Bramley Health

Glenhurst Lodge

Quality Report

Virginia House
Vinters Road
Maidstone
Kent
ME14 5DX
Tel:(01372) 744 900
Website:http://www.glencare.com

Date of inspection visit: 2 - 3 September 2015
Date of publication: 16/06/2016

This report describes our judgement of the quality of care at this hospital. 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 hospital	Good
Long stay/rehabilitation mental health wards for working age adults	Good

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because:

- Environmental risks had been assessed and action taken to remove or reduce these risks
- Men and women were cared for in separate areas
- The wards were clean and adequately maintained
- There were enough staff to provide care for patients
- All patients had had a risk assessment carried out and reviewed
- The hospital had means of managing risk which included observations and room searches
- Staff handled and administered medication appropriately.

However:

- food was not always stored properly.

Are services effective?

Requires improvement

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

- Although patient's care plans were individualised, it was not clear what their rehabilitation or recovery plan entailed
- A rehabilitation model had been implemented but staff had not had specific training in rehabilitation or in working with patients who lacked motivation
- Not all staff had received training in the Mental Health Act or the Deprivation of Liberty Safeguards
- Patient's had their physical healthcare monitored and attended for routine healthcare appointments. However, physical observations were not consistently recorded in the same way in the same place.

However:

- Staff had an induction and received supervision and appraisal
- Multidisciplinary team meetings took place each week which incorporated patient's views
- All patients had had a care programme approach (CPA) meeting within the previous 6-12 months
- The Mental Health Act was applied correctly. Patients were risk assessed before they went on leave. Patients had access to a MH Advocacy service. Patients had their capacity to consent to treatment assessed. This assessment included where complex decisions were made about physical healthcare needs.

Summary of findings

Are services caring?

Good

We rated caring as **good** because:

- Patients we spoke with were positive about the staff
- We observed friendly and respectful interactions between patients and staff
- Patients were asked for their views and this was included in their care plans
- Patients had access to an advocacy service.

Are services responsive?

Good

We rated responsive as **good** because:

- Patients had their own rooms which they had personalised
- There was a quiet room and garden area available on each ward
- Patients had access to food and drinks outside of meal times
- Patients and others knew how to make a complaint.

However;

- There were limited activities within the hospital.

Are services well-led?

Good

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

- Action had been taken to address a number of concerns that had been found at the last inspection
- There were systems for the ongoing monitoring and improvement of services and action had been taken in response to this
- Staffing levels and staffing consistency had improved and there were reported improvements in staff morale
- Learning was shared with the provider's sister hospital.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Long stay/ rehabilitation mental health wards for working-age adults	Good	• environmental risks had been assessed and action taken to remove or reduce these risks. • men and women were cared for in separate areas. • wards were clean and adequately maintained. • there were enough staff to provide care for patients. • all patients had had a risk assessment carried out and reviewed. • staff handled and administered medication appropriately. • staff had an induction and received supervision and appraisal. • a multidisciplinary team meeting took place each week which incorporated patient's views. Staff from disciplines including medical, nursing, psychology, and occupational therapy staff attended. • all patients had had a care programme approach (CPA) meeting within the previous 6-12 months. • patients had assessments in relation to their capacity to consent to treatment. This included where complex decisions were made about their physical healthcare needs. • patients we spoke with were positive about the staff and the interactions we observed between patients and staff were friendly and respectful. • patients had access to an advocacy service. • had their own rooms which they had personalised. There was a quiet room and outside garden available for each ward. • patients and others knew how to make a complaint. • action had been taken to address a number of concerns raised by the Care Quality Commission at the last inspection. There were systems for the ongoing monitoring and improvement of services and action had been taken in response to this. Staffing levels and staffing consistency had improved

Summary of findings

and there were reported improvements in staff morale. Learning was shared with the provider's sister hospital. During our last inspection we found the service non-compliant in six areas: involving patients, care and welfare, safeguarding, environment, staff and training, and monitoring the quality of service. At this inspection we found that improvements had been made in all areas and there were further improvements planned.

However,

- patient's care plans were individualised but it was not clear what their rehabilitation or recovery plan entailed. For example, patients were expected to manage their own food with support from staff. However, the care plans were not clear about how this was to be achieved.
- there were limited activities within the hospital.
- patient's food intake was not monitored to ensure patients were eating a balanced diet.
- a rehabilitation model had been implemented, but staff had not had specific training in rehabilitation or in working with patients who lacked motivation.
- not all staff had received training in the Mental Health Act or the Deprivation of Liberty Safeguards.
- physical observations were not consistently recorded in the same way in the same place. There was a risk of changes or patterns being missed and it was difficult to undertake comparative observations.

Good

Glenhurst Lodge

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Glenhurst Lodge

Glenhurst Lodge is registered to provide the regulated activities: treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures. The manager of the service became the registered manager in September 2015.

Glenhurst Lodge provides one core service: long stay/ rehabilitation mental health wards for working age adults.

Glenhurst Lodge has two locked rehabilitation wards. Davenport ward has 11 beds for men, and Sandown ward has 11 beds for women. During the inspection the service was providing care and treatment to six men and four women. Nine patients were detained under the Mental Health Act.

We have inspected Glenhurst Lodge five times since registration with the Care Quality Commission (CQC) in 2011. The last inspection took place on the 4 December 2014. Glenhurst Lodge was not meeting seven of the previous regulations. The service is now not meeting one of the current regulations.

Our inspection team

Team leader: Evan Humphries, Inspection Manager, CQC

The team that inspected the service comprised three CQC inspectors (Rachel Davies, Jane O Connor, Clem Feeney), a Mental Health Act reviewer (Christine Yeo), an expert by experience (Gary Benninson), and a nurse (Julie Gallagher).

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?

Detailed findings

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

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 five patients who were using the service, and the relatives of two patients
- spoke with the manager
- spoke with nine other staff members; including doctors, nurses, support workers, and allied healthcare professionals
- spoke with an independent advocate
- attended and observed one hand-over meeting, two community meetings, and a multi-disciplinary meeting
- collected feedback from seven patients using comment cards
- looked at eight care and treatment records of patients
- carried out a check of the medication management on both wards including prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

Our ratings for this hospital

Our ratings for this hospital are:

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

Good

Are services safe?

Our findings

Safe and clean environment

- An environmental risk assessment of the building had been carried out. This included a ligature audit. This identified and rated risks and made recommendations for their removal or management. There were ligature points on the wards, both in patient bedrooms and communal areas. There were two bedrooms on each of the wards that had ligatures removed. Some areas of the ward, such as bathrooms, were left unlocked. Staff told us there was always a nurse in the corridor who observed the area and made regular checks on all the patients. This was observed throughout our inspection. Patients had a risk assessment carried out and plans were developed from this to reduce the risks. There were ongoing plans for the future removal of risks across the building.
- Men and women were cared for on separate wards with separate gardens. There was supervised access to communal facilities, such as the laundry facilities in the basement.
- Resuscitation equipment and emergency medication was available and checked regularly.
- At our last inspection in December 2014 we found a number of problems with the upkeep and maintenance of the environment. This included broken items such as a shower, doors and a garden gate. They had been damaged for some time and not repaired. At this inspection we found that the outstanding repairs had been carried out, and that problems identified in subsequent months had also been addressed. There was a monthly health and safety walk which identified where maintenance was required. A permanent maintenance person was now employed for the hospital.
- At our last inspection in December 2014 we found a number of concerns regarding infection control practices in the hospital. These included dirty sinks and toilets, stagnant water which may increase the risk of legionella, overdue infection control audits, out of date food, storage of clean items next to dirty items in the kitchen and laundry and outstanding maintenance issues that made areas of the hospital difficult to clean effectively. At this inspection we found that these issues had mostly been addressed. The hospital was clean and there was a routine cleaning schedule. Cleaning records were completed and up to date. There were regular checks of the fridge temperatures and these were in the safe range. Food hygiene information was displayed in the kitchen. We identified some food hygiene issues. For example, there was bread that was a week over its best before date although there was no visible mould; a ready meal was a day over its use by date; and raw meat, which was in sealed packets, was on a shelf above milk in the fridge. There were open packets of cereal, sugar and flour that were not stored in sealed containers. The provider addressed all these issues on the day of our inspection. Unused toilets and sinks were regularly flushed to reduce the risk of legionella.
- At previous inspections we found that the emergency alarms did not work in the garden, so staff could not easily call for help when they were supervising patients in the garden. At our last inspection in December 2014 we saw that this had been identified as a risk at several management meetings but no action had been taken to address it. At this inspection we found the problem had been solved and the alarms now worked in the garden.

Safe staffing

- The manager told us that there had been a high turnover of staff, but this had improved. Staffing records showed in the year up to the 4 June 2015 there had been a 98% turnover of staff. The turnover of staff had been high due to the new manager making cultural changes to the service that not all staff had signed up to. There were two whole time equivalent (WTE) consultant psychiatrists, six WTE registered mental health nurses, 11 WTE therapeutic care workers, 0.5 WTE forensic psychologist, one WTE assistant psychologist and one WTE occupational therapist. At the time of our inspection there were no therapeutic care worker vacancies. There were two registered mental health nurse vacancies. Recruitment was ongoing and two specific agency nurses who worked regularly in the hospital were covering the vacant posts.
- Agency nurse usage for 4 weeks in June 2015 showed that bank or agency staff filled 159 hours out of 370 hours. However, at the time there had been six qualified

nurse vacancies and three therapeutic support worker vacancies, which was no longer the case. During the same period, there were no shifts that had not been filled.

- The NHS safe staffing model had been implemented to determine staffing levels in the hospital, the manager confirmed this. There was a qualified nurse and three therapeutic support workers on duty on each ward. The sample of nursing rotas we looked at showed that the number of staff matched the stated minimum on most shifts. Staffing levels were adjusted if necessary. For example, a patient was admitted to an acute hospital and a member of staff accompanied them. This was booked as an addition to the normal staffing levels. Agency nurses were provided with a description of their responsibilities when working in the hospital.
- Staff we spoke with reported that there were usually enough staff on duty and that escorted leave was not cancelled because of staff shortages. Leave had been cancelled in the past, but this had improved in the last two months.
- All medical staff in the unit were permanent. There was a two-tier oncall system for out of hours medical cover. The first tier system was provided by external doctors from the local NHS trust. The second tier was fulfilled by doctors from Glenhurst.
- At our last inspection in December 2014 we found that not all staff had completed their mandatory training. At this inspection we found that staff were up to date with most of their mandatory training. Staff we spoke to stated there was regular access to training much of which was e-learning. They also attended face to face training for some subjects, such as the prevention and management of violence (PMVA). All areas of mandatory training were above 75% staff completion rate with the exception of basic and immediate life support training. Immediate lift support training had only been provided to two staff members. Eight therapeutic support workers had not undertaken basic life support training. All nurses and therapeutic support workers had completed prevention and management of violence (PMVA) training, but it was not clear how many had received refresher training. Staff had all completed training in safeguarding.

Assessing and managing risk to patients and staff

- For the first six months of 2015 there had been 31 incidents of restraint, none of which were prone or face down restraints. Staff we spoke with stated that the use of restraint had reduced over the last two months as staffing levels had improved. Restraint records were reviewed to evidence this.
- All patients had a risk assessment. This used a recognised tool called the short term assessment of risk and treatability (START). These included the level of risk and actions that should be taken to remove or mitigate this. From this, each patient had a positive behavioural support plan. This identified the potential triggers and warning signs for risk behaviours, such as aggression or self-harm. The plan was tailored to the individual and included specific actions that staff should take to work with the patient.
- There was a list of prohibited and restricted items on display in the staff offices. Each patient had a locker in the office that contained restricted items such as lighters, cigarettes and toiletries. In the care plans we looked at most patients had supervised access to the kitchen, but on both wards the kitchens remained open throughout our inspection. Staff we spoke with stated there was always a member of staff around who would see and support a patient if they went into the kitchen alone.
- Most of the patients in the hospital were detained under the Mental Health Act. Patients who were not detained were able to leave the hospital when they wished. Staff met with and carried out a risk assessment of each patient before they left the hospital.
- There was a rota/allocation of a therapeutic support worker each shift to carry out routine observations on the ward. Staff carried out random and responsive searches of patients and their bedrooms. Staff were familiar with the procedure, and the searches were documented. We were told searches were carried out as the service had recently had a problem with drugs and legal highs being brought into the hospital.
- The service had no seclusion rooms. Staff told us that there had been no episodes of seclusion or long-term segregation. We saw no evidence of the use of de-facto seclusion, or of long-term segregation.
- At our last inspection in December 2014 we found an incident where a safeguarding referral should have been

made and it hadn't been. At this inspection we found that the previous safeguarding concern had been addressed. Information about how to make a safeguarding referral was on display in the staff offices. At the time of the inspection there were two safeguarding referrals that were open and being investigated. Staff we spoke with were aware of the safeguarding policy, how to use it and all had received training on safeguarding of vulnerable adults. The two wards also had CQC and safeguarding folders which contained details of the safeguarding policy and information to support staff when making a referral.

- Medication was stored and monitored appropriately. The hospital had a contract with an external pharmacy for the supply, monitoring and disposal of medication. A pharmacist visited the ward each week and carried out a monthly audit of medication. There were no significant problems identified regarding medication. The staff and manager followed up any gaps or errors. For example, if there were gaps on prescription charts. Staff ordered medication and clinical supplies through an online order form. The prescription charts were completed correctly.

Track record on safety

- There had been no serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff were familiar with the incident reporting process and all staff could report incidents. These were reviewed by the manager. The multidisciplinary team discussed incidents that involved patients.
- Incidents were reviewed by the local manager and at the corporate governance meeting. Learning from incidents that occurred at Glenhurst Lodge and its sister hospital were shared across the group. The minutes from these meetings were discussed at staff meetings and made available to staff.
- The patient safety meeting was held on a quarterly basis. This was convened more frequently if there was a very serious incident or if the number of incidents increased.
- The service had had 31 number of incidents over the past six months up to 31 June 2015. These had been investigated and action taken.
- The culture of the service was open and transparent. The service had a Duty of candour policy. Staff we spoke with were familiar with the policy. Staff told us that they were aware of their individual responsibilities to be open and transparent in respect of patients care and treatment.They also told us that they felt well supported by the managers to be open and honest.

Requires improvement

Are services effective?

Our findings

Assessment of needs and planning of care

- There had been no patients admitted within the previous year.
- At our last inspection in December 2014, we found that the care plans did not reflect individual patient's needs. For example, care plans advised staff to "de-escalate" if a patient was becoming upset, but not what may cause a specific patient to become this way, or what action would calm them down. There was no evidence of rehabilitation or recovery care plans being used and staff had limited understanding of how to implement this. At this inspection we reviewed all 10 patient care plans and found that although the care plans had improved, and elements of a recovery approach had been implemented, it was still not clear what steps patients needed to take to achieve their goals.
- The hospital had implemented "My Shared Pathway" which was a patient-focused recovery model of care. Each patient had a "My Shared Pathway" folder that contained information about their preferences. In addition each patient had a "Behavioural Support Plan". Staff stated that each patient had access to their "My Shared Pathway" folder, but many were not interested or motivated to get involved with this. Patients had an "aspirational care pathway" in their records, which included goals for the future. However, it was not clear how this was to be achieved. For example, there were goals for patients to cook their own food. However, although the main kitchen had been closed and work had been done towards self-catering, it was not clear what formal steps were in place to ensure that patients had a balanced diet every day. Similarly, some patients had goals to self-medicate, but there were no plans which included the incremental steps that were required for the patient to achieve this.
- Each patient had a health action plan (HAP) folder. This included details of their physical healthcare. Patients were registered with a GP and had visited them when necessary. Patients had attended routine healthcare appointments such as dentists and opticians and a chiropodist visited the hospital every six weeks. A physical health clinic took place in the hospital each month. This was a drop in clinic provided by nursing staff which provided health promotion advice to patients.
- Physical observations, such as blood pressure, were recorded using a standardised colour coded/traffic light system called the national early warning score (NEWS), developed by the Royal College of Physicians. We saw that where patients had long term healthcare conditions this was monitored but it was not always recorded in the same place, which could cause problems. For example, there were gaps in the monitoring of blood sugar levels for a patient with diabetes. The patient sometimes refused to have their blood sugar levels monitored and there was a care plan for action to take when it was above a certain level. However, as the levels were recorded inconsistently across three different places (the blood glucose form, the daily entry of care, and the handover sheet), there was no one place to see the information clearly. However, where there had been high levels appropriate action had been taken.
- The hospital used overhead projectors in its multidisciplinary team meetings so that everyone in the meeting, including the patient, could see the patients' care plan as it was updated.
- The care records were paper-based and were stored securely in the staff office. The multidisciplinary team minutes were maintained electronically, but copies were printed off and put in the paper records. All permanent staff had their own login for the computer.

Best practice in treatment and care

- In July 2015 the main hospital kitchen was closed to encourage patients to make their own food. Each patient had a budget of £30 a week and had a food budgeting and shopping management plan completed in March 2015, with the aim of them being able to plan, buy and cook their own food. Each patient had their own food cupboard and there were shared items such as bread and milk. Staff cooked one meal a day so that patients would always have something to eat. Staff acknowledged that patients did snack and that many were not motivated to cook. There was a kitchen on each ward which had two cookers and was potentially for 11 patients to cook their meals. Staff we spoke to

reported that patients tended to want to eat at different times so there was not a problem with lots of people wanting to use the kitchen at the same time. During our inspection we did not observe any patients cooking, but saw that they picked up snacks or went out for meals. We saw that staff cooked a meal at lunchtime but many of the servings were left untouched in the kitchen.

- There was a four week rolling menu but this did not reflect what we saw patients eating or what was in the records. Staff told us the menu was not implemented but was used for suggestions. Staff showed us that they had introduced a weekly meal planner with a food diary to be completed by patients or staff. However, the records of these showed that there were gaps and staff noted that patients often did not want to engage. Staff we spoke with stated that they spoke with patients and that patients would tell staff if they were hungry. However, it was not possible to tell from the records what patients were eating, if they were having a balanced diet, or how they were being supported and encouraged to do this. We did not observe any patients cooking meals, but observed patients going into the kitchen for snacks.
- Patients who took medication that required them to have regular physical healthcare checks, had this carried out. For example, patients who were taking clozapine had regular blood tests.
- Developments in research and healthcare were discussed at academic afternoons, which took place at a sister hospital. Audits were carried out of by the medical staff. This included of high dose prescribing of medication.
- Health of the nation outcome scales (HoNOS) were completed in patient's records.

Skilled staff to deliver care

- Staff had an induction when they started working at the hospital. However, this was not against a standard recognised programme, such as the Common Induction Standards or the Care Certificate. The induction programme consists of two days of corporate induction, followed by an induction pack that staff follow in the unit. New staff were allocated a mentor and completed their mandatory training. This was a mix of e-learning and face to face training.
- Staff had regular supervision. The frequency varied, particularly during staff changes, but the aim was for staff to have monthly supervision. All staff we spoke with had received supervision within the previous month. We reviewed supervision records to confirm this.
- All medical staff were permanent employees. There were two whole time equivalent (WTE) consultant psychiatrists, six WTE registered mental health nurses, 11 WTE therapeutic care workers, 0.5 WTE forensic psychologist, one WTE assistant psychologist and one WTE occupational therapist. The hospital had employed a forensic psychologist who had been in post for two months. The psychology model was still being developed in the hospital but the psychologist had five patients on their caseload. The hospital had a temporary occupational therapist who was working in the hospital for two weeks. The temporary occupational therapist had developed new plans and activities for patients which were in the process of being embedded. A permanent full time occupational therapist had accepted a post at the hospital and was taking up post the week after the inspection. The temporary occupational therapist was to handover their work to the new therapist and continue with plans and activities.
- In the year up to 23 June 2015 all permanent non-medical staff had had an appraisal. There had been a high turnover of staff since this time so current staff had either had an appraisal or were within their first year of working at the service. The responsible clinician/ medical director supervised medical staff. The medical director received supervision from outside the hospital.
- At our last inspection in December 2014 we found that staff had not carried out any rehabilitation training and had limited understanding of what this might include. At this inspection we found that although staff had an understanding of some aspects of the rehabilitation process, there was still no specific training for staff. It was acknowledged that patients often lacked motivation to work towards becoming more independent. However, there was no model of care or information about how staff should work with patients to address this.

Multi-disciplinary and inter-agency team work

Requires improvement

Are services effective?

- A multidisciplinary team (MDT) meeting took place in the hospital each week. Each patient was seen every other week. The MDT meeting discussed the specific treatment goals for each patient. Patients' views were recorded and taken account of. Other issues were discussed in the meeting, which included physical health, life skills, and capacity and Mental Health Act issues.
- A handover took place between shifts of nursing staff and therapeutic support workers. We observed one of the shift handovers during the inspection. This used a handover sheet which was taken into a week-day handover which included the multidisciplinary team and the manager.

Adherence to the MHA and the MHA Code of Practice

- Training records showed that approximately 50% of nursing staff and therapeutic care workers had received training in the Mental Health Act (MHA). The staff we spoke with reported that they had received training within the last year on the Mental Health Act, but were not familiar with the revised MHA code of practice.
- Patients were reviewed in the multidisciplinary team meetings every other week. During these, each patient's capacity and detention under the MHA was reviewed and discussed. However, the necessary consent forms were not consistently attached to the medication charts as required by the MHA code of practice.
- We carried out a specific review of the MHA on Sandown ward. The paperwork for all the detained patients on the ward was completed correctly. Section 17 leave was authorised and implemented correctly and patients were risk assessed and signed a log book before they left the hospital.
- Patients had their rights under the MHA explained to them each month. This was recorded and included their level of understanding.
- The Mental Health Act Administrator (MHAA) post was vacant. It was covered temporarily by an experienced MHAA from another hospital. There was a monthly audit of Mental Health Act paperwork.
- Patients had access to an independent Mental Health Act advocate (IMHA).

Good practice in applying the MCA

- There was a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguard (DoLS) policy.
- At our last inspection in December 2014 we found an instance where a patient was noted as being treated in their "best interest" but there was no evidence of the correct process being followed for this to protect the person's rights. The provider confirmed that they had addressed this and at this inspection we confirmed that to be the case.
- Some of the patients in the hospital had physical healthcare problems that they were reluctant to engage in treatment for. The service had assessed their capacity and had a patient-centred and supportive approach towards this, which minimised the distress to the patient. For example, one care plan included how with time and reassurance the patient tended to accept treatment. They had had a detailed assessment of their capacity by medical staff. From this a detailed care plan was developed and approved by the multidisciplinary team. This highlighted the situations where the patient may be treated in their best interest.
- Where patients were not detained under the Mental Health Act their capacity to consent to medication and to stay in the hospital as an informal patient had been assessed.
- Staff had received training and had some understanding of capacity. Staff had less understanding about the use of DoLS.
- There were no patients in the hospital at the time of our inspection who were subject to a DoLS authorisation. There were no patients in the hospital who were awaiting a DoLS assessment following an application.

Good

Are services caring?

Our findings

Kindness, dignity, respect and support

- The patients we spoke with were mostly positive about the staff. Staff and patients negotiated leave together (within the constraints of the Mental Health Act) and staff were prompt to do this. The interactions we observed between patients and staff were friendly and respectful. We spoke with two relatives of patients who spoke positively about the service and the kindness of staff.

The involvement of people in the care they receive

- At our last inspection in December 2014 we found that patients' views were not taken account of and patients were not involved in the development of their care plans. In some of the care plans and the governance meetings we found that the attitude towards patients was punitive and blamed patients for their lack of motivation, rather than taking account of this as part of their recovery plan. At this inspection we found that patient's views were included in their care planning. For example, patient's views were requested and recorded during multidisciplinary team meetings. These were recorded in the care records which were on display during the meetings. Patients had signed their care plans.
- The hospital used overhead projectors in its multidisciplinary team meetings so that everyone in the meeting, including the patient, could see the patients' care plan as it was updated.Patients had access to an advocacy service. An advocate visited the service each week and was contactable by telephone outside of this. The advocate supported patients in the multidisciplinary team meetings.
- There were daily community meetings on each of the wards. These were short, lasting approximately five minutes, and focused on what patients were doing during the day. For example medical appointments and activities. The meetings were chaired by patients and did not have a slot for any other business or to discuss other issues on the ward.
- The provider carried out an annual patient survey. This was last carried out in March 2015. Action points raised from the survey were about the specific care of an individual, and to focus on the strengths of patients as part of the care planning process.

Good

Are services responsive?

Our findings

Access and discharge

- The service had not admitted any patients over the last year. Davenport ward had six patients out of a potential 11, and Sandown ward had four patients out of a potential 11.
- The average bed occupancy was 36.4% for Davenport and 54.5% for Sandown in the six months prior to the inspection.
- The service had no delayed discharges in the six months prior to the inspection.
- The hospital was not currently taking new admissions following the last CQC inspection report. We were told new admissions would be orientated to the service and given information about their stay. New admissions would also be given the chance to visit the unit prior to admission to familiarise themselves with the hospital.
- Patients who went on leave returned to the same bedroom. This was hospital policy.
- There was a mixed picture with regards to discharge planning. Two of the records we looked at contained clear evidence of discharge planning in the MDT meeting, but four records did not. However, all patients had had a care programme approach (CPA) meeting within the previous six to 12 months. This was attended by the patient, staff within the service, and external professionals such as care coordinators.

The facilities promote recovery, comfort, dignity and confidentiality

- There was an activity programme in place but this did not appear to relate directly to activities on the wards. Patients were focused on organising their section 17 leave (escorted and unescorted) and staff supported them to do this. There was some adhoc engagement on the ward such as playing pool. However, although many patients had identified problems with motivating themselves to carry out day to day activities, there were no structured care plans about how this would be addressed.
- All bedrooms were single and had an ensuite shower and toilet. Patients had personalised their bedrooms and had keys to their rooms.
- There was a quiet room on each of the wards and a room off the ward for patients to meetvisitors. The pay phone in the men's ward was in the quiet room but on the women's ward it was in the corridor. There was a garden for each of the wards. The men's ward was down a flight of stairs so required supervised access.
- Patients had access to their own personal supply of food and snacks and communal food such as tea, bread and cereal. They had access to the main kitchen on the ward and to a kitchenette for making hot drinks.

Meeting the needs of all people who use the service

- All the patients in the hospital spoke English as a first language. Staff stated that they could access interpreters if necessary but they had not needed to do so.
- Patients had their own weekly food budget, so were able to choose food that met their dietary or religious requirements.
- The doors were widened and allowed for wheel chair access. There were disabled toilets. The building was split across two levels. There was lift access between the wards allowing for disabled access.
- Attempts were made to meet patient's individual needs including cultural and religious needs.

Listening to and learning from concerns and complaints

- There was information on display about how to make a complaint. Staff were familiar with the complaints process and told us if they received a complaint they would initially try to deal with it, and if unable to do so they would escalate it to the nurse in charge or the manager. Staff were aware of the hospital's complaint form which they would give to the patient or document this in their notes.
- There had been three complaints over the last twelve months. None of these were from patients. All the complaints had been responded to.
- Complex complaints were discussed at the academic meetings that took place at a sister hospital.

Good

Are services well-led?

Our findings

Vision and values

- Staff knew who the senior managers in the organisation were.
- Staff were aware of the organisations vision and values and agreed with them.

Good governance

- At our last inspection in December 2014 we found that the service had a system for identifying and monitoring problems and risks at the hospital. However, these were not always addressed promptly, and were often rolled forward from meeting to meeting. At this inspection we found that progress on actions identified at the meetings had improved and longstanding problems had been addressed. For example, the implementation of an emergency alarm system that worked in the garden.
- The hospital manager was a member of the corporate governance group which met monthly. They also attended the patient safety meeting and the monthly staff meeting, and were part of the health and safety and the clinical governance group. The clinical governance meetings monitored and reviewed audits, incidents, and staffing across the group. This included safeguarding alerts, incidents, restraints, and complaints. Monitoring information highlighted any trends that arose from these areas. Staff supervision, appraisal and training were also monitored through the group. Internal audits took place which included health and safety, the Mental Health Act, pharmacy, high dose prescribing, and care plan reviews. The Chief Executive carried out a quarterly audit which included patients' records and the environment.
- Staff received mandatory training. Staff were all up to date with supervision. All staff had an appraisal within the last 12 months.

Leadership, morale and staff engagement

- Staff told us that the staffing levels and support in the hospital had improved since the last inspection. The staff we spoke with said they felt able to raise concerns, and felt that morale had improved amongst staff. Sickness absence was low in the service. In the twelve months up to June 2015 this was less than 0.1%.

Commitment to quality improvement and innovation

- An academic lunch took place at a sister hospital once a week, for staff to share research and learning across the organisation.

Long stay/rehabilitation mental health wards for working age adults

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

Information about the service

Summary of findings

Long stay/rehabilitation mental health wards for working age adults

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

Good

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

Good

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Requires improvement

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

Good

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

Good

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Patients must have care plans that reflect their needs and goals and how these are to be achieved. This should include matters relating to food so that staff are assured that patients have the necessary support to make choices about a balanced diet.
- Staff must have training about the Mental Health Act.

Action the hospital SHOULD take to improve

- Staff should have the necessary skills to work with patients using a rehabilitation/recovery model.
- Physical healthcare checks should be recorded clearly and consistently so that any changes or concerns can be quickly identified.
- Ensure food is stored appropriately and not kept beyond the use by dates.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Patients care records did not demonstrate how their needs would be met. This included with ensuring patients were supported to eat a balanced diet.** This was a breach of regulation 12(1)(2)(a)(b)(c)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff must have training on the Mental Health Act.** This was a breach of regulation 18(1)(2)(a)