Spring Wood Lodge

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	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 Spring Wood Lodge as **'requires improvement'** because:

- The management of patient's medications was not always safe. Staff did not always follow national guidance because they did not always monitor the potential side effects of medications when using methods of rapid tranquilisation with patients. Staff were not fully aware of the guidelines in place for searching patients, and the use of a randomiser button when patients returned from unescorted leave.
- Treatment was not always effective because staff did not follow national guidance to monitor the side effects of long term medication use with patients. When patients lacked capacity to make specific decisions, staff did not always act in accordance with the Mental Capacity Act. Not all staff received adequate levels of clinical supervision.
- The governance systems in place were not entirely embedded by the time of the inspection. The service carried out regular audits however; audits in relation to the management of physical health, and the administration of the Mental Health Act had not identified all the concerns we found during the inspection. Staff understanding of certain policies and procedures was not yet entirely embedded. Managers had not ensured that all staff had access to clinical supervision.

However:

- The service had made improvements since the time of our last inspection. It no longer met our rating characteristics of inadequate in the safe and well led key questions, and the provider had put systems in place, which ensured that most areas of concern were on an improvement trajectory.
- The environment was safe and clean. Patients had detailed and thorough risk assessments in place, which staff updated regularly. There were clearly defined and embedded systems and processes in place to keep patients safe and safeguard them from abuse. When incidents occurred staff recorded them well, investigated them appropriately and they utilised the learning of lessons to ensure improvements in safety. Staff used low levels of restrictive physical interventions with patients. Staff had undertaken all required levels of mandatory training.
- Staff provided care, which was compassionate, and empowered patients to be active partners in their care. Patients described staff as kind and caring and we observed this behaviour during our inspection. Patients had access to advocates, and could make complaints and give feedback about the service they received.
- Staff were responsive to the needs of patients. Patients had access to therapies and activities, which met their emotional, spiritual and cultural needs. We saw evidence of discharge planning which was highly person centred.
- The governance processes were joined up with the corporate provider's objectives and we saw that themes and lessons were shared. The service had employed specialist staff to undertake administration roles which had enhanced the ability of the service to monitor and measure risk and concerns.

Summary of findings

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Requires improvement

Spring Wood Lodge

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

Summary of this inspection

Background to Spring Wood Lodge

Spring Wood Lodge is a high dependency rehabilitation service, provided by Elysium Healthcare Ltd. The service is able to provide care to a maximum of 22 female patients. There are two wards, Bronte and Byron.

Spring Wood Lodge has been registered with the Care Quality Commission since October 2016 to carry out the following regulated activities:

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

• Treatment of disease, disorder or injury

• Diagnostic and screening procedures

The Care Quality Commission last carried out a comprehensive inspection of this service in June 2017. At that inspection, we rated the service as 'inadequate' overall with ratings of inadequate in the safe and well key questions and 'requires improvement' in the effective, caring and responsive key questions. Following the inspection in June 2017, we placed the service into 'special measures'. Services placed in special measures are inspected again within six months of the publication of the previous report. We told the provider that if insufficient improvements had been made, such that there remained a rating of inadequate overall or for any key question or core service, we would take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This would lead to cancelling their registration or to varying the terms of their registration within six months if they did not improve.

The provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took regulatory action in line with our enforcement powers in relation to:

- Regulation 9; person centred care because there was a lack of collaborative care plans with patients, and the provider did not always ensure that patients could participate in decision making about their care and treatment.
- Regulation 12; safe care and treatment because the premises were not safe, there was not safe management of medicines and their side effects.
- Regulation 13; safeguarding service users from abuse and improper treatment because control or restraint was not always necessary and proportionate to the risk presented.
- Regulation 17; good governance because the systems in place did not ensure the provider could assess, monitor and improve the quality of the service, and accurate records were not always kept.
- Regulation 18; staffing because staff did not receive appropriate training for their role.

We reviewed all of these breaches of regulation at this inspection. We found that there had been significant improvements. The provider was no longer in breach of Regulations 9, 13 and 17, and the service no longer met our ratings characteristics of an inadequate service in the safe and well led key questions. There remained a breach in regulations 12 and 18, however the service was no longer in special measures due to the improvements made since the time of our last inspection.

At the time of this inspection, a registered manager was in place at the location. The registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations including the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2010.

The service had an accountable drugs officer. The accountable officer is a senior manager who is responsible and accountable for the supervision, management and use of controlled drugs.

Summary of this inspection

Our inspection team

The team that inspected the service comprised two CQC inspectors including the team leader, one expert by experience who had experience of using, or caring for someone who uses mental health services, one pharmacy specialist, and two specialist advisors; one mental health nurse and one occupational therapist.

Why we carried out this inspection

We undertook this inspection to find out whether Elysium Healthcare Ltd had made improvements to the service delivered at Spring Wood Lodge since our last comprehensive inspection in June 2017.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients
- spoke with three relatives or carers of patients
- spoke with the hospital director, consultant psychiatrist, and ward manager
- spoke with nine other staff members including nurses, healthcare support workers, and therapy staff.
- looked at the care and treatment records of six patients
- carried out a specific review of the management of medicines and reviewed the medication records of all patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During the inspection, we spoke with seven of the 14 patients admitted to the service. We offered all patients the opportunity to speak with us.

Patients made positive comments about the care they received. Patients said that the hospital was clean and that staff helped them to keep their own bedrooms clean. They told us that they had access to many activities, and that staff supported them to visit or remain in contact with their families.

Patients used words such as 'nice', 'respectful' and 'supportive' to describe staff.

Three patients told us that they felt safe. Four patients said that they had experienced aggression from another patient in the past twelve months, but had been able to report this to staff.

Summary of this inspection

The main area of negative patient feedback was around the food provided. Four patients commented negatively on the food provided by the service, for example by telling us that it was often not healthy.

We also spoke with three carers during the inspection. All three carers told us that they felt their relative was safe at the service. They described staff as 'fantastic', 'professional', and told us that they provided thorough updates to them. Carers said that they had seen a positive change in their relative since they moved to the service and that good activities and therapies were available.

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 had carried out an episode of rapid tranquilisation and had not recorded patient physical observations within the timescales recommended in national and provider guidance. Staff did not know where to record observations and displayed a lack of knowledge about this method of treatment.
- Staff were not fully aware of the guidelines in place for searching patients, and the use of a randomiser button when patients returned from unescorted leave. This meant that the searching of patients was not always according to individual risk and therefore was not in line with the Mental Health Act Code of Practice.

However:

- The provider had made improvements to the safety of the environment since our last inspection in May 2017. The service was clean and furnishings and decoration were of a high standard. Equipment used to provide care was clean, well maintained and clearly labelled. The service had employed a health and safety officer who had reviewed all ligature risk assessments, alongside the hospital director, and had completed an audit of these. Staff awareness of ligature risks had improved because all staff had been trained. The service had undertaken thorough environmental risk assessments, which the service regularly reviewed to ensure patient safety.
- All patients had risk assessments in place, completed using recognised tools, which staff regularly reviewed.
- Staff used low levels of restrictive physical interventions with patients, and had been trained in 'reinforce, appropriate, implode, disruptive' methods of positive behavioural support which had left them highly skilled in methods of de-escalation.
- All staff had completed the required mandatory training and the service had a system in place to monitor compliance.
- Staff's safeguarding knowledge and understanding had improved, staff made appropriate referrals and notifications and had built links with the local authority safeguarding team.

Are services effective?

Requires improvement 

We rated effective as **'requires improvement'** because:

Summary of this inspection

- Staff did not always complete all required physical health monitoring with patient's prescribed medications, which had serious side effects. This was a concern at our last inspection of the service, and whilst there had been some improvements but the new system was not entirely embedded.
- There was one occasion where a patient lacked capacity to consent to a specific decision, related to a physical health condition and staff did not follow the correct processes as per the Mental Capacity Act.
- One patient did not have the appropriate treatment certificate on their treatment file, and for the same patient there was no evidence that staff had made a referral to a second opinion appointed doctor.
- Not all staff had received clinical supervision in line with the provider's own policy. "Ward staff told us that they did not have time to attend hospital wide team meetings, and we saw that no ward level staff had attended these meetings in the last three months.

However:

- Patients had access to a highly skilled on site multi-disciplinary team. Multi-disciplinary team meetings were effective, inclusive and informative for patients and staff.
- There was good availability of therapy for patients which was individually focussed on their recovery.
- Staff used recognised rating scales to measure patient outcomes and ensure treatment was effective.
- All patients had care plans, which staff completed in a timely manner and regularly updated.
- All members of the multi-disciplinary team inputted into patient care plans to ensure a fully collaborative plan of care.
- Patient care plans contained high quality positive behaviour support planning which included advance decision making in regard to the use of restrictive physical interventions, which was very person centred.
- Staff had undertaken training in response to the specific needs of patients to ensure they could provide individualised care. For example, staff had undertaken training in Huntington's disease and in the use of continuous positive airway pressure equipment.

Are services caring?

Good

We rated caring as **'good'** because:

Summary of this inspection

- The service had worked hard to ensure the care patient's received was dignified and respectful. There had been a development in the culture of the service since the time of last inspection. Staff recordings were respectful and routed in person centred care.
- We witnessed care, which was respectful, compassionate, kind and responsive; staff knew patients well, and could quickly de-escalate patients who were distressed.
- Feedback from patients about the way staff treated them was entirely positive. They used words such as 'nice', respectful' and 'supportive'.
- The serviced had ensured that advocacy services were heavily involved in the service. They attend the ward weekly and we saw that they supported patients and their carers in meetings and with decision making.
- Carers were entirely positive about the way staff cared for their relative and used words such as 'fantastic' and 'professional' to describe them. The service had made efforts to involve carers in the service by holding open days and events, and had supported patients to visit their families over long distances to ensure patients could maintain contact.

Are services responsive?

Good

We rated responsive as **'good'** because:

- Staff worked with patients to ensure thorough discharge planning with a focus on recovery. The service continued to discharge patients to less restrictive or more appropriate settings.
- The service had created a multi-faith room since the time of our last inspection.
- Patients and carers knew how to complain and the service managed complaints well.
- Patients had access to facilities and activities on all wards, which were able to meet their recovery needs.
- Patients and their carers had access to a variety of information regarding the service, the treatment offered, and information about complaints. The admission information to aid orientation to the service was good.
- Patients had open access to outside space, which patients and staff ensured was well maintained.
- Patients had access to drinks and snacks throughout the day and night. On site catering meant that the service could provide for patients with dietary, religious or cultural needs.

Summary of this inspection

- Staff had access to interpreters, professionals trained in sign language, and information in languages other than English in order to support patients.

Are services well-led?

Good

We rated well-led as **'good'** because:

- Since the time of last inspection, the service had worked hard to ensure they made improvements in the quality of the service and to become compliant with regulations.
- The governance structure followed the structure of corporate governance to ensure a joined-up approach to quality and risk.
- The service had employed specialist staff to manage areas such as; Mental Health Act administration, health and safety and human resources.
- Staff knew and agreed with the values and vision of the organisation; staff behaviour modelled the values and behaviour of the organisation throughout our inspection.
- Staff felt supported and effectively managed, and there was a good level of morale.
- Staff had good quality training and development opportunities, which were specialised to meet the needs of the service and patient group.

However:

- The provider had ongoing work to complete to ensure high quality care at the service. The governance systems in place were not entirely embedded by the time of the inspection. The service carried out regular audits however; audits in relation to the management of physical health care monitoring following administration of medication had not flagged up the concerns we identified during the inspection. Audits of Mental Health Act paperwork had not identified that second opinion doctor requests had not been made in a timely manner and that not all paperwork was correctly located within patient files.
- Although there had been a significant focus on training since our last inspection, staff understanding of certain policies and procedures was not yet entirely embedded. Staff had difficulty entirely understanding search policies, the use of the Mental Capacity Act, and the use of oral and intra-muscular rapid tranquilisation.
- Managers ensured that there were regular team meetings, however, feedback from staff was that due to staffing levels and acuity on the ward, they found it difficult to find time to access hospital wide team meetings. Staff had limited access to clinical supervision.

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.

Training in the Mental Health Act was mandatory for all clinical staff, and compliance with training was 96%

The service had systems in place to ensure the proper implementation and administration of the Mental Health Act, this was an improvement since our last inspection. Audits of patient paperwork had taken place and where errors were found the service had followed these up.

Care records across all services evidenced that staff routinely explained to patients their rights under the Mental Health Act. Patients had access to section 17 leave as granted by the responsible clinicians. The service had displayed information on the rights of people who were detained and informal on the ward and independent advocacy services were available to support people.

We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. In addition, appropriate capacity assessments had been completed in accordance with The Mental Capacity Act 2005. However, a Second Opinion Appointed Doctor (SOAD) request was not available for one patient, and a Section 61 review of treatment certificate for one patient could not be located by staff during the inspection.

Our Mental Health Act reviewer visited the service in October 2016. This visit raised concerns about; physical healthcare checks on admission, capacity assessments of consent to treatment, blanket restrictions, internet access, information relating to the Care Quality Commission, and access to an independent mental health advocate. The provider had addressed all of these concerns by the time of the inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

Training in the Mental Capacity Act was mandatory for all clinical staff, and compliance with training was 96%. All staff we spoke with had a good understanding of the Act, and were able to explain were they could receive support with more complex issues.

We reviewed the provider's policy for the Mental Capacity Act and Deprivation of liberty safeguards (August 2017). The policy was thorough and contained all relevant guidance including updates from the 2014 Supreme Court judgement in relation to Deprivation of Liberty Safeguards.

Since the time of our last inspection, there had been an improvement in use of the Mental Capacity Act. We saw examples of where staff had followed the principles of the Act to support patients who lacked capacity to make decisions. However, we found that one patient deemed to lack capacity in relation to their physical health, did not have a capacity assessment undertaken in relation to a specific physical health decision.

The service had not made any applications under Deprivation of Liberty Safeguards.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

The service had two wards, Bronte ward (17 beds) and Byron ward (five beds). At the time of the inspection, only Bronte ward was in use and the service had closed Byron ward as part of service re-design, although staff had used the ward for the long-term segregation of one patient when they became unwell.

We checked the environment of both wards to consider whether they were safe and clean.

Bronte ward had an 'L' shape layout, which did not allow staff a clear line of sight to observe patients. Staff mitigated this risk by having one member of staff allocated to observe patients throughout the day and night. Staff discussed patient observation levels at morning meetings and in weekly multi-disciplinary team meetings and these changed according to the risk presented by the patient.

Some areas of the hospital contained ligature points (a ligature point is a place to which patients intent on self-harm might tie something to strangle themselves). Since our last inspection, the service had made significant improvement to the management of ligature points. The health and safety manager and ward manager had completed a ligature audit in October 2017.

However, we found that the service had missed a pull cord alarm in the communal bathroom from the ligature audit. The hospital director told us that the risk was low because staff kept the bathroom locked, in response to risks within the room and because pulling the chord would trigger alarms and a staff response. The hospital director agreed to rectify this at the time of our inspection. We checked during the inspection, and found that the room was locked.

Ligature cutters were available to staff in the nursing office, clinic room and emergency grab bag.

The service mitigated risk of ligature points via the use of individually risk-assessed observations of patients, and continuous staff observation in high-risk communal areas.

At our last inspection, we were concerned that staff lacked understanding about ligature points.

In order to rectify this, the hospital manager had introduced ligature training and a ligature competency workbook for all staff. This had improved staff knowledge; all staff were able to tell us what a ligature point was and where they were within the hospital.

The service admitted female patients only so was compliant with Department of Health eliminating mixed sex accommodation guidance and guidance contained within the Mental Health Act Code of Practice.

The service had one clinic (treatment) room, and two medication-dispensing rooms. The treatment room was located in the communal entrance to the service. Staff used the treatment room for physical examinations with patients. The room was spacious, clean and staff had correctly calibrated, cleaned and labelled all equipment. There was an examination couch, and equipment for physical healthcare checks such as an electro-cardiograph machine and blood pressure monitor.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff stored medications in the dispensing rooms, which were clean, well-stocked and clearly labelled. Staff monitored the temperatures of the rooms and fridges on a daily basis and clearly recorded this.

There were adequate supplies of emergency equipment and medications. The corporate policy stated which emergency medications and equipment the service should hold on site. Staff kept oxygen and a defibrillator in an emergency grab bag in the staff office, which was accessible to all staff. A system was in place to ensure these remained fit for use by staff undertaking daily checks.

The service did not have a seclusion room. There was a de-escalation room for patients and staff and told us this was never used for seclusion.

The provider had decorated and furnished the service to a high standard; all ward areas, and patient bedrooms were clean. The service employed two full time cleaners and a maintenance worker who kept the building clean and in good repair. Patients said that the hospital was clean and that staff helped them to keep their own bedrooms clean.

Staff adhered to principles of infection control and there were hand gel dispensers available throughout the hospital. During the inspection, we checked the arrangements for infection prevention and control. An external contractor had completed an infection control audit in March 2018. The service reached a compliance score of 92% and were in the process of completing an action plan.

Staff securely locked away substances hazardous to health. In the main kitchen, we observed staff using personal protective equipment and food was correctly labelled and stored.

The health and safety manager had undertaken environmental risk assessments of the whole hospital, and a staff member completed daily walk arounds to check security and safety, and noted any new risks or changes to the environment.

All staff carried alarms and call alarms were available in all patient bedrooms. Staff checked the alarms, which were allocated to them each morning to ensure they were working.

Safe staffing

The service provided us with data regarding staffing. The service had a staffing establishment of ten whole time equivalent qualified nurses, (which included two charge nurses), and 12.5 whole time equivalent healthcare support workers.

At the time of the inspection, the service had 9.75 whole time equivalent qualified nurses in post and had recently recruited to one more post, which would take the service beyond their original staffing requirement. The service had 10.7 whole time equivalent healthcare support workers, and one recently recruited. This left only one vacancy for the whole service.

The service had recognised the need to increase the number of healthcare support workers employed, to reduce the impact of the use of agency staff. The provider had agreed this increase in budget and the service was planning recruitment with interviews for additional staff planned for June 2018.

Between 1 November 2017 and 1 May 2018, the service had an average 4% sickness rate, which was higher than the provider's own target of 3%. However, this had reduced to 1.5% by May 2018. In the same time period the service had five staff leavers; two staff transferred to other Elysium sites and three staff transferred from permanent staff to bank staff.

The hospital also employed a full time psychiatrist who was available Monday to Friday during office hours. Outside this time, there was an on call rota for the doctor (shared with doctors from other services) and a senior manager, all of whom could reach the service within 30 minutes.

The service used a staffing tool based on the acuity of patients. Staff worked one of two twelve-hour day or night shifts. During the day there were with two qualified nurses, and three health care support workers. At night, there were two qualified nurses and two health care support workers.

During the day, therapy staff and the ward manager were not included in planned staffing numbers and could support staff on the ward if required.

We received mixed views from patients and staff about staffing levels. Two health care support workers and two patients told us that staffing levels were low and this meant that staff could not always facilitate leave as planned. However, according to the provider's safer staffing report, between 9 November 2017 and 9 May 2018 there were eight

shifts which did not meet full staffing requirements. All eight shifts related to being one qualified nurse less than planned, but staff covered the shift by the addition of the ward manager.

The ward manager was able to use bank or agency staff when shifts were unfilled or in response to patient need. Out of 2366 available shifts between 1 November 2017 and 1 May 2018, the service used bank or agency staff to fill shifts on 886 occasions, this equated to 37% of available shifts. The hospital director told us that this was because a patient had been admitted to the local acute hospital for treatment and the service were providing regular two to one staffing at the acute hospital to support this patient. They had employed an additional two members of temporary staff per shift to manage this.

We reviewed the daily staffing planners from 12 April 2018 to 5 May 2018. The service allocated a nurse to be in charge of each shift, who allocated tasks to each staff member.

During our inspection there were staff available in the communal areas of the ward, who were accessible to patients. We saw in patients' records that patients had access to, and utilised one to one time with nursing and therapy staff on at least a weekly basis.

Staff completed a variety of mandatory training courses including; management of violence and aggression, fire safety, immediate life support, safeguarding adults and children and administration of medication. Since the time of our last inspection, compliance with mandatory training had improved significantly. Of the 20 training courses, staff compliance was above 90% for 15 of the courses, and the remaining five courses were all above 83%.

Assessing and managing risk to patients and staff

There had been no uses of seclusion in the six months prior to our inspection. The service was using long-term segregation in the empty Byron ward with one patient. The patient had become unwell and was waiting for a move to a psychiatric intensive care unit for approximately three weeks. This patient had a care plan in place, which was thorough and followed the provider's own policy. The care and treatment of this patient was in line with guidance contained in the Mental Health Act Code of Practice.

Between 9 November 2017 and 9 May 2018, there had been 108 uses of restraint. There had been one use of prone (chest down) and five uses of supine restraint in the same period. Staff had recorded that the remaining restraints were low-level 'come along' holds or forearm holds. Staff had carried out 79% of restraint with patients in a standing or seated position which meant that they used lower level restraint holds where possible.

The service used low levels of restraint. During the inspection, we reviewed five incidents of restraint, which had taken place between 8 March 2018 and 22 April 2018. Four of the five incidents involved the use of low-level forearm holds, and the longest incident lasted for six minutes. Staff recording of the incidents was high quality; all records evidenced that the use of restraint was proportionate to the risk presented by the patient, and that staff had attempted verbal de-escalation prior to the use of restraint. Four out of five incidents stated that patients had been offered de-briefs after the incident, and staff de-brief was noted in three of the five records.

The service had used rapid tranquilisation on one occasion (this is where an injection is given to quickly calm an agitated patient). We reviewed the record from this incident, and found that although staff monitored and observed this patient they had not recorded the patient's physical observations in accordance with national guidance and the hospital policy. The hospital policy stated that staff should record observations every 15 minutes for at least an hour. National guidance (NG10: Violence and aggression: short-term management in mental health, health and community settings) from the National Institute for Health and Care Excellence, states that observations should be recorded every hour until there are no further concerns about the service user's physical health status. Staff had made an entry in the notes at the time they had given the injection, but had not repeated physical health monitoring until 110 minutes later. Staff lacked understanding of the physical health monitoring requirements. Staff gave us different information when we asked where they would record observations, which evidenced a lack of understanding about this method of treatment.

However, during the service's audit of reducing restrictive practices they had recognised errors in recording physical health observations after oral rapid tranquilisation. The review stated, "physical health observations were only

evident for the intra-muscular dose". This had formed part of the service's action plan, which stated that the service would offer training to staff and that nurses would be reminded of the policy in supervision.

During the inspection, we reviewed the care records of six patients admitted to the service. Staff had undertaken a pre-admission risk assessment with each patient. Staff had updated patient's risk assessments every three months, or sooner if there had been an incident or change in the patient's risk level. Staff also discussed risk assessments at weekly multi-disciplinary team meetings. The service used a variety of recognised tools to assess risk which included the 'short term assessment of risk and treatability' for all patients, and other risk assessment tools such as the 'historical clinical risk assessment version 20', and the 'health of nation outcome scale'.

At our last inspection in June 2017, we told the provider that they must address some of the blanket restrictions in place at the service. A blanket restriction is a rule, which applies to all patients, which is not individually risk assessed or reviewed. The service had improved practice via the completion of a blanket restriction audit, which had identified actions to be undertaken to reduce restrictions. Staff had removed some restrictions since our last inspection, such as the use of polystyrene cups.

Some restrictions remained which were justified for the patient group and risk assessed and reviewed in line with guidance with the Mental Health Code of Practice. For example, staff locked access to the main kitchen and to some communal bathrooms, which had ongoing risks inside them. Patients told us that they did not feel the service was overly restrictive, and we saw evidence that patients and staff discussed blanket restrictions in every patient community meeting.

The service had a list of contraband items, which patients were not allowed to bring into the building; this included standard items such as lighters, alcohol and drugs, which are a known risk and acceptable restrictions in this type service. This contraband list had been risk assessed by the service and staff reviewed it annually to measure the levels of restriction. Because this was a provider wide list that did not always fit with this patient group, the service had removed some of the restrictions in line with individual patient risks such as allowing perfumes and mobile telephones.

The service had attempted to reduce the restrictions around patient searches since the time of our last inspection. Three patients admitted to the service had unescorted leave. Two of these patients had a risk history of bringing high risk items of contraband into the service, such as lighters to set fire. With these two patients, staff used a 'randomiser' button on return from leave, which chose at random whether staff should search the patient. The hospital director felt that this was a less restrictive approach than searching all patients with a risk history on each return from leave.

However, four staff members told us that there was blanket search policy in place, and that they searched all patients on their return from unescorted leave. Following the inspection, the provider showed us copies of the individual search plans in place for these patients, which did include the use of the 'randomiser' button. However, staff had completed these after the time of our inspection, we were unsure of how often staff reviewed and changed these according to individual risks.

At the time of the inspection there were no informal patients admitted to the service, however information on patient rights was available should this be necessary.

Staff undertook differing observation levels dependent on the risk presented by the patient at the time. Patient observation levels varied from every 60 minutes to continual observation. Nursing staff were able to increase or decrease observation levels should this be required, and staff discussed observation levels at handover meetings and in weekly multi-disciplinary team meetings. We saw examples were staff had reduced one to one observations as quickly as possible in order to provide least restrictive care.

Since the time of our last inspection, safeguarding practice and processes had improved. The hospital director had made links with the local authority safeguarding team and they had met to discuss referrals and practices. Staff had appropriately referred all incidents requiring referrals to safeguarding and to the CQC. The provider had a safeguarding policy in place which was accessible to staff. The service had two senior staff members who had undertaking level four safeguarding training.

All staff had received training in safeguarding adults and children and compliance with training was 96%. All staff we

spoke with had a good awareness and knowledge of safeguarding policies and procedures and were able to explain how they would record and report allegations of abuse.

During the inspection, we checked the arrangements for managing medicines. Medicines were stored securely, and according to manufacturer's instructions in locked medication rooms.

A pharmacist visited the ward weekly to conduct an audit of medication cards and storage. They provided the senior management team with reports including a medicines management audit. The audit reviewed medication charts, medication stock and medication storage. The pharmacist also highlighted medical alerts and new policies to the service. The pharmacist used an online system to report errors and concerns alongside copies of weekly audits, which the senior management team reviewed each week. This was an improvement since our last inspection when there was not an audit schedule in place. The provider had changed pharmacy providers since our last inspection. We saw that staff had taken action in response to pharmacy audits, for example in April 2018, there was a concern about how nurses had reset thermometers, and staff had rectified this by the time of our visit in May 2018.

There were safe procedures for children that visited the ward. Any patients who wished to have children visit the ward would request this from staff. Staff held a multi-disciplinary meeting to discuss any risks and to ensure the process was safe. The service had a visitor's room with games and toys available away from the ward should children visit.

Track record on safety

Between 9 November 2017 and 9 May 2018, there had been two serious incidents recorded by the service. One incident in relation to a serious patient on patient assault, and one in relation to a patient leaving the service without authorised leave. The provider had investigated both incidents by the time of the inspection. Each incident investigation was followed up with a detailed action plan. The service had implemented immediate changes because of both incidents, for example by changing window locks and had shared learning from this incident with other Elysium hospitals.

Reporting incidents and learning from when things go wrong

The service used an electronic system to report and record incidents. All staff were able to use the system. During the inspection, we reviewed nine incidents which had occurred between March 2018 and May 2018. Staff had recorded all incidents clearly with good descriptions of the actions taken. Staff also discussed incidents in weekly multi-disciplinary meetings and in every morning meeting and handover, and considered any changes required to patient observation levels, risk assessments or care plans following incidents. We observed senior managers discussing all incidents from the previous day at their daily morning meeting. The same team held a longer meeting on the Friday of each week where they discussed the service's data around incidents.

Staff received feedback from incidents within the service, and from services across this provider, via lessons learned newsletters, which the provider sent out monthly. These were visible in the hospital at the time of the inspection. Staff were able to describe incidents from within and outside the service where they had implemented learning as a result of an incident and had changed practices. We saw evidence of changes being made as a result of this feedback.

Senior managers told us that they also shared lessons learned in team meetings, staff debriefs and supervision. However, we saw that although managers had made efforts to gain staff input into hospital wide team meetings no ward level staff had attended the hospital wide team meeting in the three months prior to our inspection. Staff told us that clinical staff such as nurses and healthcare support workers did not attend hospital wide team meetings, supervision rates were low for ward level staff, and the incident reports we reviewed did not always record debriefs. This limited staff opportunities for learning and development and the sharing of best practice.

Duty of Candour

The Duty of Candour regulation explains the need for providers to act in an open and transparent way with people who use services. It sets out specific requirements that providers must follow when things go wrong with care and treatment. The provider had a Duty of Candour policy in place and staff understood the need to be open and transparent when they had made mistakes and to make written apologies when required. Staff told us that they had received training and were aware of the provider's policy; they were always open and honest with patients. We saw

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

evidence that the provider had used the Duty of Candour legislation when one patient had seriously injured another patient. The provider had given written and face-to-face apologies and remained in contact with the patient throughout the ongoing investigation.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed the care plans of six patients. All patients had detailed care plans in place which, dependent on the individual needs of the patient, included 'personal care', 'insight', 'life skills' and 'physical health'. Staff had undertaken the care plans within one month of admission to the service and reviewed them at least monthly.

Care plans were person centred and holistic. They were written in the own words of patient's, and clearly stated their needs, wishes and views on their care, treatment and goals for discharge. All care plans were collaborative, and included the views of and work patients had undertaken with members of the multi-disciplinary team. We saw that all members of the multi disciplinary team contributed to care plans.

At our last inspection of this service, we told the provider that the care plans in place were not person centred and did not always follow a best practice model of care such as 'positive behavioural support'. Positive behavioural support is a way of using assessment and planning to understand the reasons why an individual exhibits behaviours which others find challenging. This allows staff to support and address the issues that trigger the behaviour. The use of this model of care often leads to a reduction in incidents and the need for physical interventions with patients. We saw a significant improvement in care planning at this inspection. All patients had a positive behaviour support plan, which gave details in patient's own words of how they would like staff to support them in times of crisis or distress. These plans also included detailed restraint plans, which described that if patients were restrained as a last resort how they would prefer this happen in order to reduce distress.

All patients had received a physical health examination and staff used the national early warning scores system to record patients' physical observations on a regular basis dependent on their individual health needs.

Patient records were kept on a secure electronic system accessible to all staff and protected with secure passwords.

Best practice in treatment and care

Patient care plans and medication practices referred to guidance from the National Institute of Health and Care Excellence for example in the management of violence and aggression (NG10), the Mental Health Code of Practice and guidance from the Mental Health Recovery Foundation (MHF2016).

The service offered a range of psychological therapies and occupational therapy to patients. Staff delivered these in both group and individual sessions and they included areas such as dialectical behaviour therapy, a substance misuse programme, and life skills development. In addition to therapy staff, nursing staff had undertaken training in dialectical behaviour therapy to enable to support patients outside of specific therapy groups on a day-to-day basis.

The ongoing monitoring of patients' physical health needs had improved since our last inspection. Two patients had long term physical health conditions, such as diabetes. We found both patients had received a recent review of their health condition with an appropriate practitioner outside of the service. Staff had worked with professionals outside of the service to support patient's with complex needs and had received specific training in the needs of individual patients such as the use of a 'continuous positive airway pressure' treatment machine, and on Huntington's disease. Staff had supported referrals to external professionals to ensure patients had access to high quality healthcare.

There were patients at the service who needed support with nutrition. The service had created specific care plans for these patients and referred them for the support of a dietician.

Staff used rating scales to assess and record severity and outcomes for patients, including; the malnutrition universal screening tool, the health of the nation outcome scale, the

national early warning score system, the Liverpool university neuroleptic side effect rating scale, and the 'Lester' tool for the monitoring of cardiac and metabolic health. The therapy teams used nationally recognised assessment tools with patients to contribute to care planning and the development of life and independence skills. Staff completed a standardised side effect assessment tool for all patients to check if they were experiencing any adverse effects from their treatment.

The service had improved the processes in place for the monitoring of patients prescribed anti-psychotic medications. At out last inspection we were concerned that there was no system in place to ensure that staff carried out the required blood tests and monitoring. We reviewed the medication records of six patients prescribed anti-psychotic medicines. The two patients prescribed medications, which required a specific blood test had these tests undertaken. However, five other patients prescribed anti-psychotic medication did not have all tests recommended by national guidance undertaken such as electro-cardiograms, urea and electrolytes tests, and thyroid function tests. However, for two of these patients we saw evidence that staff had chased these requests with the GP surgery.

Staff completed clinical audits such as checking fridge and clinic room temperatures weekly and daily checks of the emergency equipment. Staff also completed weekly stock orders of equipment. A pharmacist visited the service weekly to audit medication stocks and patient medication cards.

The provider had an annual audit schedule in place for each hospital. These were broken down into subject areas such as clinical effectiveness, patient safety, patient involvement and infection control. The service had a local schedule of audits they carried out to meet the provider's audit schedule, which included audits of rapid tranquilisation and clozapine management.

Skilled staff to deliver care

There was a range of professional disciplines available that made up the multidisciplinary team at the hospital. These included a full time psychiatrist, part time clinical psychologist, two assistant psychologists, an occupational therapist and two assistant occupational therapists, and qualified and unqualified nursing staff. The range and amount of multi-disciplinary professionals at the service was in line with best practice guidance for this type of service.

Staff had received an appropriate induction. Since the time of our last inspection, the service had revised their induction programme and staff had re-taken this where required. Temporary bank staff undertook the same induction processes as permanent staff.

The provider had targets of 95% for both clinical supervision and appraisal. At the time of the inspection, staff compliance with clinical supervision was 70%, and 83% for appraisal. The hospital director had recognised that supervision rates required improvement to meet the provider's targets as this was detailed in the hospital's data dashboards. The newly appointed human resources manager had created a system by the time of the inspection to monitor supervision rates, and the rate of supervision was on an upwards trajectory, however did fall short of expected standards at the time of the inspection.

The hospital manager held monthly hospital wide team meetings. We reviewed these meetings for the three months prior to our inspection. Meetings were thorough and followed the governance agenda to ensure information sharing and lessons learned. However, no ward level staff attended the last three meetings. We asked staff about this and they told us that they were aware the meetings took place and minutes were available, but they were unable to attend due to ward staffing pressures.

The provider had a thorough human resources policy to address poor staff performance. However, no staff were being supported in line with this policy at the time of the inspection.

Multi-disciplinary and inter-agency team work

There was a range of professional disciplines available at the service, which made up the multidisciplinary team. This included psychiatry, psychology, nursing and occupational therapy.

The team held weekly multi-disciplinary meetings, chaired by the consultant psychiatrist on site, to discuss patient needs and review care plans and risk assessments. All

professionals involved in the patients' care attended the meeting. Staff also invited the patient, their carer or relative and any relevant professionals from outside of the service to the meeting.

Staff discussed a range of issues for each patient and we saw respectful and detailed discussions had taken place in the meeting minutes we reviewed.

There was a ward handover meeting twice daily at the start of each shift, including the nurse in charge of both shifts and the staff beginning the new shift. The team also met with the patient group each morning to plan the day and arrange facilitation of leave, visits and appointments. In addition to this, the senior leadership team met each morning for a thorough handover meeting. A representative from the ward and a lead from each discipline followed a set agenda and discussed areas such as risk, leave, complaints, safeguarding, observation levels, and maintenance and the environment.

The service had effective working relationships with professionals outside of the service. The team worked closely with the local GP and had made links with the local authority safeguarding team. Staff had made referrals to other professionals to support patients with ongoing physical health problems that required specialist support. The service worked closely with community mental health services to ensure patients were able to access the right support when they were discharged from the service under section 117 of the Mental Health Act.

Adherence to the MHA and the MHA Code of Practice

Training in the Mental Health Act was mandatory for all clinical staff, and compliance with training was 96%

We reviewed the provider's 'working with the Mental Health Act' policy. The policy was detailed and thorough and referenced relevant legislation including the Mental Health Act Code of Practice (2015). All staff we spoke with had a good understanding of the Act, and were able to explain where they could receive support with more complex issues.

At our last inspection, we were concerned about the administration and management of the Mental Health Act.

By the time of this inspection, there had been an improvement. The service had employed a Mental Health Administrator and in the interim that they were fully trained had been supported to put systems into place by the Mental Health Act Administrator from another service. Audits of patient paperwork had taken place and where they found errors the service had followed these up.

We checked the Mental Health Act documentation for six patients. Paperwork was stored electronically and in good order. All patient records contained a copy of their detention papers and a relevant approved mental health practitioner report. All patients had their rights explained to them under the Act at the appropriate time and senior managers monitored the recording of this.

The service had displayed information on the rights of people who were detained and informal on the ward and independent advocacy services were available to support people. The independent advocate attended the weekly community meeting to ensure they could meet with all patients.

We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act. In addition, the doctor had completed appropriate capacity assessments in accordance with The Mental Capacity Act 2005. However, a Second Opinion Appointed Doctor request and Section 61 review of treatment certificate were not available for one patient. Staff had not stored these documents with the prescription charts and ward staff could not access them on the day of our inspection.

Our Mental Health Act reviewer visited the service in October 2016. This visit raised concerns about; physical healthcare checks on admission, capacity assessments of consent to treatment, blanket restrictions, internet access, information relating to the Care Quality Commission, access to an independent mental health advocate. The provider had addressed all of these concerns by the time of the inspection.

Good practice in applying the MCA

Training in the Mental Capacity Act was mandatory for all clinical staff, and compliance with training was 96%. All staff we spoke with had a good understanding of the Act, and were able to explain were they could receive support with more complex issues.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We reviewed the provider's policy for the Mental Capacity Act and Deprivation of liberty safeguards (August 2017). The policy was thorough and contained all relevant guidance including updates from the 2014 supreme court judgement in relation to Deprivation of Liberty Safeguards.

The processes and understanding of the Act had improved since our last inspection. We saw good examples of staff undertaking capacity assessments thoroughly using a two-stage test. Following this, where necessary they had documented a best interest's discussion and drawn up a specific care plan.

However, we reviewed the care plan of one patient who from previous assessments, staff had deemed to lack capacity to understand their own physical health conditions. This patient was refusing one method of treatment and staff had not undertaken a decision specific capacity assessment about whether this patient had capacity to refuse this treatment. Staff undertook a capacity assessment the week after our inspection.

The service had not made any applications under Deprivation of Liberty Safeguards.

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

Good

Kindness, dignity, respect and support

We observed behaviour from staff, which was responsive, kind, caring and compassionate. We witnessed staff who were skilled in de-escalating patients with complex needs and offering alternative solutions to reduce the risk of incidents. Staff, including the senior management team knew the patient group well and were able to describe their needs and respond to them appropriately.

We spoke with seven of the 14 patients admitted to the service. We offered all patients the opportunity to speak with us.

Patients used words such as 'nice', 'respectful' and 'supportive' to describe staff.

At our last inspection, we concerned about the restrictive treatment of patients, this had improved by the time of this inspection and we had no concerns about respectful treatment of patients.

The involvement of people in the care they receive

The service had a good admission process, which included staff introducing patients to the ward prior to admission. The service had detailed admission booklet, which explained the service and the facilities and therapies available.

Staff told us that patients were actively encouraged to be involved in the planning of their care. Patients were involved in multi-disciplinary meetings and in planning goals for their care, treatment and discharge. The care plans we reviewed reflected this because they used the patients' own words.

All patients had access to the support of advocates, who visited the ward weekly to speak with patients. We saw active involvement from advocates in patient care, who supported them to attend meetings, make complaints, and visit new placements.

Five patients we spoke with told us that service had kept their families informed appropriately and involved them in their care where necessary. Carers we spoke to told us that staff gave them regular and relevant updates on the care of their relative.

Patients were able to give feedback about the care they received via complaints and comments boxes located throughout the hospital, and via fortnightly community meetings. We reviewed minutes of these meetings between 1 February 2018 and 12 April 2018. The agenda for meetings included; actions from previous meetings, patient feedback, the environment, and ward matters such as events and activities, achievements, concerns, blanket rules and restrictions and suggestions for improvements. We saw that the meetings were patient focussed, and a patient recorded the notes of each meeting. We saw examples staff making changes to the service from these meetings, for example, patients stated the Wi-Fi was not working, and staff had addressed this by the following meeting.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The ward had a daily morning meeting between staff and patients where they made plans together for the day. This ensured that patients were involved and able to make choices about leave and activities.

The ward had detailed 'you said we did boards' and we saw that the service had made changes in response to feedback. For example due to patients' dislike of the smoke-free environment, the hospital was revising the policy on the use of electronic cigarettes.

The provider used annual patient and family/friends surveys to seek feedback about the service. The survey undertaken in June 2017 received six responses from patients. Feedback was mainly positive about the care received. One hundred percent of patients said that; staff listened to them, that they discussed blanket rules and restrictions with staff, they attended community meetings, knew their rights, knew about their medication and knew how to complain. All patients also said that staff either helped them to remain in contact with their family or that they did not need help.

There were some more negative comments which included; 50% of patients said that did not know about voluntary opportunities available to them, 35% of patients rated the food as fair or poor and 33% of patients said that they did not receive enough support with physical healthcare needs.

There was a zero response rate to the 2017 family/friends survey. This was due to take place again in June 2018. The provider had an ongoing project to look at the engagement of patient's family and friends in order to increase engagement and responses to requests for feedback.

Patients' wrote, produced and printed a recovery newsletter using in-house facilities. It contained inspiring written pieces and poetry, information about staff and patient's own favourite recipes, and cooking instructions.

The service had supported patients to make decisions in advance of their treatment to explain to staff caring for them how they would like to have treatment during times of crisis. All patients had a positive behaviour support plan, which gave details in patient's own words of how they would like staff to support them in times of crisis or distress. These plans also included detailed restraint plans which described that if patients were restrained as a last resort how they would prefer this to take place to reduce distress they used the patient's own voice with comments such as 'I have pain in my left arm, so please do not restraint me using this arm'.

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

Good

Access and discharge

At the time of our inspection, Bronte ward had thirteen patients, and there were no patients admitted to Byron ward. Between 9 November 2017 and 9 May 2018, the average bed occupancy at the service was 56%. The service worked to a target of a two-year maximum length of stay for patients, to ensure a focus on planned recovery and discharge. However, there was flexibility within this to ensure the service met the needs of individual patients.

The service reported that they accepted patients from outside of the local area, but due to the low level of occupancy at the service, beds were available to patients in the local area if other services requested them.

Patients' beds were allocated to them until they were entirely discharged, meaning that their bed was always available on their return from leave.

Between 9 November 2017 and 9 May 2018, the service had admitted seven patients and discharged five, which evidenced an improved focus on discharge from the service. The service had worked closely with one patient and her community mental health team to facilitate a move into the local community. In order to facilitate this discharge the service had supported the patient with funding applications for furnishings and had allowed their in-house maintenance worker to support the patient to decorate and add fixtures and fittings to their new home.

Due to the longer stay nature of the service, staff planned discharges in advance, and therefore they always took place at appropriate times of the day. The service reported no delayed discharges in the last six months.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We saw evidence in one specific case (in response to a serious incident) that the service had referred to services that provided more intensive care when a patient's needs changed, and the service could no longer support them. The service had made referrals to support patients to move for example to nursing homes or to psychiatric intensive care units when they recognised they could no longer meet the needs of these patients.

The average length of stay of current patients was 14 months.

We reviewed the care plans of six patients admitted to the service. Five patients had discharge plans in place (one was a newly admitted patient). The discharge plans we reviewed were detailed and contained the patient's own words on their needs and choices for the future. They were goal orientated and linked to other plans for care and recovery. We saw in the minutes of multi-disciplinary team meetings that staff and patients discussed discharge and recovery.

The facilities promote recovery, comfort, dignity and confidentiality

The service had a wide range of facilities and equipment to support treatment and care. This included visitors' rooms, activity rooms, an information technology hub, therapy kitchen, gym/exercise space and communal lounges with activities for patients.

Patients had their own mobile phones, and were able to use them to make phone calls in private. Patients had access to the hospital Wi-Fi which was an improvement since the time of last inspection.

Patients had access to outside space, which consisted of an internal courtyard that was unlocked throughout the day and closed at night to promote good sleep hygiene and ensure building security.

The hospital was a no smoking site. Since the time of our last inspection, the service had renewed their smoking policy. Patients were no longer allowed to smoke within the hospital grounds or whilst on escorted leave with staff. At the time the provider brought this revised policy into place, patients were unsettled and there was in increase in aggressive behaviour and complaints. However, the service responded to this by bringing in a new policy on the use of e-cigarettes and a more focussed approach to smoking cessation and nicotine replacement therapies.

The dining area was open to patients throughout the day and night, and patients could make their own hot and cold drinks using the 'beverage bar'. Patients also had access to a toaster and microwave in the beverage bar, which was unlocked throughout the day and night.

Patients were able to personalise their bedrooms, and had safe places in their room to store their possessions. Patients told us that they felt their possessions were safe.

The service had a dedicated occupational therapy and psychology department. The service offered each patient a range of group and individual activities between Monday and Friday. These included dialectical behavioural therapy, mindfulness, life skills programmes, and substance misuse programmes. At the weekends, there was an expectation that nurses and support workers would provide patients with activities.

To ensure they could monitor the amount of meaningful activity delivered to patients, the service monitored the planning, offers and delivery of activities to patients, and reviewed this data in weekly management team meetings The data we reviewed showed that all patients had at least 25 hours per week of planned meaningful activity timetabled and the service monitored whether this was delivered. The week prior to our inspection, 13 out of the 14 patients admitted to the service had received more than 25 hours of planned activity.

During the inspection, we observed patients undertaking activities, leave and therapies with staff. Patients and carers told us that access to activities and therapies was good. Patients were encouraged to use facilities in the local area and some patients used the local gym and library to undertake studies.

Meeting the needs of all people who use the service

Both wards were located on the ground floor of the building and accessible to patients who had mobility needs.

During the inspection, we saw a range of information on display for patients including information about how to complain, how to contact the Care Quality Commission and the rights of informal patients. Staff were able to obtain leaflets in other languages should this be required, and had access to an interpreter service.

Since our last inspection, the service had provided a multi-faith room for patients.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The service had a large well-equipped kitchen with two full time members of catering staff. Staff cooked food on site, which meant that staff could respond to individual patient cultural or religious needs. The service had a menu and had recently taken the advice of an independent dietician to review to menu choices and support patients with healthy eating options. Patients were also able to self-cater using the patient therapy kitchen.

We saw patient comments boxes located on the ward to encourage feedback and a poster was visible to all patients to advise them of how to contact the independent mental health advocacy service.

Listening to and learning from concerns and complaints

The service had received no formal complaints since the time of our last inspection.

The service had received five informal complaints in the last six months. We reviewed these complaints: all complaints were made directly by patients, recorded by staff, and were all resolved at a local level. We saw that when complaints concerned safeguarding allegations, the service referred the information appropriately to the local authority and followed their own processes and procedures. Two complaints were about clinical decision making in regarding to searching and leave, one complaint related to staff behaviour, and two related to patients making complaints about the behaviour of other patients.

The senior management team reviewed complaints and responses on a daily basis as part of their morning meeting.

We saw that the management team responded immediately to patient complaints by planning one to one sessions with patients to discuss the complaint and any investigations or findings.

Patients told us that they knew how to complain and the service ensured patients had opportunities to make complaints via advocacy, complaints boxes and in community meetings.

The service had received nine compliments from patients and carers since our last inspection in May 2017. They had made comments such as “my mum is as well as I have ever seen her” and “I have built confidence, and I can imagine living alone”, “staff are caring and listen and come up with solutions”.

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

Good

Vision and values

Elysium Healthcare Ltd launched their revised organisational values in March 2017 in consultation with patients, staff and board members. These were;

- innovation; so we drive forward the standards and outcomes of care
- empowerment; to encourage all to lead a meaningful life.
- collaboration; because in partnership we can deliver transformational care
- compassion; show respect, consideration and afford dignity to all
- integrity; because we are open, honest and transparent.

We observed that staff displayed the values when working with patients.

The hospital director had launched a ‘values tree’ in the reception of the service. Staff, patients and visitors could make comment on care they had received or observed which met with the values of the organisation. This created positive messages about the service, but also supported the organisation to embed the values in the day-to-day practices of the hospital.

Staff were able to tell us who the senior managers were within the organisation and knew how to contact them should they wish too.

Good governance

Elysium Healthcare Ltd had a clear governance structure, which they had formatted across all of its service provision. Spring Wood Lodge followed this same governance structure which involved a monthly governance cycle of corporate, regional and local governance meetings following a set agenda. The cycle ensured that information flowed from ward to board and back.

Each local governance meeting followed a set agenda linking to corporate governance via what the service called a ‘golden thread’ of ward to board information. We

reviewed the local governance meeting minutes for November 2017 to January 2018. The governance meetings discussed agenda items such as; actions from the previous meeting, recruitment, policies, hospital compliance action plans, audits, physical health, quality dashboard, safeguarding, risk assessments, patient experience, advocacy report, and the culture of care survey. Each meeting had an action plan which was rated as 'red' 'amber' or green' in order of urgency for completion.

The service had made improvements in establishing their governance systems since the time of our last inspection, which was evidenced in the improvements made in areas such as mandatory training.

Senior managers had access to data dashboards, which they reviewed weekly. These shared data regarding the use of restraint, staff training, patient one to one time, patient activity levels and compliance with the Mental Health Act. This allowed staff to monitor and act upon concerns or changes in data and information. We saw an example of this when the hospital director had noticed a reduction in supervision levels and acted on this by creating a supervision monitoring system with the human resources manager.

The service had increased its administration team to include a health and safety manager, human resources manager and Mental Health Act administrator. This meant that these staff had been able to utilise their specialist skills and expertise to improve the safety and quality of the service.

The service had a number of key performance indicators to meet within the next twelve months, to improve the safety and effectiveness of the service these included:

- developing healthier lifestyles with the roll out of 'mission fit'
- roll out of 'safewards'
- development of strategies to reduce medication errors
- evaluating the efficiency of the service using outcome measures
- implementation of national early warning scores (two).

The hospital director monitored risk using a local risk register and risk matrix, which fed into the corporate risk register and matrix. Staff could bring up risks and concerns in team meetings, which fed into local governance meetings. The hospital manager would then bring these concerns to regional governance meetings for discussion regarding addition to the local and corporate risk registers.

The service had 16 risks on the risk register rag rated in order of concern. Six risks were recorded as 'medium' post control measures, and ten were recorded noted as 'low' post control measures. There were a number of risks that were shared across both risk registers, which evidenced a joined up approach to sharing information about risks.

Although there had been improvements in governance, the service had ongoing work to complete. Some areas of governance were not entirely embedded by the time of the inspection. Audits carried out by the service had not identified that the monitoring of the side effects of patient's prescribed anti-psychotic medications and receiving rapid tranquilisation was not always taking place according to national guidance. Mental Health Act audits had not recognised that a Second Opinion Appointed Doctor (SOAD) request was not available for one patient, and a Section 61 review of treatment certificate for one patient could not be located by staff during the inspection.

There had been a significant improvement in training since the time of our last inspection. However, staff were unclear about certain areas of their practice, for example when to carry out capacity assessments, when to search patients and the recording of physical health observations following rapid tranquilisation. Ward level staff had limited opportunities for clinical supervision and told us that they were unable to attend hospital wide team meetings, although the hospital manager had encouraged attendance, they had not attended these meetings for the three months prior to our inspection. We acknowledged through discussions with the hospital director that some areas of more complex practices take time to learn and embed. The senior management team acknowledged that increased opportunities for supervision and encouraging staff attendance at team meetings would support the further development of staff skills.

Leadership, morale and staff engagement

Staff we spoke with during the inspection told us that they were happy in their jobs, they spoke of an emphasis on team work within the service and good levels of morale.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff said that line managers who were open and approachable. There had been no episodes of bullying or harassment recorded by the service and staff told us that they were not aware of this taking place.

Staff were aware of the provider's whistleblowing process and told us that they had not used it but would feel confident in raising concerns without fear of victimisation.

The provider had carried out a staff survey in June 2017. There had been 18 responses from staff at Spring Wood Lodge. Responses were mainly positive, 100% of staff said that they felt supported by their line manager, had not experienced any discrimination and felt that they could rely on their colleagues for support. Eighty-three percent of staff would recommend the care provided to their family and friends, and 82% of staff would recommended the service as a place to work. The provider had an action plan in place to address areas were staff were not wholly positive such as in relation to development opportunities and staff ability to influence changes.

The service did not have high rates of sickness; there was an average sickness rate in last six months of 4%, which had reduced to 1.5% by May 2018. There had been five staff leavers, however all staff had remained within the organisation, transferring to other services of from permanent to bank staff for personal reasons.

The hospital director told us that staff were encouraged to input into service development and that these innovations and ideas would be discussed at hospital wide staff meetings. However, we saw that no ward level staff had attended hospital wide team meetings in the last three months prior to the inspection. The management team had made efforts to encourage attendance but these had not been successful.

Commitment to quality improvement and innovation

The service wished to work towards accreditation, and continued to develop plans towards this.

The ward manager and psychology lead continued to work on a research project. The research will look at the service's plan to introduce compassion focussed therapy, i.e. the current need, how it would be introduced, and then will review the results from pre- and post-therapy outcomes.

Outstanding practice and areas for improvement

Outstanding practice

We found that the quality of positive behaviour support planning and recording the advanced decisions of patients was of particularly high quality and this supported the service to maintain low levels of the use of restrictive interventions.

The service had supported patients with complex needs in their discharge pathways either into the community or into more appropriate settings. For two patients, the care had developed beyond what would usually be expected. For example, the hospital had maintained care (despite the staffing pressures this brought) with a patient admitted to an acute hospital ward, which included daily two to one support and weekly reviews by the consultant psychiatrist to maintain the stability of the patient's mental health with staff who knew them well.

For another patient being discharged to her own home, the service had gone beyond their role to ensure a safe discharge for this patient by offering the services of their maintenance staff to decorate and provide a handyman service when preparing the patient's new accommodation. This was caring, responsive and incredibly person centred.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients prescribed medication have all the required monitoring of side effects undertaken as per national guidance.
- The provider must ensure that the correct monitoring and recording of patient's physical health observations is undertaken following the use of rapid tranquilisation.
- The provider must ensure that all staff have clinical supervision.

Action the provider SHOULD take to improve

- The provider should ensure that staff are able to attend team meetings to enable them to learn and develop skills.
- The provider should ensure that all staff understand the search policy and the use of the randomiser button.
- The provider should ensure that staff adequately record when patient's return from section 17 leave.
- The provider should ensure that section 61 treatment certificates are available to staff and accessible in patient files, and that requests for second opinion appointed doctors are completed appropriately.
- The provider must ensure that where patients lack capacity to make decisions, staff follow the principles of the Mental Capacity Act.
- The provider should ensure that the governance systems and processes in place enable the service to assess, monitor and improve the quality of the service and mitigate risks to the health, safety and welfare of patients. This includes that audits in place include all areas of risk and concern.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Care and treatment was not provided in a safe way for patients because the service was not regularly assessing the risks to the health of patients by ensuring there was proper monitoring of long-term anti-psychotic use. Staff did not carry out appropriate observations following the use of rapid tranquilisation. **This was a breach of regulation 12 (1) (2) (g)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** Staff had not all received the appropriate clinical supervision necessary to enable them to carry out the duties they were employed to perform. **This was a breach of regulation 18 (1) (2) (a)**