew the manager and senior managers within the service.
- Overall, the managers had oversight of the hospital in terms of regular audits, staff management, staffing numbers and incidents.
- Sickness and absence rates were low at 1%.
- Staff described and we saw good multidisciplinary team working and a good morale amongst ward based staff.

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.

We reviewed Mental Health Act policies and found these were all up to date and compliant with the Mental Health Act code of practice. However, there was no policy for recruitment of hospital managers and their powers under the Act.

Hospital managers have specific duties under the Mental Health Act in relation to reviewing detention and authorising discharge for detained patients. The current group of six hospital managers had been recruited several years ago. The Mental Health Act Code of Practice outlines a need for governance arrangements in relation to hospital managers, that there is assurance managers appointed understand their role and receive suitable training, that appointments should be for a fixed period and that managers panels understand equality issues and specific needs of particular patient groups. We were not assured that this was in place.

We reviewed four Mental Health Act files. All necessary papers were up to date and accurate.

A Mental Health Act administrator worked within the hospital. They were available during the week to scrutinise detention papers prior to admission for patients. They also ensured that the Mental Health Act was followed in relation to renewals, consent to treatment and appeals against detention.

All staff undertook Mental Health Act training and at the time of inspection all staff had completed this. Staff understood how the Mental Health Act applied to their role.

Forms authorising section 17 leave were in place for all patients and appropriately completed. This included space for staff to capture feedback following leave and any issues.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received training in the Mental Capacity Act and 97% of staff were up to date with this.

There had been no Deprivation of Liberty safeguards applications made in this service.

Staff showed a good understanding of the Mental Capacity Act and the five statutory principles. Where patients might have impaired capacity, capacity to consent was assessed and recorded appropriately.

Staff made best interest decisions following the Mental Capacity Act code of practice. Best interest meetings were convened and included relatives and other professionals where possible.

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Jigsaw independent hospital had four wards over four floors. Two wards were not in use. Linden ward was on the first floor and Cavendish ward was on the ground floor. Both these wards were being refurbished at the time of this inspection. Refurbishment work had been planned with contractors and risk assessed prior to work commencing. The work and risk assessments were reviewed on a daily basis. At the time of inspection, the work remaining was to replace the kitchens.

Both wards had a layout of a bedroom corridor from a central area off the entrance to the ward, the ward office, clinic, dining room and communal lounge. Each ward had a de-escalation room at the end of the bedroom corridor although these were also being refurbished for use as quiet lounges. The observation of the ward was generally good, and staff were aware of "blind spots". Closed circuit television cameras were used in communal areas of both wards. These were not used for real time monitoring but recordings could be used for post incident reviews or safeguarding investigations. The provider consulted with staff and patients prior to the decision to install these and had followed the information commissioner code of practice, including completion of a comprehensive policy.

Staff completed ligature risk assessments every month. Ligature points are places to which a patient intent on self-harm might tie something to strangle themselves. Assessments were completed with the head of maintenance to ensure any building work which had changed risks was captured. We checked these assessments during ward visits and found they included risks on each ward. Staff were aware of ligature risks on their wards and how these were managed.

Both wards had well equipped clinic rooms which were clean and tidy. Equipment was well maintained. Clinic room temperatures and fridge temperatures were checked daily to ensure medicines were stored appropriately. Resuscitation equipment was stored in the ground floor reception area and all staff had a key to access this.

All ward areas were clean and most furnishings were new. A refurbishment programme was underway within the hospital and new furniture and fittings had recently been purchased.

All staff were trained in the prevention of the spread of infection. Staff understood the importance of handwashing and there was antibacterial hand gel at the entrances to the wards. Staff wore plastic aprons and gloves when completing tasks which required these. Infection control audits were completed each month on the wards and actions were taken when needed. This included handwashing and equipment available. Senior managers completed a yearly infection prevention and control summary for the service.

Equipment was generally well maintained. One patient used a four-wheel rollator to mobilise. The seat had broken and was awaiting repair. This equipment was still usable but the seat is important as this allows the patient to stop and rest safely.

Long stay/rehabilitation mental health wards for working age adults

Good

Both wards were clean and a programme of cleaning was undertaken each week. Cleaning records showed this was completed correctly.

Maintenance and clinical staff undertook environmental audits every six months. When work had been needed this had been undertaken promptly. Cleaning schedules had been amended to include maintenance issues identified and actions taken so that domestic staff ensured a record was kept where they were documenting and reporting issues. This worked well, with issues escalated and acted upon.

Clinical staff carried alarms which they could use to summon assistance. Call buttons were in each patient bedroom for patients to use if they needed staff help.

Safe staffing

There were 44 nursing staff posts for the hospital. There were 12 registered nurse posts with nine full time registered nurses employed working across both wards and three vacancies.

The establishment numbers for shifts were for one registered nurse and four support workers in the day on Cavendish ward with one registered nurse and three support workers at night. On Linden ward, there was one registered nurse and three support workers in the day and one registered nurse and two support workers at night. In the eight weeks prior to inspection, these staffing levels had been maintained, and often exceeded, with additional staff booked when needed, for example, if a patient required enhanced observations.

Between March and June 2018, there were 154 shifts covered by bank staff and 554 shifts covered by agency nurses. There were no shifts that could not be filled. During this period of time the hospital had one other ward open which had closed by the time of inspection. Agency nurses booked in the two months before inspection were familiar with the service, and on occasions were block-booked, for example, to cover several consecutive shifts, to ensure continuity for patients.

The clinical lead nurse was responsible for booking additional staff and was able to adjust staffing levels if needed.

Two doctors provided medical cover during the week, with one consultant psychiatrist working full time and one psychiatrist working two days per week. At nights and weekends a consultant psychiatrist was available on call and could attend the ward if needed.

Staff were up to date with some mandatory training, including health and safety, infection control and moving and handling. All registered nurses had completed immediate life support training in the last 12 months.

Staff undertook first aid at work training with an annual refresher which included basic life support training. Training figures for staff (including bank staff) up to date with this were 80% and 75% respectively.

Staff undertook two courses incorporating techniques for managing aggressive behaviour, an intermediate course and an advanced additional one-day course. The advanced course included “ground recovery techniques”, which are floor restraint techniques. For the intermediate course 85% of all staff who needed to attend were in date and for the advanced course 62% of staff required to attend had attended. The provider had booked staff to attend the advanced refresher courses on upcoming courses and had one course trainer off work for some time which had affected course availability.

Assessing and managing risk to patients and staff

In the six months between January and June 2018 there had been 13 uses of restraint on Linden ward with two of these being prone restraints and resulting in rapid tranquillisation. On Cavendish ward there had been three restraints overall, with no prone restraints and none resulting in rapid tranquillisation.

We reviewed eight care and treatment records. Staff had completed comprehensive risk assessments for patients and these were up to date and reviewed regularly.

Staff completed positive behaviour support plans for patients who needed these. These were detailed and individualised. However, one patient’s positive behaviour support plan did not include previous high risk incidents. Patients also had positive handling plans which contained information aligned to team teach techniques and guidance for staff if restrictive interventions, particularly

restraint were needed. In one file, the plan made clear a need to avoid prone or supine restraint due to physical health conditions although in one other record similar conditions were not considered.

The clinical psychologist completed specific validated risk assessments where these were indicated, for example, relating to offending behaviour. The psychology team had also recently constructed a vulnerability risk assessment tool which looked at identifying specific vulnerabilities, a formulation of these and scenarios where these vulnerabilities may increase. Scenarios included post discharge community scenarios and these were valuable in planning next steps for patients in terms of what support needs there were. These had been completed for several patients and were well completed, individualised and detailed.

Staff had completed personal emergency evacuation plans for patients who needed these.

We reviewed three files for patients who had mobility issues. All records contained completed individual moving and handling risk assessments. These contained sufficient detail for staff to be able to assist patients. These were a new format which incorporated moving and handling assessments, safe handling plans, a bed rail risk assessment, falls risk assessment and formulation and equipment risk assessments and maintenance.

Falls care plans were in place for patients who were assessed as needing these. Staff completed care plans which contained guidance for staff and pictures of equipment being used, including actions to be taken if patients fell. Occupational therapy or nursing staff had completed equipment risk assessment section for aids in use by patients, including shower chairs, bath handles, rollators, walking frames, wheelchairs and mobility scooters.

Staff had reviewed risks of using bed rails for all patients and at this inspection these were not in use.

The provider had focused on improving practice in relation to blanket restrictions and restrictive practice across the service. A policy had been devised to look at reducing blanket restrictions. This included a flowchart that was related to using restrictive interventions in the form of restraint, despite the specific guidance from the Mental Health Act code of practice which was included in the policy.

There were blanket restrictions in place on both wards in the form of access to the garden areas for smoking. On Cavendish ward, staff kept patient's cigarettes and lighters in the ward office which some patients had not agreed to. The laundry room on Cavendish ward was locked, and this was not recognised as a blanket restriction, whilst the laundry room on Linden ward was unlocked with free access for patients.

On both wards, the kitchens were locked but individual risk assessments were in place. As a result, four patients on Linden ward and two patients on Cavendish ward had keys to access the kitchen without staff. All patients had been assessed and there were clinical indications relating to restricted access for some patients.

Patients had had capacity assessments completed for some of the restrictions placed on them, and some individual restrictions were care planned and necessary to maintain patient's safety. For some practices, evidence based practice was unclear, for example, three patients had restrictions in the form of restricting access to excessive amounts of clothing including having wardrobes locked, but this seemed to be with the overall aim to continue the restriction, rather than prompting a review of other ways the behaviour could be addressed or less restrictive options. However, there were examples otherwise where other options had been considered and alternative plans made, rather than imposing restrictions.

Staff followed the provider policy for observations and these were increased and reduced for individuals as their needs changed. There was a policy for searching patients but this would only be undertaken on an individual basis if there were risks identified which warranted this.

Restraint was used as a last resort if de-escalation failed. The training provided to staff included training staff in de-escalation approaches.

Use of rapid tranquillisation was in line with NICE guidance. The provider policy included monitoring charts but physical observations were often recorded in the clinical notes. Staff were not monitoring for the period suggested by the policy following administration of a fast acting antipsychotic medication.

Staff were trained in safeguarding and knew how to make safeguarding referrals. In the twelve months leading to this inspection there had been 25 notifications made to the Care Quality Commission.

Long stay/rehabilitation mental health wards for working age adults

Good

Medicines were stored securely and at the right temperatures in the two clinic rooms. Resuscitation equipment, oxygen and medicines for emergency use were stored safely but were easily accessible. Staff checked emergency equipment on a daily basis.

All prescription charts were clearly completed and included patients' allergies. A pharmacist visited fortnightly to clinically screen prescriptions and complete an audit of medicines. Stock levels and ordering of medicines were managed by a pharmacy technician, through weekly visits.

All patients were registered with a local GP practice. The hospital kept some stock medicines but medicines were usually prescribed for patients by their GP. Regular prescriptions were requested by the supplying pharmacy on the hospital's behalf.

The supplying pharmacy provided medicines training and annual medicines competency assessments for nurses.

Staff maintained controlled drugs safely. Controlled drugs books and stock were checked and correct. The service had a controlled drugs accountable officer.

Medicines management meetings were held every three months and medicines incidents were reviewed, audits discussed and training levels reviewed. Policies were drafted and reviewed in relation to medicines practice. The pharmacist attended or sent feedback relating to pharmacy audits.

Staff followed the provider policy for visits by family members. A visiting room was available to use adjacent to the reception area for family visits including child visits. This was a good size, comfortably furnished and with toys and games available.

Track record on safety

There had been one serious incident since the last inspection. A root cause analysis had been undertaken for this but this was brief and did not explore wider circumstances around the incident. Actions had been taken following this incident to prevent further similar incidents.

Reporting incidents and learning from when things go wrong

All staff knew how to report incidents. The provider used an electronic incident system. Staff were open and transparent and explained to patients when things went wrong.

Incidents and learning were discussed in staff team meetings and daily meetings. Incidents were also discussed in multidisciplinary meetings.

The service undertook a monthly analysis of incidents and accidents to identify themes and actions needed.

Duty of Candour

The provider had a policy for staff outlining the duty of candour. Staff were aware of their responsibilities relating to duty of candour. There had been no incidents since the last inspection which met the threshold for duty of candour.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed eight care records at this inspection. Staff completed comprehensive assessments when patients were admitted. Physical healthcare needs were assessed and monitored, with care plans devised to capture this. A practice nurse had been appointed part time to assist staff with physical healthcare monitoring. All patients were registered with a local GP service and attended for appointments and screening as needed.

Care records contained up to date, personalised, holistic care plans. Staff had created easy read or pictorial care plans for some patients who needed these.

The service used mainly paper based records, with computer systems available for incident reporting, Mental Health Act monitoring and staffing and training oversight. Not all staff had their own email address and each ward had a mailbox which all staff accessed. This worked well for updates sent to all staff to read or action, for example, the weekly pharmacy audits. However, this meant that emails could be deleted or sent and there was no clear audit trail as to who had actioned this. It also meant that information could not be addressed to one specific person or a specific group of staff.

Long stay/rehabilitation mental health wards for working age adults

Good

Best practice in treatment and care

Medical staff followed National Institute for Health and Care Excellence guidance when prescribing medication, and when patients were prescribed high dose antipsychotic medication this included additional monitoring as advised by the Royal College of Psychiatrists guidance.

The clinical psychologist worked with two assistant psychologists. They provided psychological support to patients. Psychological interventions were provided on a one to one basis and included interventions recommended by the National Institute for Health and Care Excellence. Interventions included illness related work and mental health awareness, substance misuse work including motivational work and understanding problematic use and dialectical behaviour therapy informed interventions. The psychology team also completed structured specialist risk assessments and formulations for the whole multidisciplinary team to inform care. A range of standardised tools were used as needed, including positive and negative symptom scales and mood assessments.

There was good access to physical healthcare including access to specialists when needed and consultant psychiatrists maintained good communication with the GP service.

The occupational therapist outlined a structured approach with all patients including screening and assessment using the Model of Human Occupation Screening Tool with patients. Occupational therapy plans outlined needs and plans in relation to self care, leave, habituation and productivity. There were specific assessments undertaken as needed, for example, road safety assessments and sharps kitchen assessments. Interest checklists were completed with patients and colour pictorial versions were available. Three occupational therapy assistants worked in the service, offering a full programme of individual and group activity, both in the hospital and in the community.

Monthly reports were completed showing activities attended and offered, both individual sessions and groups.

The occupational therapist had also worked to improve practice across the service in falls management and moving and handling, bringing tools and assessments together into one document. This ensured staff had access to information relating to moving and handling, falls and equipment in one place.

Some files contained completed Recovery STAR forms, although it was not clear what patient involvement there had been with these.

Skilled staff to deliver care

The hospital had a full range of mental health disciplines and workers providing input to the wards including nursing and medical staff, occupational therapy staff, psychology team and clinical pharmacy services. The recruitment of a practice nurse to work within the company was positive in focusing on patient's physical health.

Staff told us they had been supported when they started work and had received an induction and mandatory training.

Staff were receiving individual supervision and appraisals and records were available and up to date in the three personnel files reviewed. Supervision was being undertaken as per the providers policy. Supervision included managerial and clinical components, although some staff sourced their own clinical supervision. All staff had had an appraisal within the last 12 months.

Staff meetings took place on a bi-monthly basis, with some reflective practice sessions and nurse meetings arranged also.

Staff were able to access some additional training within the company when this was arranged. This had previously included one-day learning disability and autism awareness training sessions and risk assessment training. There were no current figures available for the number of staff trained across the service. Some staff had previously attended relevant conferences, for example, wound care approaches.

In terms of clinical audit, there was a structured audit schedule overseen by the company audit lead. Clinical staff audited practice within the hospital and undertook actions because of these.

Poor staff performance was addressed. Managers had a company human resources advisor to provide assistance. There were relevant policies available for staff performance. An annual leavers report was completed by the human resources advisor to identify themes and this evidenced staff who had been dismissed after they had failed to complete probationary arrangements.

Multi-disciplinary and inter-agency team work

Long stay/rehabilitation mental health wards for working age adults

Good

Multidisciplinary meetings were held for each patient every two weeks. Inspection staff attended one multidisciplinary meeting and found these to be well organised and structured. Representatives from all clinical disciplines were present and contributed.

There were two handovers each day between nursing staff. These were recorded on a template form which covered staff on duty, clinical changes such as risks, observation levels needed, accidents, incidents, multidisciplinary meetings, reviews, environmental issues and a summary report for each patient.

There were good working relationships with commissioners and care managers. We asked for feedback from stakeholders and had a good response, with five staff providing feedback who represented four separate commissioning groups. There was positive feedback regarding pre-admission assessments and reports.

Care managers reported being informed of any significant changes or incidents by the service. They were positive about the skills of the multidisciplinary team. They had positive experience of carer involvement. Commissioners and care managers found the service was responsive to requests for reports and information and that they were informed well in advance of care programme review meetings and tribunals which helped them attend.

Feedback included reference to the service being open to continued improvement and positive accounts of improvements for patients in the service and their care.

Adherence to the MHA and the MHA Code of Practice

We reviewed Mental Health Act policies and found these were all up to date and compliant with the Mental Health Act code of practice. However, there was no policy for recruitment of hospital managers and their powers under the Act.

Hospital managers have specific duties under the Mental Health Act in relation to reviewing detention and authorising discharge for detained patients. The current group of six hospital managers had been recruited several years ago. The Mental Health Act Code of Practice outlined a need for governance arrangements in relation to hospital managers, that there should be assurance managers appointed understand their role and receive suitable training, that appointments should be for a fixed period and that managers panels understand equality issues and specific needs of particular patient groups. We were not assured that this was in place. However managers told us they were aware of this and were working with the human resources manager to address these issues.

We reviewed four Mental Health Act files. All relevant papers were present and correct.

A Mental Health Act administrator worked within the hospital. They were available during the week to scrutinise detention papers prior to admission for patients. They also ensured that the act was followed in relation to renewals, consent to treatment and appeals against detention.

All staff undertook Mental Health Act training and at the time of inspection all staff had completed this. Staff understood how the Mental Health Act applied to their role.

Forms authorising section 17 leave were in place for all patients and appropriately completed. This included space for staff to capture feedback following leave and any issues.

Patients had their rights under the Mental Health Act explained at admission and at appropriate intervals thereafter. We saw that staff would attempt to explain these more frequently for patients who needed assistance to understand or retain this information.

There was a contracted independent advocacy service in place for patients. The advocate visited twice per week and attended meetings and reviews as necessary. They also chaired the patient forum. Posters informing patients how to contact the advocate were displayed on the wall of the service.

Consent to treatment documentation, along with completed capacity assessments in relation to medicines, were kept with the eight patients' medicine charts we looked at.

Good practice in applying the MCA

Staff received training in the Mental Capacity Act and 97% of staff were up to date with this.

There had been no Deprivation of Liberty safeguards applications made in this service.

Staff showed a good understanding of the Mental Capacity Act and the five statutory principles. Where patients might have impaired capacity, capacity to consent was assessed and recorded appropriately.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff made best interest decisions following the Mental Capacity Act code of practice. Best interest meetings were convened and included relatives and other professionals where possible.

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

Good

Kindness, dignity, respect and support

During this inspection there were observations of positive and caring interactions between staff and patients. Staff knew patients in their care well and were respectful and responsive when support was needed.

We spoke with seven patients about their care. Patients were positive about staff, describing them as kind, respectful, polite and caring. Some patients noted high levels of agency staff and that staff changed frequently. Three patients described feeling unsafe, in two instances this was related to illness and in one instance due to a previous assault from peers.

Most patients were involved in activities but three mentioned a lack of activities at the evenings and weekends. Four patients mentioned having to ask staff for drinks and drinks and snacks not being freely available. One patient was unhappy with the food choices, but all other patients were positive about food choices and quality of the meals provided.

Most patients were aware of likely discharge plans and were involved in these.

All patients felt the wards were clean and were happy with their own bedrooms, which they could personalise.

One carer fed back in person and via a comment card positively about the care their relative received and feeling they were cared for well and safe. Another carer had fed back by comment card with praise for the staff and care their relative was receiving.

Seven other comment cards were reviewed, with positive feedback regarding staff, community trips, activities and cleanliness although there were also comments regarding concerns about patient mix on wards and high numbers of temporary staff at times.

The involvement of people in the care they receive

In records we reviewed, there were detailed, individualised care plans which showed patient involvement and included patients signing their plans and in some cases adding comments.

Patient surveys had been undertaken in June 2018 with nine patients completing questionnaires. All patients reported being welcomed to the ward when admitted and most patients were positive about involvement in their care and treatment, felt listened to and felt multidisciplinary reviews were effective. All but one patient reported family or friends were positive about the care patients were receiving. Seven patients would recommend the service to family and friends.

There were mixed responses regarding safety, privacy and dignity, with three patients reporting feeling unsafe and four patients who felt staff did not respect their privacy and dignity or knock before entering their bedrooms.

The most negative response was around discharge pathways, with two thirds of patients completing the survey saying they were unaware of this, although seven patients reported being actively involved in discharge planning so it is possible that some patients felt unaware of where specifically they were likely to be discharged to.

A patient survey had also been completed over two months in June and July 2018. This asked about activities and groups. The advocate had also led on assisting patients in completing surveys if needed. These highlighted patients feeling there were not enough activities in the evenings or at weekends. The actions taken following this were for individual planners to be updated with activities in evenings or at weekends that nursing staff could assist with and to re-audit in near future.

Several patients had section 17 leave to visit family and friends, and staff either accompanied them throughout the leave or arranged dropping off and picking up at times that suited the patients and their families.

The advocate chaired a patient forum every month for patients to attend. Patients had raised suggestions for

Long stay/rehabilitation mental health wards for working age adults

Good

improvements and any service related issues. These were fed back to the senior management and actions taken if possible, although some issues were raised recurrently before action was taken. At the most recent meeting patients raised concerns about staffing and particularly staffing at nights, with patients reporting not being able to go out for cigarettes and feeling unsafe due to incidents occurring at nights. There was positive feedback about the refurbishments. The forum minutes were sent to the hospital quality lead and the plan was for actions and managerial responses to be fed back by the quality lead at weekly ward meetings.

The patient's forum had also discussed plans for refurbishment and been involved in choosing colours, furnishings and flooring.

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

Good

Access and discharge

The bed occupancy rate for the hospital at the time of inspection was 75%.

Most patients residing at the hospital were commissioned from the Greater Manchester area.

All admissions to the hospital were planned. A pre-admission assessment was completed by clinicians before placement was offered and this included a detailed breakdown of proposed interventions and treatment and a timescale for admission. When the hospital could not offer placement, the reasons were explained and recommendations made. Patients and relatives were encouraged to visit the service prior to admission.

Pre-admission assessments were discussed at a regular admissions and discharges meeting. This took place each month to review assessments, referrals being considered by funding panels and progress relating to discharge for each in-patient. This detailed clinical progress being made, likely discharge placement and timescales.

During the six months prior to the inspection visit there had been six admissions and discharges for patients who were identified as needing short term admission. The service had reviewed their model of care and pathways, noting more recent admissions had admissions planned for a maximum of two years and often less, but a small number of patients at the hospital who had complex needs had had longer admissions and there have been difficulties identifying next steps for some patients. Since the last comprehensive inspection, four patients had been discharged from the hospital who had long admissions and there had been considerable progress in planning for discharge for some patients with complex needs.

In the feedback received from commissioners, one account noted that some individuals had moved to Jigsaw independent hospital after a higher than average number of previous placements and on occasion having been informed by other providers that there was no further rehabilitation potential. Despite this, the hospital team had enabled these patients to make significant progress towards independence and successful transition into the community.

The hospital managers and commissioning lead had been proactive in identifying next steps for some patients, and in liaising closely with commissioners to plan successful patient discharges.

Discharge plans were in place in all patient files reviewed and discharge planning was discussed at each multidisciplinary meeting.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had activity rooms available away from the wards for occupational therapy and psychology sessions. There were meeting rooms away from the wards for multidisciplinary team meetings. On each of the wards, there was a communal lounge and dining room and an additional room on each was being refurbished to provide a quiet lounge and multi-faith room. A visitor's room was available adjacent to the main reception area and this was light and bright, with comfortable furniture.

Some patients had their own mobile phones to make calls. There were cordless phones available on the ward for patients to make private phone calls.

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Good

Patients could access a secure garden area at set intervals during the day to smoke with staff. One patient with unescorted leave had a swipe card to allow them to access the garden area.

Meals were made on site in the hospital kitchen. The cook devised a four-week menu with input from patients. There was support to provide special diets if needed for health or religious reasons. The cook described meeting with patients to ask about preferences and likes and dislikes shortly after admission.

Patients could make drinks on the wards if they had access to the kitchens. Otherwise patients told us they would ask for drinks. Cold drinks were provided on Cavendish ward during this inspection but patients told us this did not happen every day and was dependent on certain staff.

All patients said they could personalise their bedrooms and we saw bedrooms had patients own belongings as well as posters and furnishings.

The service did not have wireless internet access for patients, but patients could access the internet using a computer in the activity room off the wards. The service had provision for skype access for patients to keep in contact with families.

A full activity programme was running during the week, but there was a lack of activities in the evenings and at weekends, identified through interviews with patients, patient forum minutes and the patient survey. Patients enjoyed regular community group leave on a weekly basis which centred around a social activity or visit, including a trip to Blackpool on one of the inspection days.

Meeting the needs of all people who use the service

The hospital had been adapted to allow disabled access, with a ramp leading up to the front door. The ward areas could all be accessed by lift.

At the time of this inspection, there were no patients who required interpreter services, but services could be sought if needed. Information leaflets were available in an easy read format regarding Mental Health Act rights.

Patients with a learning disability had, "all about me" profiles in their files which were individualised and detailed. Health passports were stored with medicines cards so that these were accessible and could accompany the patient to healthcare appointments or in an emergency. Easy read or pictorial care plans were in place for patients who needed these.

Listening to and learning from concerns and complaints

Staff and patients were aware of the hospital complaints policy. Patients we spoke to knew how to make a complaint, but several said they had no faith in the formal complaints system and therefore did not use it. There had been one patient complaint in the last six months made in February 2018 which was not upheld.

The service recorded compliments and there were 19 received between October 2017 and March 2018. These were often from external professionals visiting the service.

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

Good

Vision and values

Staff were aware of the vision and values of the service. Staff knew the manager and senior managers within the service.

Good governance

There had been changes to the hospital and company management structures over the last year. The hospital continued to use the governance structures put into place two years ago and the governance meetings worked well. These fed into a provider wide senior management meeting which was held monthly.

Overall, the managers had oversight of the hospital in terms of regular audits, staff management, staffing numbers and incidents.

The manager had sufficient autonomy and administrative support for their role. The clinical lead was responsible for staffing rotas and supervision of clinical staff.

Long stay/rehabilitation mental health wards for working age adults

Good

There was a local risk register for Jigsaw independent hospital and this was reviewed by the senior management team each month. Issues were escalated to board level where necessary.

Leadership, morale and staff engagement

A staff survey had been completed in June 2018. Staff felt positive about being encouraged to report incidents, access to mandatory training, knowing responsibilities and being trusted in their work. Staff were positive about their line manager and colleagues. Staff expressed job satisfaction in their role and felt they made a difference to patients. Negative responses related to questions about career development, developmental reviews and questions about staff wellbeing. Less than 50% of staff felt involved in changes in their immediate workplace. Less than half the staff who responded felt there were sufficient staff to work properly. The hospital was planning actions to address the issues raised.

Sickness and absence rates were low at 1%. There had been 12 staff leavers in the last 12 months. Staff were aware of whistleblowing processes and a freedom to speak up guardian was in post. Staff told us they would feel able to raise concerns.

Staff described good multidisciplinary team working and a good morale amongst ward based staff.

The company had recently started a newsletter for distribution across all their services to ensure staff were informed about changes occurring or events taking place.

Commitment to quality improvement and innovation

Jigsaw independent hospital was an associate member of the Quality Network for Mental Health rehabilitation (also known as AIMS rehab) network. Senior clinicians in the service had been involved in network peer reviews. The managers were in the process of completing the self-assessment to become a developmental or accredited member of the network.

The service was developing a quality improvement strategy, involving staff in identifying areas in their workplace for improvement. This had only recently started.

Outstanding practice and areas for improvement

Outstanding practice

The development of a vulnerability risk assessment tool was innovative. These were psychology led and future focused. The tools were used in identifying specific vulnerabilities, a formulation of these and scenarios where these vulnerabilities may increase. Scenarios included community scenarios and these were valuable in planning next steps for patients in terms of what support needs there were. These were psychology led and future focused.

These had been completed for several patients and were well completed, individualised and detailed.

Patients also found them beneficial in terms of a model for understanding patterns of behaviour. This was particularly useful in conceptualising personality disorder and traits in a less stigmatising or negative way.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review blanket restrictions in this service and review the provider policy.
- The provider should review arrangements for ensuring access to medicines on leave.
- The provider should assess the current information technology provision in relation to shared ward email addresses.
- The service should ensure there is review of recruitment and training of hospital managers in relation to the Mental Health Act.
- The provider should review activity provision at evenings and weekends.
- The provider should review the complaints process and policy with patients.