Rhodes Wood Hospital

Quality Report

Shepherds Way
Brookmans Park
Hatfield
AL9 6NN
Tel:01707 29150
Website:www.elysiumhealthcare.com

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive?	Good
Are services well-led?	Inadequate

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 did not rate this inspection. The ratings from the inspection which took place 09 to 11 April 2019 remain the same.

At the inspection in April 2019, we issued enforcement action because the provider failed to provide safe care and treatment to young people.

We carried out a focused inspection in October 2019 to check against the enforcement action taken in April 2019. Following this inspection, we issued urgent enforcement action because the provider was failing to provide safe care and treatment to young people. The provider was required to make improvements in the use of seclusion and long term segregation. These, specifically were:

- Patients did not have care plans to reflect that seclusion and segregation was required as part of their care.
- Staff confirmed they had received training on seclusion and long-term segregation. However, there was noticeable confusion as to what they were, and the differences.
- Significant numbers of seclusion paperwork were incomplete and not comprehensive.
- We were not assured that staff understood or followed the Mental health Act Code of Practice in relation to seclusion and long term segregation.

This inspection looked specifically at these areas of concern. The inspection was focused and unannounced. We do not revise ratings following inspections of this type. Following this inspection, we issued further enforcement action. We found the following during our focused inspection:

- Staff that we spoke with had received training on seclusion and long-term segregation. Only seven out of ten frontline staff were able to clearly explain the meaning of seclusion and six out of ten frontline staff were able to explain long-term segregation. Staff knowledge varied considerably, and staff remained uncertain on the meaning of long term segregation. We were therefore not assured that all staff had retained their knowledge of the training or that they would be competent in implementing seclusion or long term segregation.
- Data received during the inspection indicated that 80% of permanent staff had received training on seclusion and long term segregation however we did not gain clarity on the figures for agency staff.
- During the inspection we received a copy of the seclusion and long term segregation policy. This was incomplete as it was still under review and was not therefore ready for use by the staff.
- On the morning of the inspection, we requested the nursing and medical reviews for long term segregation as they were not recorded in the patient records. They were provided to us after further requests. The medical reviews were not in line with the Mental Health Act code of practice. The record showed a log of the Doctor's signature each day. We noted that medical reviews had not always been undertaken at the weekends and those that had been done were completed over the phone and not face to face.
- The nursing reviews were not in line with the Mental Health Act code of practice. The records showed a question had been posed for staff to complete within the daily shift checklist (and not a separate long term segregation record). The question read: "Is the LTS care plan being followed?" In some instances, this was left blank or recorded as not applicable. This checklist commenced in February 2020 one month after the period of long term segregation had started.

However:

- The provider had submitted a weekly update on any patients with restrictions on their movements. There were none until mid-January 2020.There had been no episodes of seclusion and on reviewing the patient records for Mymwood we were assured that this was the case.
- We received a submission from the provider that a young person on Mymwood ward had commenced long term segregation in mid-January 2020. The records that we reviewed during the inspection stated that the plan was discussed at the Multi Disciplinary Team Meeting in early February 2020 and then shared with the Local Authority social worker and NHSE.

Summary of findings

- During the inspection we reviewed the long term segregation care plan which was detailed. We reviewed the records and the long term segregation was reviewed weekly by the multi disciplinary team starting on 16 February 2020 and weekly thereafter. We saw from the patient records that staff were making regular efforts to engage the young person in appropriate activities and that the young person went out on leave with their parents and with nursing and occupational therapy staff.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	

Summary of findings

Contents

Inadequate

Rhodes Wood Hospital

Services we looked at

Child and adolescent mental health wards.

Summary of this inspection

Background to Rhodes Wood Hospital

Rhodes Wood hospital is a registered location under the provider of Elysium Healthcare Limited. The hospital comprises of three different wards: Shepherd, Cheshunt and Mymwood Place. Shepherd and Cheshunt wards can accommodate males and females, between the ages of

eight and 18 years, who have a primary diagnosis of an eating disorder. Mymwood place is a

neuro-developmental service, which can accommodate males and females, between the ages of 12 to 18.

The provider has agreed with NHS England, that they will not accept any further admissions onto Mymwood place. There are ongoing discussions about the future of this ward. There are a total of 42 beds across the hospital. Mymwood Place has 12 beds, Cheshunt ward has 15 beds, and there are a further 15 beds on Shepherd ward.

The CQC registers Rhodes Wood Hospital to carry out the following legally regulated services/activities:

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

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

The hospital has been registered with CQC since October 2016. Since this time, the service has been inspected three times. The overall rating following the first inspection was good in 2017. The second inspection was in April 2019, and the service was rated as inadequate.

Following this inspection, the provider was told to make significant improvements in seven areas of care and treatment. We then carried out a focussed inspection in October 2019 and found that improvements had been made in six out of the seven areas.

We were not assured that the provider had made sufficient improvements in the use of and documentation of seclusion and long term segregation.

At the time of this inspection, the hospital had a registered manager and an interim hospital director.

Our inspection team

The inspection team comprised one Mental Health Act Reviewer and two Inspectors with experience of Child and Adolescent Mental Health Services.

Why we carried out this inspection

We inspected Rhodes Wood Hospital in April 2019. At this time, we identified that the provider was failing to meet Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. As a result of this, we took enforcement action

against the provider and issued a warning notice under Section 29 of the Health and Social Care Act 2008. We issued this, as we identified:

- The provider did not have robust management of ligature risks. Ligature risk assessments did not identify all potential risks and did not contain adequate mitigation of risks. Staff could not refer to the ligature risk assessments easily as they were held centrally, as opposed to being available on each ward.
- Staff had used seclusion of patients on two occasions, and had failed to recognise, or record this as seclusion. Therefore, documentation had not been completed, in line with hospital policy and the Mental Health Act Code of Practice.

Summary of this inspection

- Not all staff carried alarms. Staff were able to summon assistance via calls bells across the hospital. However, when the alarms sounded, it only alerted staff who were located in certain offices. This had caused some delays in staff response to alarms.
- Staff had not checked the contents of the emergency bag on Cheshunt ward properly. Staff had signed to indicate that all contents were present and correct. We found this to be inaccurate, as we identified that some emergency medicines were absent.
- Staff were not adhering to infection control principles in relation to waste management. We found general waste in clinical waste bags and sharps bins. Nursing staff had failed to date or sign a sharps box upon opening.
- Staff were not undertaking individual risk assessments for young people in a timely way following admission. We found that risk assessments were not always comprehensive.
- Staff had failed to manage Section 17 leave adequately. We found many gaps, including specific durations of leave; names of escorting staff; details of home address when the young person was on home leave; a lack of a contingency planning for if things went wrong, and staff had not always recorded how the leave had gone, from the perspective of the young person, escorting staff, or appropriate others.

We identified in October 2019 that the provider had met all of the concerns except the use of seclusion and long term segregation as we identified:

- Staff were not clear as to what seclusion and long-term segregation was and could not clearly explain the differences between the two. Seclusion and segregation paperwork had been put in place so staff could record any instances. However, the paperwork was incomplete and not comprehensive.
- We found a lack of care planning, and limited records to show reviews of young people in seclusion or long term segregation had taken place.
- We could not ascertain, in a number of records viewed, the length of time the seclusion or segregation had lasted. Secluding or segregating young people for any longer than necessary is an infringement of their human rights.
- We were not assured that staff understood or followed, the Mental Health Act Code of Practice, in relation to seclusion and segregation safeguards.

We carried out a focused inspection in October 2019 to check on progress made against the warning notice issued in April 2019. We were not assured the provider kept young people safe in respect of seclusion and long term segregation. We then took further enforcement action and issued an Urgent Notice of Decision under Section 31 of the Health and Social Care Act, imposing the following conditions:

1. The Registered Provider must provide the Care Quality Commission by 5pm every Friday with a log of all incidents where any restrictions on a patient's movements have taken place.
2. The Registered Provider must provide the Care Quality Commission by 5pm every Friday with records for each episode of seclusion.

This must include:

The start and end time for each episode of seclusion.

Confirmation of the authorisation for seclusion and by whom.

Complete records to show regular reviews and other information as required by the Mental Health Act Code of Practice.

3.The Registered Provider must provide the Care Quality Commission by 5pm every Friday with all records of long-term segregation, care plans for each patient subject to segregation, multi-disciplinary team reviews of said segregation and safeguarding referrals.

4.The Registered Provider must provide the Care Quality Commission with an Action Plan to review its processes for seclusion and long-term segregation and all essential safeguards surrounding this.

5.The Registered Provider must send to the Care Quality Commission all reports made to the Local Authority and stakeholders regarding all incidents of long-term segregation and seclusion.

This inspection looked specifically at these areas of concern. This inspection was focused and unannounced. We do not revise ratings following inspections of this type.

Summary of this inspection

How we carried out this inspection

We have reported specifically upon the five areas of concern listed in the Notice of Decision. All of these concerns fell into the key question of safe. Therefore, our report does not include all the headings and information usually found in a comprehensive report. We have not re-rated this service. The ratings from the last inspection remain the same.

Before the inspection, we reviewed the information that we had about the service.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- carried out a specific review of incidents
- carried out an observation of care
- spoke with six patients who were using the service
- spoke with the interim hospital manager
- spoke with 11 other staff members; including nurses, therapeutic care workers, speech and language therapist, clinical lead and practice development lead
- looked at eight care and treatment records of patients 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 six young people who were using the service at Rhodes Wood Hospital. All of the patients that we spoke with said that they felt safe on the ward. All six patients also said that the permanent staff were kind, caring and supportive.

Three patients said that this was not always the case with the agency staff and that they had experienced staff falling asleep whilst doing their observations. They also said that it was sometimes apparent that agency staff could not wait to get away at the end of the shift. One patient said that on occasion staff spoke in their own language whilst on duty.

Two patients stated that there had been times when it was challenging on the ward for example, when they had witnessed incidents involving other patients. However, all of the patients said that staff responded quickly to alarms when an incident was occurring.

Three out of the six patients said that they could always access fresh air and that staff were flexible and made the effort to ensure that they had their leave.

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?

Inadequate

- Staff that we spoke with had received training on seclusion and long-term segregation. Only seven out of ten frontline staff were able to clearly explain the meaning of seclusion and six out of ten frontline staff were able to explain long-term segregation. Staff knowledge varied considerably, and staff remained uncertain on the meaning of long term segregation. We were therefore not assured that all staff had retained their knowledge of the training or that they would be competent in implementing seclusion or long term segregation.
- During the inspection we received a copy of the seclusion and long term segregation policy. This was incomplete as it was still under review and was therefore not ready for use by the staff.
- On the morning of the inspection, we requested the nursing and medical reviews for long term segregation as they were not recorded in the patient records. They were provided to us after further requests. The medical reviews were not in line with the Mental Health Act Code of Practice. The records showed a log of the Doctor's signature each day. We noted that medical reviews had not always been undertaken at the weekends and those that had been done were completed over the phone and not face to face.
- The nursing reviews were not in line with the Mental Health Act Code of Practice. The records showed a question had been posed for staff to complete within the daily shift checklist (and not a separate long term segregation record). The question read: "Is the long term segregation care plan being followed?" In some instances, this was left blank or recorded as not applicable. This checklist commenced in February 2020 one month after the period of long term segregation had started.

However:

- The provider had submitted a weekly update on any patients with restrictions on their movements. There were none until mid-January 2020. There had been no episodes of seclusion and on reviewing the patient records for Mymwood ward were assured that this was the case.
- We received a submission from the provider that a young person on Mymwood ward had commenced long term segregation in mid-January 2020. The records that we reviewed

Summary of this inspection

during the inspection stated that the plan was discussed at the Multi Disciplinary Team Meeting in early February 2020 and then shared with the Local Authority social worker and National Health Service England.

- During the inspection we reviewed the long term segregation care plan which was detailed. We reviewed the records and the long term segregation was reviewed weekly by the multi disciplinary team starting on 16 February 2020 and weekly thereafter. We saw from the patient records that staff were making regular efforts to engage the young person in appropriate activities and that the young person went out on leave with their parents and with nursing and occupational therapy staff.

Are services effective? Not inspected as part of this focused inspection	**Requires improvement**
Are services caring? Not inspected as part of this focused inspection	**Requires improvement**
Are services responsive? Not inspected as part of this focused inspection	**Good**
Are services well-led? Not inspected as part of this focused inspection	**Inadequate**

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Seclusion and long term segregation

The provider had submitted a weekly update to the Care Quality Commission on any patients with restrictions on their movements. There were none from October 2019 until mid-January 2020.There had been no episodes of seclusion and on reviewing the patient records for Mymwood ward we were assured that this was the case.

The provider ensured that the Care Quality Commission were informed of any young people who had restrictions placed on their care. We received a submission from the provider that a young person on Mymwood ward had commenced long term segregation in mid-January 2020. The records that we reviewed during the inspection stated that the plan was discussed at the multi disciplinary team meeting in early February 2020 and then shared with the Local Authority social worker and NHS England. All parties agreed with the plan, as did the young person's parents. During the inspection we reviewed the long term segregation care plan which was detailed. We reviewed the records and the long term segregation was reviewed weekly by the multi disciplinary team starting on 16 February 2020 and weekly thereafter. We saw from the patient records that staff were making regular efforts to engage the young person in appropriate activities and that the young person went out on leave with their parents and with nursing and occupational therapy staff.

Staff that we spoke with had received training on seclusion and long-term segregation. However, only seven out of ten frontline staff that we spoke with, were able to clearly explain the meaning of seclusion and six out of ten frontline staff were able to explain long-term segregation. Staff knowledge varied considerably, and staff remained uncertain on the meaning of long term segregation. We were therefore not assured that all staff had retained their knowledge of the training or that they would be competent in implementing seclusion or long term segregation.

Data received during the inspection indicated that 80% of permanent staff had received training on seclusion and long term segregation however we did not gain clarity on the figures for agency staff.

During the inspection we received a copy of the seclusion and long term segregation policy. This was incomplete as it was still under review and was not therefore ready for use by the staff.

On the morning of the inspection, we requested the nursing and medical reviews for long term segregation as they were not recorded in the patient records. They were provided to us later in the day after further requests. The medical reviews were not in line with the Mental Health Act Code of Practice. The record showed a log of the Doctor's signature each day. We noted that medical reviews had not always been undertaken at the weekends and those that had been done were completed over the phone and not face to face.

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Inadequate

Child and adolescent mental health wards

being followed?" In some instances, this was left blank or recorded as not applicable. This checklist commenced in February 2020 one month after the period of long term segregation had started.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

We did not inspect this key question during this inspection.

Are child and adolescent mental health wards caring?

Requires improvement

We did not inspect this key question during this inspection.

Are child and adolescent mental health wards responsive to people's needs?

(for example, to feedback?)

Good

We did not inspect this key question during this inspection.

Are child and adolescent mental health wards well-led?

Inadequate

We did not inspect this key question during this inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are trained to a sufficient standard to ensure they have retained knowledge of long term segregation (LTS) and seclusion. Regulation 12 (1) (2) (c)
- The provider must check the competency of staff knowledge of seclusion and long term segregation. Regulation 12 (1) (2) (c)
- The provider must review and implement the seclusion and long term segregation policy in a timely way. Regulation 12 (1) (2) (a) (b)
- The provider must complete nursing and medical reviews of seclusion and long term segregation and record appropriately in accordance with the Mental Health Act Code of Practice. Regulation 12 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) • The provider did not train staff to a sufficient standard to ensure they had retained knowledge of long term segregation (LTS) and seclusion. • The provider did not check competencies of staff knowledge of long term segregation and seclusion. • The provider did not review and implement in a timely way, a policy in respect of long term segregation and seclusion. • The provider did not complete and record medical and nursing reviews of long term segregation in accordance with the Mental Health Act Code of Practice.