Southern Hill Hospital

Quality Report

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Date of inspection visit: 10-11 March 2020
Date of publication: 04/05/2020

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?	Requires improvement
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 Southern Hill Hospital as good because:

- The service provided safe care. The ward environments were clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to a full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However:

- Although the provider generally administered and dispensed medication safely, staff did not consistently prescribe and manage medicines safely. We found one example of a medication which was out of date, one prescription error and one example of staff administering a medication that the patient reported they were sensitive to, without recording a clear rationale or discussion with the patient. Staff did not consistently record clinic room temperatures or fridge temperatures. One of the clinic rooms on Lincoln ward was untidy, had cobwebs on the windowsill and did not display 'clean' stickers which staff used in the other rooms, despite having them available.
- The provider did not have a system in place for signing patient records in and out so staff could locate them at all times.
- The environment occasionally made it difficult to maintain the safety of patients easily. The staircase to the outside space on Lincoln ward did not have a handrail and the overspill on Cavell ward was situated some distance from the main ward.
- Staff did not receive standalone safeguarding children training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good 	Cavell ward Lincoln ward

Summary of findings

Contents

Good

Southern Hill Hospital

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units

Summary of this inspection

Background to Southern Hill Hospital

Southern Hill is an independent mental health care facility located close to the North Norfolk coast. The hospital has 33 beds for adults who require assessment and treatment in a mental health inpatient setting.

The provider is Southern Hill Limited.

The hospital comprises of two acute wards. Since the last inspection, the psychiatric intensive care unit (PICU) had been decommissioned. Staff sometimes used this unit as an overspill to Cavell ward to a maximum of five beds, but this unit was not in use at the time of this inspection.

- Lincoln ward is a female only ward with 13 beds.
- Cavell ward is a male only ward with 15 beds. Cavell 2, previously the PICU, was used as an overspill on occasions to a maximum of five patients.

Southern Hill Hospital was registered by the Care Quality Commission in May 2018 and admitted patients for the first time in June 2018. The hospital is registered to carry out the following regulated activities:

- Assessment and treatment for persons detained under the Mental Health Act 1993
- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely

The hospital has a registered manager. The registered manager, along with the provider, are legally responsible and accountable for compliance of the Health and Social Care Act 2008 and associated regulations, including the Health and Social Care Act 2008 (Regulated Activities) 2014 and the Care Quality Commission (Registration) Regulations 2010.

At the time of this inspection, both acute wards were full but there were no patients on the former psychiatric intensive care unit.

Our inspection team

The team that inspected the service comprised four CQC inspectors and a variety of specialists, including a nurse and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

Summary of this inspection

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 eight patients who were using the service;
- spoke with two carers of patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;
- spoke with 16 other staff members; including doctors, nurses, healthcare workers, occupational therapists, psychologist and housekeepers;
- received feedback about the service from one care co-ordinator or commissioner;
- attended and observed one morning meeting, two multi-disciplinary ward round meetings and one patient community meeting;
- looked at 12 care and treatment records of patients:
- carried out a specific check of the medication management on both 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 eight patients who were using the service. They told us staff treated them well and were kind to them. They told us staff made time for them, did activities with them and genuinely cared about their wellbeing and tried to help them. They said staff were approachable and available and that they could request additional one to one support when they needed it.

They said that staff treated them as individuals and made them feel understood, sometimes for the first time in a hospital setting. Four patients we spoke with told us that the doctors and nursing staff had given them fresh hope that they could manage their condition effectively. Two patients told us they appreciated staff being discrete when they did night time checks, using the dim lighting and not waking them up.

We spoke with two carers of patients who used the service. They said the service communicated with them appropriately and were very focused on the needs of patients and how to get their relative better.

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 rated safe as requires improvement because:

- Staff did not consistently prescribe and manage medicines safely. We found one example of a medication which was out of date, one unsigned prescription which staff had used to administer medication, and one example of staff administering a medication that the patient reported they were sensitive to, without recording a clear rationale or discussion with the patient.
- Staff had not consistently maintained clinic rooms to a high standard. Staff had not consistently recorded clinic room temperatures or fridge temperatures. One of the clinic rooms on Lincoln ward was untidy, had cobwebs on the windowsill and did not display 'clean' stickers which staff used in the other rooms, despite having them available.
- The provider did not have a system in place for signing patient records in and out so staff could locate them at all times.
- Staff did not undertake standalone safeguarding children training in their mandatory training.
- Ward layouts did not always make it easy for staff to ensure patient safety easily. The staircase to the outside space on Lincoln ward did not have a handrail which meant patients could not use this safely without supervision. The overspill on Cavell ward was some distance from the main ward, which made it more difficult to monitor effectively.

However:

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Summary of this inspection

- Staff had access to and maintained high quality clinical records.
- Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Summary of this inspection

- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood and were sensitive to the individual needs of patients and gave them help and emotional support when they needed it.
- Staff supported patients to understand and manage their care, treatment or condition, sharing information and supporting patients to make decisions about their care whenever possible. Four patients reported that the service had given them fresh hope they could manage their condition effectively.
- Staff truly respected and valued patients as individuals and worked with them to empower them and help them recover.
- Staff consistently involved patients in care planning and risk assessment. They actively sought patient feedback on the quality of care provided and patient involvement in all aspects of their treatment, including medication which they reviewed weekly. They ensured that patients had easy access to independent advocates.
- Patients were continually positive about the service they received from staff and said staff genuinely cared about them. Patients commented that staff provided exceptional care and support.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

We rated responsive as good because:

- Staff managed beds well. This meant that a bed was available when needed and that staff did not move patients to another service unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Summary of this inspection

- The service met the needs of all patients who used the service – including those with a protected characteristic under the Equality Act 2010. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision to provide high quality, individualised care to patients and applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

However:

- There was a risk agency staff might not be aware of information circulated on the provider's electronic systems including emails to staff. Agency staff did not receive login details and had to rely on permanent and bank staff to access information distributed in this way.

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.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. At the time of the inspection, 92% of staff across the service had received training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Where patients did not understand, staff repeated this on several occasions until they were sure that the patient understood.

Patients had easy access to information about independent mental health advocacy and automatically referred patients who lacked capacity to this service. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. However, when some informal patients asked to leave, staff completed risk assessments to ensure their safety.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up to date with training in and had a good understanding of the Mental Capacity Act. At the time of the inspection, 87% of staff across the service had received training in the Mental Capacity Act.

Staff considered capacity issues consistently in their interactions with patients. Staff assumed capacity and gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

There was a clear policy on the Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. There was one deprivation of liberty safeguards application made in the last 12 months. There were no patients under a deprivation of liberty safeguard at the time of the inspection.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Acute wards for adults of working age and psychiatric intensive care units

Good

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

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Requires improvement

Safe and clean environment

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. However, we found cables in two communal rooms on Lincoln ward enclosed in removable plastic trunking which could pose a ligature risk to patients. We raised this with the provider during the inspection who addressed this immediately.

Ward layouts did not allow staff to observe all parts of the ward making it difficult for staff to ensure patient safety in blind spot areas. The provider had installed mirrors where appropriate, although this was not possible in all areas. The provider mitigated this risk by individual risk assessments, security checks and staff observations. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature is the term used to describe a place or anchor point to which patients, intent on self-harm, might tie something to for the purposes of strangling themselves. Staff had completed ligature risk assessments for both wards in the last 12 months.

Cavell ward had an additional, overspill area on the old psychiatric intensive care unit, separate to the main ward, which could take up to five patients. There were no patients in this area at the time of the inspection so were unable to assess whether the unit was safely staffed when in use. Should additional support be required during an incident, staff needed to go through three locked doors on the most direct route to this ward. We observed the response time for staff to reach this was 35 seconds.

Bedroom doors and doors to communal areas opened outwards to reduce the risk of patients barricading themselves into rooms.

There was access to outside space. On Lincoln ward, this was via a steep staircase, which did not have handrails. Staff escorted patients to the garden area to ensure their safety.

The service complied with guidance on mixed sex accommodation. We observed that female patients sometimes walked through the male ward to access the gym. Staff rang down to ensure that the male ward was settled and that bedroom doors were closed. There was also an external access route to the gym if female patients did not want to walk through the male ward.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Ward areas were clean, well maintained, well-furnished and fit for purpose. Staff made sure cleaning records were up to date and the premises were clean.

Staff followed infection control policy, including handwashing. Staff had introduced additional measures across the whole hospital in response to the threat from Covid-19. This included notices to staff and visitors and additional cleaning of surfaces and door handles.

Seclusion rooms allowed clear observation of patients. They had a toilet and a clock for patients to see the time.

Acute wards for adults of working age and psychiatric intensive care units

Good

The seclusion rooms were clean; however, in one of the rooms, the two-way communication system did not work. There was a musty smell and there was a blind spot underneath the sink.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Equipment was calibrated and in date.

Staff checked, maintained, and cleaned equipment the majority of equipment. However, one of the clinic rooms on Lincoln ward was untidy, had cobwebs on the windowsill and did not display 'clean' stickers which staff used in the other rooms, despite having them available. On both wards, staff had not consistently recorded clinic room temperatures or fridge temperatures. Where temperatures were recorded as out of the recommended range, staff took appropriate action to escalate this.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Managers had calculated the numbers of staff required to staff the wards safely. We looked at rotas for a three-week period in January 2020 and found that the wards were staffed at these levels. The ward managers could adjust staffing levels according to the needs of the patients, in discussion with the multidisciplinary team. Staff took breaks throughout their shift. There were enough staff to undertake physical interventions when needed.

We were not assured the provider had safe systems in place when patients were placed on the old psychiatric intensive care unit. The provider told us they did not always have a qualified nurse on duty when they admitted patients to the unit. Managers told us that when this unit was being used, it would generally be staffed by two healthcare assistants, with access to nursing staff from the main ward. Managers said that this was used by patients nearing discharge and was quieter and calmer than the main ward. We observed response times from the main ward were quick, should additional staff be required during an incident.

In addition to regular nursing staff, the service deployed specialist physical health nurses and patient safety officers to enable ward staff to ensure other staff could maximise the time they spent with patients.

The service had low rates of bank and agency nurses. Between 1 August and 31 October 2019, there were 194 shifts covered by bank staff and 276 shifts covered by agency staff, with 16 shifts left unfilled. During a more recent period, this had reduced significantly; between 1 January 2020 and 29 February 2020, there were 22 shifts covered by bank staff and 62 shifts covered by agency staff, with no shifts left unfilled. Where agency nurses were employed, they used experienced staff who knew the hospital and the patients wherever possible. Managers ensured agency nurses had a full induction and training before working on the wards. However, agency staff could not access emails sent to permanent and bank staff in connection with lessons learnt and did not receive supervisions or an appraisal.

The provider reported that the service had 55 substantive nursing staff and the vacancy rate was 19% across both wards. Between 1 November 2018 and 31 October 2019, 16 members of staff had left the service and the vacancy rate was 19%. Staff sickness across the service during this period was 2%.

Patients had regular one-to-one sessions with their named nurse. Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients we spoke with confirmed this and told us they could request additional one to one sessions when they felt they needed it.

The service had enough staff, suitably trained, on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others. They did this at handovers and the morning meeting, where risks and concerns were shared.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Staff had completed and kept up to date with their mandatory training. At the time of the inspection, mandatory training compliance was 94%. Managers monitored mandatory training and alerted staff when they needed to update their training.

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Acute wards for adults of working age and psychiatric intensive care units

Good

Assessing and managing risk to patients and staff

Staff did a risk assessment of every patient on admission and updated it regularly, including after any incident. We reviewed 12 patient records. All contained up-to-date risk assessments which were thorough, individualised, involved the patient and regularly updated following incidents, changes in presentation or multidisciplinary discussions. Staff also displayed risk information on the white board in the nursing office, which folded when needed to preserve patient confidentiality.

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Staff reviewed patient risks regularly at handovers, morning meetings and ward rounds. Staff documented these discussions well and transferred new changing risk levels to patient notes, risk assessments and care plans.

Staff followed procedures to minimise risks where they could not easily observe patients. The provider had fitted mirrors to aid visibility of patients where possible.

Staff did not apply blanket restrictions to patients. Staff completed individual risk assessments and only used restrictions to ensure patient safety.

The provider did not have a smoke-free policy. There were outside areas where patients could smoke.

Informal patients could leave at will and knew that. The provider displayed posters advertising this on both wards. One informal patient we spoke with told us that staff would not allow them out for a cigarette without providing an escort. When we enquired about this, staff explained that they would assess patients' mental state and environmental factors, such as the staircase leading to the outside area on Lincoln ward.

In the last 12 months before the inspection, there were no episodes of seclusion and no episodes of long-term segregation. Between 1 May 2019 and 31 October 2019. There were 105 incidents of restraints, in relation to several patients. These were highest on Lincoln ward with 86 incidents. There were no prone restraints and no restraints which led to an episode of rapid tranquilisation. The wards in this service participated in the provider's reduction of restrictive practice programme.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint. The provider put great emphasis in training on using de-escalation wherever possible. Several patients had specific care plans detailing how to apply restraint, whilst considering their mental and physical health issues and conditions.

Safeguarding

Staff received and kept up to date with their training on how to recognise and report abuse, appropriate for their role, with 98% compliance for safeguarding adults training. However, we were not assured that staff received comprehensive training for safeguarding children. Safeguarding training contained some elements concerning safeguarding children, but the provider did not provide separate mandatory training in this area.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff followed clear procedures to keep children visiting the ward safe.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff used paper records to access and record information about patients. The provider used an electronic system to communicate with staff via email and kept some blank documents on the shared drives. Patient notes were comprehensive, and all staff could access them easily. Staff transferred discussions in ward rounds and multidisciplinary meetings into patient notes, risk assessments and care plans. However, there was no patient tracking system in place to tell staff when a patient's notes were being used by another member of the team and when they would become available.

Staff stored patients' records securely.

Acute wards for adults of working age and psychiatric intensive care units

Good

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We reviewed 24 prescription charts. These contained patient photographs, where patients had consented.

The provider contracted a pharmacy to complete audits of medicines management including prescriptions. This audit picked up on the inconsistent testing and recording of clinic room and fridge temperatures. There had been a significant improvement since the most recent medication audit in February 2020.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Patients we spoke with told us that doctors reviewed their medication every week and involved them before making any changes. They also told us that doctors and nursing staff gave them enough information about different medications for them to be able to express preferences at these meetings. We observed this in one of the ward rounds.

Staff generally stored and managed medicines and prescribing documents in line with the provider's policy. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. However, we found one example of a medication which was out of date and one prescription error. We also found one example of staff prescribing and administering a medication the patient reported they were sensitive to, without recording a clear rationale or discussion with the patient. We raised these issues with the provider at the time of the inspection and they addressed them immediately.

Decision making processes were in place to ensure peoples' behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence. guidance. Physical health monitoring was thorough and comprehensive.

Track record on safety

There were three serious incidents in the last 12 months, all on Lincoln ward. Two patients tied ligatures and required treatment in hospital as a precaution, and one patient died from natural causes.

Reporting incidents and learning from when things go wrong

Staff reported incidents clearly and in line with their policy. Staff knew what incidents to report and how to report them. Staff recorded incidents thoroughly, detailing the build-up, incident, aftermath and debriefs for patients and staff. When staff restrained patients, times were given, together with treatment given, any injuries sustained, and any lessons learnt.

Staff discussed learning from incidents and complaints at the morning meetings and team meetings. Staff documented these meetings and transferred details into patient notes where appropriate.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff debriefed patients after incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from the investigation of incidents and met to discuss the feedback and look at improvements to patient care. There was evidence that staff had made changes as a result of feedback. For example, managers had analysed data from incidents and found incidents increased at certain times and were able to make changes to staffing practices to reduce patient anxieties at these times.

Acute wards for adults of working age and psychiatric intensive care units

Good

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. We reviewed 12 patients' care records, which all contained thorough information about the patients' history and current presentation.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The service employed a physical health nurse and an assistant practitioner who worked across the service. They completed physical health assessments on admission and physical health care plans. Assessments were thorough, comprehensive and used a number of recognised assessment and risk evaluation tools. Staff monitored patients' physical health throughout their stay, for example using food and fluid charts where appropriate, electrocardiograms, blood tests and wound care.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Care plans were personalised, holistic and recovery-orientated. Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

We reviewed 12 patient records which contained comprehensive information about each patient's care and treatment. All contained full information about the strategies used for each patient with explicit references to specific tools and guidance, including the National Institute for Health and Care Excellence.

Staff provided a range of care and treatment suitable for the patients in the service, which staff delivered in line with best practice and national guidance. These included cognitive behavioural therapy, coping skills and trauma therapy, such as eye movement desensitisation reprogramming. Occupational therapists completed thorough assessments of patients' likes and dislikes to produce an individualised programme of therapeutic activities for each patient.

Staff identified patients' physical health needs and recorded them in their care plans. Physical health nursing staff completed separate physical health care plans for patients, which were thorough and comprehensive and took account of patients' long-term health conditions where appropriate. Staff completed specialised care plans to use when patients needed restraint, where appropriate. Physical health nurses raised awareness of sexual health issues and liaised with the sexual health clinic, including in relation to testing. Staff completed monthly physical health audits.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. We saw several examples of audits that had analysed information from incident forms and other sources of information. The provider identified trends and causes, and made changes to improve patient care, for example, in staff training and to ensure staff always discussed and recorded 'as-required' medication in ward rounds.

Skilled staff to deliver care

The service had access to a full range of specialists to meet the needs of the patients on the ward. These included doctors, nurses, physical health nurses, occupational therapists and psychologists. There was also a social worker post; although this was vacant, the provider was recruiting to this post at the time of the inspection. The team also had access to pharmacy support and to a dietician when needed.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their

care, including bank and agency staff. Managers gave each new member of staff a two-week induction to the service before they started work, using the care certificate standards.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). Compliance with supervision within the provider's policy was 95%. Supervision meetings were well documented and covered a wide range of topics. However, agency staff did not receive supervision from the provider. Staff we spoke with said they could raise issues outside of supervision when needed and felt supported by their managers.

Managers supported staff through regular, constructive appraisals of their work. All staff, apart from new staff, who were supported through the induction process, had received an appraisal in the previous 12 months.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge, including specialist training for their roles.

Managers ensured that all staff had access to regular team meetings. Staff discussed recent audits, learning from incidents, complaints and work-related issues. Staff documented these meetings so that staff who were not present could read them. However, although staff said meetings had taken place, they were unable to locate any meeting minutes since 13 December 2019.

Managers dealt with poor staff performance promptly and effectively.

Multidisciplinary and interagency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff held daily morning meetings to discuss patients, admissions, discharges and any incidents or risk management issues which had arisen in the previous 24 hours. We attended one of the morning meetings. It was clear, thorough and collaborative in its approach.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings, which took place between shifts. The multidisciplinary teams held weekly ward rounds where they discussed progress and treatment options with patients. We attended a ward round meeting. Staff engaged with the patient and discussed options with them concerning their care and treatment.

Ward teams had effective working relationships with other teams in the organisation, such as psychology and occupational therapy. Ward staff had effective working relationships with external teams and organisations, such as commissioners, the local authority safeguarding team and GPs who visited the hospital regularly.

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. At the time of the inspection, 92% of staff across the service had received training in the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was and when to ask them for support. The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

Patients had easy access to information about independent mental health advocacy and automatically referred patients who lacked capacity to this service. Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Where patients did not understand, staff repeated this on several occasions until they were sure that the patient understood.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Informal patients knew that

they could leave the ward freely and the service displayed posters to tell them this. However, when some informal patients asked to leave, staff completed risk assessments to ensure their safety.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff received and kept up to date with training in and had a good understanding of the Mental Capacity Act. At the time of the inspection, 87% of staff across the service had received training in the Mental Capacity Act.

Staff considered capacity issues consistently in their interactions with patients. Staff assumed capacity and gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

There was a clear policy on the Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications. There was one deprivation of liberty safeguards application made in the last 12 months. There were no patients under a deprivation of liberty safeguard at the time of the inspection.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. We spoke with eight patients. They said staff treated them well and behaved kindly. They told us staff made time for them, did activities with them and genuinely cared about their wellbeing and tried to help them. Two patients told us they appreciated staff being discrete when they completed night time checks, using the dim lighting and not waking the patients up.

Staff gave patients help, emotional support and advice when they needed it. We observed staff interacting with patients, helping them make decisions and encouraging their independence. Patients we spoke with said staff were approachable and available and that they could request additional one to one support when they needed it. Four patients we spoke with told us that the doctors and nursing staff had given them fresh hope that they could manage their condition effectively.

Staff supported patients to understand and manage their own care, treatment or condition. Staff understood and respected the individual needs of each patient. Patients we spoke with said they felt treated as individuals and when staff made decisions about risk and care planning, it was always based on individual assessments.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Acute wards for adults of working age and psychiatric intensive care units

Good

Involvement in care

Staff introduced patients to the ward as part of their admission. Staff gave a welcome pack to patients on admission and showed them round the ward. However, one patient said they did not receive a welcome pack.

Staff involved patients and gave them access to their care planning and risk assessments. We spoke with eight patients, who told us that staff involved them in risk assessments and care plans. They said staff, including doctors, involved them in decisions about their care and gave them information about different treatments and supported them to decide what would help them get better. Five patients we spoke with told us doctors reviewed their medication every week and involved them fully in decisions about changing their treatment. We observed staff, including doctors, involving patients within their care and providing information on medications within a multidisciplinary meeting between staff and a patient.

Risk assessments and care plans were all individualised and evidenced that staff had involved the patient as fully as was possible. We looked at 12 patient records. All records consistently evidenced patient involvement in their care and treatment. Patients signed their care plans and staff offered them copies.

There were separate occupational therapy care plans which looked at an extensive range of therapeutic activities and supported patients to engage with what was most important to them and considered their preferences. Occupational therapy staff were involved within group therapeutic activities and told us of the positive interactions between staff and patients within these activities.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients we spoke with said staff supported them to give feedback continually. Staff also arranged daily community meetings for patients and conducted patient surveys.

Staff made sure patients could access advocacy services.

Staff supported, informed and involved families or carers unless patients asked them not to share information. Staff helped families to give feedback on the service. We spoke with two carers of patients who used the service. One carer we spoke with told us that staff had gone to great lengths to encourage their relatives to engage with activities away from the hospital.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

Between 1 May 2019 and 31 October 2019, average bed occupancy was 78% on Cavell ward and 66% on Lincoln ward. The hospital took placements from out of area. Staff discharged patients to suitable placements nearer home if possible.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay between 31 October 2018 to 31 October 2019 was 30 days for Cavell ward and 32 days on Lincoln ward. In February 2020, average length of stay was 29 days for Cavell ward and 32 days for Lincoln ward.

Beds were generally available for patients living in the local area. When patients went on leave there was always a bed available when they returned.

Managers and staff made sure they did not discharge patients before they were ready. Managers we spoke with told us they could discharge patients who they were unable to manage safely to a psychiatric intensive care unit, but that this happened rarely.

Staff did not move or discharge patients at night or very early in the morning. Staff made clear arrangements to discharge patients through ward rounds and multidisciplinary meetings. Delayed discharges were rare but occurred when patients were admitted with no fixed abode or when commissioners could not find an appropriate community placement. Staff worked closely with care co-ordinators to discharge patients when they were ready. Discharge planning was a focus from the point of admission and was well recorded.

Acute wards for adults of working age and psychiatric intensive care units

Good

Facilities that promote comfort, dignity and privacy

Each patient had their own bedroom, which they could personalise. Patients we spoke with confirmed this and we saw that some patients had done this. All bedrooms had en-suite bathrooms.

Patients had a secure place to store personal possessions. Patients could access items under staff supervision where they presented risks to individual patients and returned to the secure area after use.

Staff used a full range of rooms and equipment to support treatment and care. The service had quiet areas and a room where patients could meet with visitors in private. The rooms were furnished and well maintained but walls were bare. Staff helped and supported patients to identify activities and interests that were important to them. From a list of 91 options, these included drama, making jewellery, cooking, woodwork, listening to and playing music, different sports and gardening.

All patients could make phone calls in private. Patients had access to mobile phones and chargers, subject to risk assessment.

The service had an outside space that patients on Cavell ward could access easily. Access to outside areas on Lincoln ward was down a steep staircase which did not have a handrail fitted. Staff provided support and supervision to patients so they could access this area.

Patients could make their own hot drinks and snacks at any time. However, staff locked kitchen areas, and patients had to request access. Patients we spoke with told us this area was always available when they asked.

The service offered a variety of good quality food. Patients we spoke confirmed this and said there was a good selection, including healthy options.

Patients' engagement with the wider community

Staff supported patients to stay in contact with families, carers and friends either through the telephone, via the internet, visiting the wards or meeting outside of the hospital.

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service, including those with a protected characteristic as identified by the Equality Act 2010. Staff helped patients with communication, advocacy and cultural and spiritual support. Access to and from Lincoln ward for people with mobility issues was via a lift. However, access to the outside area on Lincoln ward presented challenges, due to the steep staircase. Patients with mobility issues could use the lift and access outside space in front of the hospital.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. Patients we spoke with told us they knew how to complain, and that staff told them what their rights were regularly. Patients said staff explained treatment options to them and that they were fully involved in decisions about their care and treatment. The provider displayed information about services, including advocacy services, clearly on notice boards.

The service had information leaflets available in languages spoken by the patients and local community. Leaflets in different languages were available if needed. Managers made sure staff and patients could get help from interpreters or signers when needed. Staff had recently used an interpreter to help them communicate with a patient's carer.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients had access to spiritual, religious and cultural support. Staff supported patients to access these where appropriate.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The provider gave patients information about how to complain in the welcome pack given on admission.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Acute wards for adults of working age and psychiatric intensive care units

Good

Managers investigated complaints and identified themes. Between 1 March 2019 and 29 February 2020, the hospital received 16 complaints. Four were upheld and one was partially upheld. No complaints were referred to the ombudsman.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and used this learning to improve the service. However, one patient we spoke with was not happy about the outcome of their complaint.

The service used compliments to learn, celebrate success and improve the quality of care. The provider completed an audit of complaints and compliments in March 2020 for the previous quarter. The audit identified areas for improvement, lessons learnt, and actions taken to improve the service, including actions identified from complaints that had not been upheld.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. Ward managers covered weekends and some shifts where staff called in sick at short notice. Staff and patients knew the senior leaders in the organisation and were comfortable to approach them.

Vision and strategy

The provider did not have a clearly articulated statement of values. However, staff knew and understood the provider's vision to provide high quality, individualised care to patients experiencing acute mental distress. Staff shared this vision and worked together to provide the best possible care to patients.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The provider was looking for ways to improve communication to staff, particularly in relation to changes to service delivery and configuration.

Culture

Staff felt respected, supported and valued. We spoke with 18 staff, including the ward managers. All staff we spoke with told us they felt supported, respected, positive and proud about working for the provider and their team. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression.

Staff felt able to raise concerns without fear of retribution and felt that their concerns would be properly investigated. Staff knew how to use the whistle-blowing process.

Managers dealt with poor staff performance when needed. Teams worked well together and where there were difficulties managers dealt with them appropriately.

Staff appraisals included conversations about career development and how it could be supported.

The service's staff sickness and absence was around 2% for the nursing team and less than 1% for the multidisciplinary team.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well. Managers ensured there were enough staff, that they were well trained and supervised, treated patients well and planned their discharges well with their care co-ordinators. Managers ensured staff monitored patients' physical health well throughout their stay and reviewed their medication carefully whilst fully involving the patient. However, there was no patient tracking system in place to tell staff when a patient's notes were being used by another member of the team and when they would become available.

Acute wards for adults of working age and psychiatric intensive care units

Good

There was a clear framework of what must be discussed at a ward, team or senior level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed and that staff acted on recommendations.

Staff undertook or participated in local clinical audits, including analysing data from incidents and complaints. The audits were sufficient to provide assurance and staff generally acted on the results when needed. However, the medication audits for December, January and February consistently identified that staff were not consistently recording clinic room and fridge temperatures. There was no evidence that staff had fully addressed this, although some improvement had taken place since the February audit.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Reporting maintenance issues was easy and staff took action quickly.

Management of risk, issues and performance

Staff maintained and had access to the hospital risk register. Staff at ward level could escalate concerns when required, via the ward manager. Staff concerns matched those on the risk register. Staff addressed issues raised on the risk register and resolved them in a timely way.

Managers ensured that staff managed risk issues well at ward level.

The service had plans for emergencies – for example, adverse weather or a flu outbreak. The service had introduced additional measures in response to the Covid-19 outbreak. This included managers screening new admissions and housekeeping staff cleaning surfaces and door handles more frequently. There were signs for visitors to use the hand gels provided before entering any new area. Patients all had up-to-date evacuation plans where appropriate.

Staff confirmed that financial considerations did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, agency staff could not access the provider's email system, and required permanent or bank staff to pass on information that was distributed by email. Information governance systems included confidentiality of patient records. Information was in an accessible format, and was timely, accurate and identified areas for improvement.

The provider used paper files to record patient information, which all staff could access. Managers told us the provider had plans to introduce an electronic system but the timescale for this was uncertain.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Managers did not have up-to-date access to information about the performance of their team. However, administrators sent ward managers information monthly about staff compliance with training, supervision and appraisals. Managers we spoke with told us this process enabled them to manage the performance of their staff.

Staff made notifications to external bodies as needed.

Engagement

Patients and carers had opportunities to give feedback on the service, either informally at multidisciplinary reviews or through patient satisfaction questionnaires. Patients and carers had access to up-to-date information about the work of the provider and the services they used – for example, through bulletins, newsletters and so on.

The provider completed six-monthly staff satisfaction surveys and made changes to the service as a result.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation which led to changes in the service.

The service had a strategy document in place to identify areas for improvement. The service did not participate in any national accreditation programme.

Outstanding practice and areas for improvement

Outstanding practice

Occupational therapists, in partnership with other staff, went to great lengths to help patients identify what they were interested in doing, what skills they needed to improve and what was most important to them. Staff used this information to create individual packages for patients to assist them in their recovery.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure best practice in relation to the safe storage, audit and administration of medication, in line with guidance, across all wards [Regulation 12 (2) (g)].

Action the provider SHOULD take to improve

- The provider should ensure that when patients are admitted to the overspill facility on Cavell ward, there are sufficient staff, including registered staff, to cover the unit.
- The provider should ensure that all clinic rooms and equipment are clean and well organised.
- The provider should ensure that there is a system in place for signing patient records in and out so they can be located at all times.
- The provider should ensure that both seclusion rooms comply with the Mental Health Act Code of Practice.
- The provider should review safeguarding children training for staff to ensure staff have a thorough understanding in this area.
- The provider should ensure risk agency staff are aware of information circulated on the provider's electronic systems including emails to staff. Agency staff did not receive login details and had to rely on permanent and bank staff to access information distributed in this way.
- The provider should consider ways of improving the safety of the steep staircase on Lincoln ward.

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 Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment