The Priory Ticehurst House

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

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.

Overall summary

We retained our rating of the long stay/rehabilitation mental health wards for working-age adults at the Priory Ticehurst House as requires improvement because:

- Patient care plans were not based on building on the strengths of patients and lacked a recovery or rehabilitation focus. The majority of care plans contained reference to providing patients with a meaningful and purposeful life, but did not show how this would be achieved. There was little evidence of discharge planning and how staff would support patients to lead a more independent life in the community.
- The therapeutic and developmental quality of the overall activity program was limited. The type of activities on offer were of an entertainment type, rather than assisting patients to recover or rehabilitate.
- The ability of staff to observe all parts of the units was restricted. There were blind spots on all three units. The controls in place for managing or minimising idenitifed ligature risks lacked substance and were generic in nature. There were no notes to describe how each identified risk was to be reduced or eliminated.
- The environment on Highlands was not appropriate for people with restricted mobility. There were narrow corridors that had uneven flooring and a number of tight corners. The clinic rooms on each unit were small

Summary of findings

and did not have sufficient space for an examination couch. As a result, staff had to carry out some duties (for example administration of medicines, health checks and electrocardiograms) in patients' bedrooms.
- Staff turnover levels were high, at 36% during the period 01 June 2016 to 31 May 2017.
- Not all staff had completed every mandatory training subject within the last 12 months.
- There were no rooms allocated for patients to spend time with visitors. They either used the patient's own bedroom, an activity room, or the quiet lounge on Highlands.

However:

- Individual risk assessments were thorough and tailored to each patient. They were completed at the point of admission and appropriately updated thereafter. Staff used tools appropriate to the age and abilities of the patient group, such as the malnutrition universal screening tool and falls risk assessments.
- Staff met the physical health needs of patients. Ongoing general monitoring of physical health monitoring was carried out and appropriately recorded. Patient records also showed evidence of ongoing physical health monitoring in respect of known conditions such as epilepsy and diabetes. Every patient medicines chart showed evidence of following National Institute for Health and Care Excellence guidance in prescribing medicines.
- Staff we spoke with knew how to make an incident report and what types of incident they should report. We saw evidence that learning from previous incidents was being shared, both at unit level and at managerial level.
- The units were compliant with Department of Health same sex accommodation guidance. Since our last inspection in January 2016, the service had moved to make all three units single gender patient groups.

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Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Our inspection team

Team leader: Steven McCourt, CQC inspector

The team that inspected the service comprised three CQC inspectors, two specialist professional advisors with experience working within in-patient mental health settings, and one expert by experience.

Why we carried out this inspection

We undertook this unannounced, focussed inspection to find out whether The Priory Ticehurst House had made improvements to their long stay/rehabilitation mental health wards for working-age adults since our last comprehensive inspection of the hospital in January 2016.

When we last inspected the hospital in January 2016, we rated long stay/rehabilitation mental health wards for working-age adults as **requires improvement** overall. We rated the core service as requires improvement for safe, effective and well-led, and good for caring and responsive.

Following our last inspection, we told the provider it must take the following actions to improve long stay/ rehabilitation mental health wards for working-age adults:

- The provider must review arrangements around emergency response to the Lodge and arrangements about a defibrillator.
- The provider must review mixed gender accommodation on Highlands ward to comply with guidance on gender segregation.
- The provider must ensure incident reports on the long stay rehabilitation wards have sufficient detail and investigations and information about lessons learnt are available.
- The provider must ensure daily health monitoring checks are undertaken.

We issued the provider with three requirement notices for long stay/rehabilitation mental health wards for working-age adults. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 10 Dignity and respect
- Regulation 12 Safe care and treatment
- Regulation 17 Good governance

A requirement notice is issued by CQC when an inspection identifies that the provider is not meeting essential standards of quality and safety. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

How we carried out this inspection

During a comprehensive inspection 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?

On this inspection we just looked at the five key questions for the long stay/rehabilitation service. We did not inspect the other services delivered at The Priory Ticehurst House.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

Summary of this inspection

- visited the the hospital, looked at the quality of the environment on each unit delivering long stay/ rehabilitation services and observed how staff were caring for patients;
- spoke with eight patients who were using the service;
- spoke with two carers of patients who were using the service;
- looked at 14 patient care and treatment records;
- reviewed 14 medicine charts
- spoke with the ward manager and the ward consultant;
- spoke with 14 other staff members; including ward doctor, nurses, healthcare assistants, therapists and housekeeping staff;
- attended and observed one multidisciplinary meeting; one daily planning meeting; and two therapy sessions;
- carried out a specific check of the medicines management on each unit;
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about The Priory Ticehurst House

The Priory Ticehurst House is a hospital located in East Sussex. The hospital offers inpatient mental health services for young people and adults, although on this inspection we only looked at long stay/rehabilitation mental health wards for working-age adults.

The hospital's three long stay/rehabilitation units had a total of 21 beds.

The hospital also has two acute psychiatric care units, two children and adolescent mental health units and three long stay rehabilitation and recovery units.

Priory Ticehurst is registered for the following regulated activities: Assessment or medical treatment for persons detained under the Mental Health Act 1983; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Accommodation for persons who require nursing or personal care; Accommodation for persons who require treatment for Substance misuse.

The hospital was inspected in January 2016. The acute units for adults of working age and psychiatric intensive care units, and the child and adolescent mental health units each received a overall good rating. The long stay/ rehabilitation mental health units for working-age adults were rated as requires improvement.

The hospital had a registered manager.

What people who use the service say

The patients we spoke with told us they felt safe on the units. Most of them were also very positive about the way staff treated them.

We observed a large number of interactions between staff and patients. Staff consistently treated patients with care, dignity and respect. They displayed a high level of understanding of the individual needs and personality of each patient.

Carers we spoke with were complimentary about the way staff treated patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We retained our rating of safe as requires improvement because:

- The ability of staff to observe all parts of the units was restricted. There were blind spots on all three units. The controls in place for managing or minimising idenitifed ligature risks lacked substance and were generic in nature. There were no notes to describe how each identified risk was to be reduced or eliminated.
- The clinic rooms on each unit were small and did not have sufficient space for an examination couch. As a result, staff had to carry out some duties (for example administration of medicines, health checks and electrocardiograms) in patients' bedrooms.
- The service relied heavily on bank and agency staffing. Staff turnover levels were high, at 36% during the period 01 June 2016 to 31 May 2017. This had a negative impact on consistency of the service provided to patients.
- The service struggled to recruit and retain members of staff, due in part to the remote rural location of the hospital.

However:

- Individual risk assessments were thorough and tailored to each patient.
- Ongoing monitoring of physical health (including blood pressure and body mass) was carried out and appropriately recorded.
- Since our last inspection in January 2016, the service had moved to make all three units single gender patient groups so meeting Department of Health same sex accommodation guidance .
- The clinic rooms on each of the units were clean, tidy and well organised. They were equipped with resuscitation equipment and emergency drugs. Medicines were stored appropriately in locked cabinets that were secured to the walls. All medicine charts were properly completed and signed.

Are services effective?

Requires improvement

We retained our rating of effective as requires improvement because:

- Patient care plans were not based upon the individual strengths and abilities of each patient. They did not sufficiently focus on the personal recovery or rehabilitation to the patients

Summary of this inspection

The majority of care plans contained reference to providing patients with a meaningful and purposeful life, but did not show how this would be achieved. There was little evidence of recovery focussed discharge planning and how staff would support patients to lead a more independent life in the community.
- Not all staff had completed available training within the last 12 months.

However:

- The ongoing nutrition and hydration needs of patients was assessed through the monitoring of body mass and calculation of body mass index.
- Every patient medicines chart showed evidence of following National Institute for Health and Care Excellence guidance in prescribing medicines
- Staff demonstrated good understanding of the Mental Health Act (MHA), the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). MHA paperwork was securely stored and correctly completed.

Are services caring?

Good

We retained our rating of caring as good because:

- Staff treated patients in a caring, respectful and responsive manner.
- Staff displayed a high level of understanding of the individual needs and abilities of patients.
- Patient care records showed evidence of their involvement in the care planning process and were offered a copy of their care plan.
- Patients had access to advocacy services and were able to attend community meetings, where they could provide feedback on the service.
- Staff from The Lodge had helped to prepare three patients for a move from The Lodge to Highlands, by discussing the reasons for the move with them, and enabling them to visit Highlands, to see the unit and to meet patients there.

Are services responsive?

Good

We retained our rating of responsive as good because:

- At the time of our inspection, there were no out-of-area placements on the units.
- Beds were kept open for patients when they go on leave.

Summary of this inspection

- Highlands and The Lodge both had an activity room. Highlands also had a quiet lounge. All three units had a garden, for use by patients.
- Patients were actively engaged in activities, including a variety of outings into the local community.
- Patients were able to personalise their bedrooms and had access to drinks and snacks throughout the day and night.
- Lowlands was a fully adapted bungalow for people with restricted mobility. The building had level access throughout, doorways had been widened and bath and shower facilities were suitable for wheelchair users. There were ramps to the front door and rear door leading into the garden.
- Patients we spoke with knew how to make a complaint and there was information about how to complain on unit notice boards. However, no complaints had been received during the last 12 months.

However:

- The environment on Highlands was not appropriate for people with restricted mobility. There were narrow corridors that had uneven flooring and a number of tight corners.
- There were no rooms allocated for patients to spend time with visitors. They either used the patient's own bedroom, an activity room, or the quiet lounge on Highlands.

Are services well-led?

Good

We re-rated well led as good because:

- All staff received regular supervision and had had an appraisal within the last 12 months, and most had completed mandatory training relevant to their role.
- Staffing levels were sufficient to meet the needs of patients. Although the service relied heavily on the use of bank and agency staff, those workers were usually familiar with the unit and patients. The manager had arranged block contracts for locum nurses and multidisciplinary team members to best ensure continuity.
- The ward manager had access to appropriate administrative and managerial support.
- Staff could submit items to the hospital risk register. The risk register was discussed at monthly clinical governance meetings.
- Staff demonstrated a high level of passion for their work. They told us that managers encouraged them to pursue opportunities for relevant training and career development.

Summary of this inspection

- Staff felt able to raise any concerns or issues without fear of recriminations or victimisation. Staff told us they felt supported by colleagues and managers within the organisation. Staff said that morale had significantly improved since the present manager took control of the three units in August 2016.

However:

- Managers had not sufficiently included staff when planning the closure of The Lodge to patients. Some staff we spoke with did not have a clear understanding of when the closure was due to happen, or of what the building was subsequently going to be used for. It is evident that these changes were set to bring about fundamental changes to the service and staff working arrangements.

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.

- Mandatory training rates for Mental Health Act training were 80% and staff demonstrated a good understanding of the legislation.
- Informal patients were made aware of their right to leave at any time.
- Mental Health Act paperwork was all securely stored and correctly completed. Staff had clearly completed capacity to consent to treatment documentation in all patient files.
- Staff had links with the local authority approved mental health professional service and knew the process for requesting a Mental Health Act assessment.
- Specialist independent mental health advocacy was available to all patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.
- Staff completed MCA training as part of their mandatory training. Staff training rates were 83% compliant.
- At the time of the inspection three patients were subject to a DoLS authorisation.
- Specialist independent mental capacity advocacy was available to all patients.

Overview of ratings

Our ratings for this location are:

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

Notes

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

- There were three long stay/rehabilitation units at Priory Ticehurst House: Highlands, Lowlands and The Lodge. All three units provided a single-gender environment. Highlands and The Lodge were allocated for female patients and Lowlands was allocated for male patients.
- Each unit was a sited in a separate building within the main hospital grounds. Highlands was sited in an old two storey listed building with 11 single bedrooms. The Lodge was sited in a two-storey house with six single bedrooms, while Lowlands was a four bedroom bungalow.
- The ability of staff to observe all parts of the units was restricted. There were blind spots on all three units. Convex mirrors were installed in some parts of Highlands, but other corners in the unit were unsighted. The environment within The Lodge was more open than in Highlands, and so afforded better lines of sight. There were some blind corners in Lowlands, but the domestic style environment was manageable for staff.
- Staff had identified various potential ligature anchor points throughout the units, in a comprehensive ligature risk audit. However, the controls in place for managing or minimising idenitifed ligature risks lacked substance and were generic in nature. There were no notes to describe how each identified risk was to be reduced or eliminated. Ligature cutters were easily accessible in the nursing offices.
- The clinic rooms on each unit were small and did not have sufficient space for an examination couch. As a result, staff had to carry out some duties, for example, administration of medicines, health checks and electrocardiograms in patients' bedrooms.
- The clinic rooms on each of the units were clean, tidy and well organised. They were equipped with resuscitation equipment and emergency drugs. Medicines were stored appropriately in locked cabinets that were secured to the walls. All medicine charts were properly completed and signed.
- All three units were clean, tidy and well lit. However, the state of the décor on the Highlands and The Lodge was poor and in need of updating.
- Equipment on all three units was well maintained, clean and stickers were visible and in date. We reviewed cleaning records and schedules. They were all up to date.
- Staff on all three units adhered to infection control processes.
- Staff used radios to communicate with each other and between different units. There were nurse call buttons on the wall in each room. These alerted staff if a patient required assistance.
- Regular environmental risk assessments were carried out, to assess and manage risks present within the units.

Safe staffing

- Staff on each of the three units worked a two shift pattern of 7.30am – 8pm and 7.30pm – 8am. This allowed for a 30 minute handover between staff at the

start of each shift. On Highlands and The Lodge, there was a qualified nurse on each shift, who was accompanied by healthcare assistants. Lowlands was normally staffed by exclusively healthcare assistants. A qualified nurse from either Highlands or The Lodge was available to assist Lowlands staff, as required.

- The three units had a dedicated staff grade doctor and consultant psychiatrist who was the responsible clinician. A local general practitioner visited the units one day every week.
- Recruitment and retention of staff presented an ongoing challenge for managers. This was due in part to the rural location of the hospital.
- At the time of our visit, the three units had a combined total of the following staffing vacancies: three and a half qualified nurse posts; nine unqualified healthcare assistant posts; a part-time psychologist; a full-time occupational therapist; and, a vacancy for a part-time fitness instructor.
- Staff sickness across the service during the period 01 June 2016 to 31 May 2017 was 4%.
- Staff turnover across the service during the period 01 June 2016 to 31 May 2017 was 36%. This was lowest in the multidisciplinary and management team (25%) and highest on The Lodge (50%).
- The three units regularly used bank and agency staff. The hospital had contracts with local agencies that provided staff on a block booking basis, to avoid using ad hoc agency staff that were unfamiliar with the patients or the units. During the period 01 March to 31 May 2017, a total of 144 shifts were filled by bank staff; 395 shifts were filled by agency staff; and, 17 shifts were left unfilled by either bank or agency staff.
- Escorted leave or unit activities were rarely cancelled because there were too few staff.
- The ward manager was able to adjust staffing levels in accordance with the needs of the patients.
- Staff had generally received and were up to date with mandatory training. Compliance rates were below 75% in the following subjects: managing violence and aggression: using restraint (73%); rapid tranquilisation (50%) and confidentiality and data protection (36%).

Assessing and managing risk to patients and staff

- There were five reported instances of physical restraint used during the six month period from 01 December 2016 to 31 May 2017. They all occurred on Highlands unit. During that same period, there had been no reported use of prone restraint or rapid tranquilisation on any of the three units.
- Risk assessments were completed on admission and regularly updated thereafter. The assessments and accompanying management plans were thorough and tailored to each individual patient. Ongoing monitoring of physical health including blood pressure and body mass was carried out and appropriately recorded. Staff used tools appropriate to the age and abilities of the patient group, such as the malnutrition universal screening tool and falls risk assessments.
- The doors to Highlands and The Lodge were kept locked. However, informal patients were able to leave upon request.
- Staff followed the company observation policy, which employed an assessment of current risks, to decide the most appropriate supervision level for each patient.
- Children under the age of 18 could were not allowed to the units. However, there was a child friendly visiting room available within the main hospital building.
- 78% of staff had received training in safeguarding within 12 months leading up to the inspection. Staff we spoke with could identify different forms of abuse and were familiar with the process of making a safeguarding alert.
- A local pharmacist visited the units once a week. They delivered medicines and conducted audits of medicine charts. We saw evidence of good medicines management in respect of storage, dispensing and reconciliation of medicines.

Track record on safety

- Data from the hospital showed there were a total of six serious incidents during the period 01 June 2016 to 31 May 2017. All of these incidents occurred on Highlands unit.

Reporting incidents and learning from when things go wrong

- Staff we spoke with were able to provide examples of the type of incidents that would need to be reported.
- All staff had access to the electronic reporting system. Incident reports we looked at contained a description of the incident, details of subsequent actions taken and changes to working practices implemented as a result of the incident.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Incidents were discussed at monthly staff meetings, management meetings and clinical governance meetings. Minutes of the meetings were recorded and made availbable to staff. We saw evidence of discussion about the facts and causes of recent incidents; lessons that could be learned; and, resultant changes to future working practice.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at the care records for 14 patients which all showed that staff had completed comprehensive and timely assessments at the point of admission.
- Staff completed physical health monitoring and the ward doctor completed a full physical health check for all patients when they were admitted. The physical health checks included weight, blood pressure and electro-cardiograms. Patient records showed evidence of ongoing physical health monitoring.
- Patient care records were stored securely in electronic form.
- Care records contained up to date, personalised care plans, however these were not strength based and lacked a recovery, or rehabilitation focus. The majority of care plans contained reference to providing patients with a meaningful and purposeful life, but did not show how this would be achieved. There was little evidence of discharge planning and how staff would support patients to lead a more independent life in the community. Although the combination of patients' ages and physical health issues might make living more independently a remote possibility in some cases, care plans could have displayed a more meaningful attempt to promote recovery or rehabilitation.

Best practice in treatment and care

- Psychological input was provided by a part-time locum psychologist and a part-time assistant psychologist. They delivered low lovel interventions, primarily aimed at providing behavioural support, rather than in-depth psychological input. According to the staff we spoke with, the main challenge for delivery of psychological therapies was the resistance to treatment of most of the patients. The focus was therefore for psychology staff to establish a level of trust with each patient, so they could employ gentle questioning to enable patients to connect with who they are, and their past life.
- The ongoing nutrition and hydration needs of patients was assessed through the monitoring of body mass and calculation of body mass index. Staff also used the malnutrition universal screening tool to establish nutritional risk.
- We reviewed fourteen medicine charts, which all showed evidence of following National Institute for Health and Care Excellence guidance in prescribing medicines. This ensured that all medicines were prescribed within approved limits to enable best possible patient outcomes.
- A full range of health professionals either visited the units regularly. A general practitioner visited the units one day each week, and a podiatrist and continence nurse visited the units every six weeks. Staff could also refer to specialist services between these times.

Skilled staff to deliver care

- The staff team working on the three units included qualified mental health nurses, a qualified physical health nurse and healthcare assistants. The multidisciplinary team for the units comprised a ward manager, a part-time consultant psychiatrist, a full-time staff grade doctor, a full-time qualified occupational therapist, a part-time assistant psychologist, and a part-time locum psychologist. The hospital was in the process of trying to recruit a permanent psychologist and an assistant ccuptional therapist. A general practitioner and a pharmacist visited the unit on a weekly basis.
- All staff had received an appraisal within the last 12 months.
- Staff had regular supervision sessions with either the ward manager or a qualified nurse.
- Team meetings took place on a monthly basis. The minutes of these meetings were circulated to staff. Topics discussed learning from recent incidents, staffing issues and training.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- A wide range of training courses relevant to the patient group were available to staff. Some were delivered face-to-face, but the majority were in the form of online elearning. Training completion rates were generally above 75%. Courses with a completion rate below 75% were safeguarding children and young people (59%) and clinical risk assessment (66%).

Multi-disciplinary and inter-agency team work

- Ward managers from across the hospital and multidisciplinary team members attended a hospital daily meeting each morning. Topics discussed included staffing levels, incidents, admissions, current risks and emergency arrangments including fire marshalls and fast response team.
- Following the conclusion of the hospital daily meeting, a meeting took place for the long stay/rehabilitation units. Each of the three units were represented, along with members of the wards' own multidisciplinary team. They discussed events over the preceding 24 hours and made plans for the next 24 hour period. Topics discussed incidents, feedback from the hospital daily meeting, present risks, health appointments, outings and smoking cessation work.
- There was a 30 minute handover from staff at the start of each shift to update the oncoming staff of any incidents and planned activities and appointments.
- Staff reported having good links with local health and support services, who either visited the hospital regularly for example general practitioner, pharmacist and podiatrist or who were available upon request for example dentist, physiotherapist, optician, speech and language therapist and continence nurse.

Adherence to the MHA and the MHA Code of Practice

- Eighty per cent of staff had received training in the Mental Health Act within the last 12 months. Staff we spoke with demonstrated a good understanding of the legislation.
- Informal patients were made aware of their right to leave at any time.
- Mental Health Act paperwork was securely stored and correctly completed. Staff had clearly completed capacity to consent to treatment documentation in all patient files.
- Staff had links with the local authority approved mental health professional service and knew the process for requesting a Mental Health Act assessment.
- Patients could access specialist independent mental health advocacy services as required.
- An appropriate level of Mental Health Act administrative support was provided by a dedicated officer within the main hospital building.

Good practice in applying the MCA

- Eighty three per cent of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) within the last 12 months. Staff we spoke with demonstrated a good understanding of the legislation and its guiding principles.
- During the period 01 December 2016 to 31 May 2017, a total of three DoLS applications had been made in respect of patients on the three units. All three of the those applications had been granted.
- We found evidence that capacity to consent was assessed and recorded appropriately for people who might have impaired capacity. Decisions were recorded appropriately.
- Patients could access specialist independent mental capacity advocacy services as required.

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

Good

Kindness, dignity, respect and support

- We observed many instances in which staff interacted with patients in a caring, respectful and responsive manner. We saw staff supporting patients with physical tasks, and also assisting them in respect of their current mental and emotional state.
- Staff displayed a high level of understanding of the individual needs and abilities of patients. For example, we witnessed how a member of staff skilfully de-escalated a situation in which a patient was emotionally distressed. They clearly had a strong understanding of what approach to adopt with that individual.
- Most of the patients we spoke with were complimentary about the way staff treated them.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Both of the carers we spoke with told us they were happy with the care provided by staff.

The involvement of people in the care they receive

- We reviewed 14 patient care records which all showed evidence of patient involvement in care planning. Staff offered patients a copy of their care plan.
- There had been no new admissions during the previous six months. However, the admission process to all three units was thoroughly planned. The manager and occupational therapist visited the patient prior to admission. The patient would also visit the hospital once or twice prior to admission to help orientate themselves to the unit. New patients received an information pack about the unit and the service provided.
- Patients were able to attend community meetings, where they could provide feedback on the service.
- At the time of our visit, the three patients from The Lodge were in the process of moving to Highlands, due to the closure of The Lodge which was scheduled for the following week. Staff had discussed the reasons for the move with patients, and had enabled patients from The Lodge to visit Highlands, to see the unit and to meet patients there.

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 three units had a combined capacity of 21 patients. At the time of our inspection, there were 14 patients on the units.
- In respect of the 14 current patients, the most recent admission was 18 months ago. The average length of stay was five years. The expected length of stay in this type of complex care inpatient rehabilitation unit is five to ten years.
- The average occupancy rate during the period 01 December 2016 to 31 May 2017, was 63% on Highlands, 100% on Lowlands and 50% on The Lodge.
- At the time of our inspection, there were no out-of-area placements on the units.
- Admissions and discharges were carried out in a well planned way.
- Beds were kept open for patients when they go on leave.

The facilties promote recovery, comfort, dignity and confidentiality

- Highlands and the Lodge both had a clinic room. However, they were too small to accommodate an examination couch. Patient examinations and procedures were routinely conducted in the patient's bedroom.
- Highlands and the Lodge both had an activity room. Highlands also had a quiet lounge on the first floor.
- There were no rooms allocated for patients to spend time with visitors. They either used the patient's own bedroom, anactivity room, or the quiet lounge (on Highlands only).
- Every unit had its own garden, which patients could use. The rear gardens for Highlands and the Lodge were secured by a high perimeter fence. The garden for the Lowlands was open and only partially enclosed by a hedge and low fence.
- All patients had access to a communal cordless telephone, on which they could make calls in privacy.
- Patients had access to activities seven days per week. Activities were facilitated by the occupational therapist and unit staff.
- Each patient on Lowlands had a small safe and lockable drawer in their bedroom. Patients on Highlands and The Lodge did not have their own lockable space in their room. However, they were able to store personal possessions in the large unit safe.
- Patients on all three units had access to drinks and snacks 24 hours a day.
- Patients were able to personalise their bedrooms. We saw evidence that patients had done so.
- Meals were cooked centrally in the main hospital building and delivered to the three units. Patients we spoke with were happy with the quality of food provided. However, two of them told us that they were bored with the choices of main meals offered.

Meeting the needs of all people who use the service

- Lowlands was a fully adapted bungalow for people with restricted mobility. There were ramps to the front door

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

and rear door leading into the garden. Internally, the building was level access throughout and the doorways had been widened. The bath and shower facilities were also suitable for wheelchair users. However, the environment on Highlands was not appropriate for people with restricted mobility. There were narrow corridors that had uneven flooring and a number of tight corners. Access to some areas of the building would therefore be problematic for wheelchair users.

- Information leaflets were available in accessible formats, such as large print or in easy read or pictorial formats. Leaflets could be translated if required and there was information about interpreting services on the unit notice boards.
- Details on sources of spiritual support, including local churches, were clearly displayed on unit notice boards.
- Staff identified dietary requirements of patients upon admission to the units. Any dietary requirements were discussed with the hospital kitchen so arrangements could be made for cultural and religious food preferences. Arrangements were also made for patients who may have allergies or require gluten free options.

Listening to and learning from concerns and complaints

- Most of the patients we spoke with told us they knew how to make a complaint, and were happy to raise any issues they encountered.
- According to figures supplied by the service, no complaints were received during the period 01 June 2016 to 31 May 2017.
- Staff we spoke with were aware of what to do if a patient or carer wanted to complain.
- There was information on how to complain on notice boards within the units.

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

Good

Vision and values

- Staff were aware of, and agreed with, the visions and values of the Priory Group, particularly that of "putting people first".
- Staff we spoke with told us that they knew the members of the hospital senior management team and that they visited the units.

Good governance

- Staff received regular supervision and had had an appraisal within the last 12 months.
- Most staff had completed mandatory training relevant to their role.
- Staffing levels were sufficient to meet the needs of patients. Although the service relied heavily on the use of bank and agency staff, those workers were usually familiar with the unit and patients. The manager had arranged block contracts for locum nurses and multidisciplinary team members to best ensure continuity.
- The management team used weekly reports to monitor the performance of the three units. The report presented data on a range of factors, such as adherence to the regular updating of care plans and risk assessments. Monthly clinical governance meetings took place, during which incidents, accidents and safeguarding alerts were discussed.
- The ward manager had access to appropriate administrative support.
- The ward manager had sufficient authority and was appropriately supported by senior managers.
- Staff could submit items to the hospital risk register. The risk register was discussed at monthly clinical governance meetings.

Leadership, morale and staff engagement

- The manager of the three rehabilitation units had been in post since August 2016. They had focussed their efforts on stabilising the day-to-day operation of the service, following an extended period of unsettled management. They had successfully improved the processes in place to provide support to staff (including regular and effective supervision appraisals and meetings); improved the consistency of monitoring and managing the physical health of patients; and, raised staff morale.
- The staff sickness rate for the period 01 June 2016 to 31 May 2017 was 4%.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff demonstrated a high level of passion for their work. They told us that managers encouraged them to pursue opportunities for relevant training and career development.
- There had been no reported bullying or harassment cases and one instance of whistleblowing during the period 01 June 2016 to 31 May 2017. Staff we spoke with were aware of the whistleblowing process and felt able to raise any concerns or issues without fear of recriminations or victimisation. Staff told us they felt supported by colleagues and managers within the organisation. Staff said that morale had significantly improved since the present manager took control of the three units in August 2016.
- During our visit, we discovered that there was a plan to close The Lodge and transfer the three female patients from that unit to Highlands. Some staff we spoke with did not feel that they had been sufficiently incuded in the planning for the unit closure, and were unaware of the date for the closure of The Lodge, or what for the building was subsequently going to be used for. Managers told us that their plan was to close The Lodge during the week after our inspection visit.
- The hospital management team published an annual staff engagement action plan, which cited operational priorities to improve communication and the recruitment and retention of staff. Staff engagement survey results were published and available to all staff to read. Staff took part in regular meetings within the hospital and had regular supervision sessions and an annual appraisal.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must update the ligature risk assessment to be more specific and have an action plan to mitigate any identified risks.

The provider must ensure that care plans are individualised, strengths based, and have a recovery and rehabilitation focus. They must also improve the therapeutic and developmental quality of the activity program for each individual patient.

Action the provider SHOULD take to improve

The provider should ensure that all staff have a complete, up to date set of mandatory training, including the Mental Health Act, the Mental Capacity Act and adult safeguarding.

The provider should continue to work to improve retention of staff.

The provider should improve disability access within Highlands unit.

The provider should increase the size of the clinic room on Highlands unit.

The provider should involve staff in making decisions affecting the service.

The provider should update the decor of Highlands unit.

The provider should improve facilities in which patients can meet with their visitors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patients and others were not protected against the risks associated with unsafe care and treatment: • Ligature risks were identified and rated in the ligature risk assessment, but the control for every risk was to "accept risk". • There was no plan for how each individual ligature risk that had been identified, was to be eliminated, reduced or managed.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Patient care plans were not based upon the individual strengths and abilities of each patient. They did not sufficiently focus on the personal recovery or rehabilitation to the patients. • There was little evidence of recovery focussed discharge planning and how staff would support patients to lead a more independent life in the community. • The activity program provided to each individual patient lacked a sufficient level of therapeutic and developmental quality.