

Enbridge Healthcare Limited

Magna House

Inspection report

Main Road
Anwick
Sleaford
NG34 9SJ
Tel: 01526809771

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The hospital was clean and well maintained. Cleaning records were up to date and the wards were bright, airy, well-furnished, and fit for purpose. The hospital had a dedicated maintenance team, we saw all staff had access to an electronic log, where issues were prioritised, actioned in a timely manner and signed off on completion.
- Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff documented the individual risks for each patient and acted to prevent or reduce them. Staff we spoke were aware of what strategies to use to minimise and manage risks and how to support individuals when they posed a risk to themselves, others, or their environment. Accurate risk information was handed over and recorded in the morning management meeting.
- Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. They ensured it was recorded in the care record and an incident form completed. The hospital incident reporting system would not allow the incident to be closed unless all physical health checks had been completed and recorded appropriately.
- Staff completed a comprehensive assessment of each patient either on admission or soon after. We looked at six care records, all of which reflected patients' assessed needs and were holistic and recovery oriented.
- Managers supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Staff supervision and appraisal rates were 100%. They identified any training needs and gave staff the time and opportunity to develop their skills and knowledge. Staff received specialist training for their role, for example Oliver McGowan training, diabetes, oral health and learning disability. Staff told us managers were supporting them to undertake a master's degree.
- We saw "you said - we did" boards on all wards. Patients had provided feedback and suggestions which they recorded on the boards. Managers had acted upon feedback for example; we saw white boards had been installed in bedrooms where patients could write down the name of their nurse, and more evening activities had been planned and a new washer/dryer had been purchased.
- We saw staff involved patients in decisions about the service, when appropriate for example suggestions on the décor, menu choice and therapeutic activities. Staff and patients attended weekly community meetings where topics discussed included the environment, meals, patient involvement opportunities, achievements and celebrations and staying connected with family and friends.
- Leaders were visible and approachable, not only to them but for patients too. Staff told us leaders often visited the wards and would work shifts to support the team and were always available whenever for whatever they needed. They confirmed development opportunities for career progression were available and were encouraged to take these up.

However:

- Staff used a range of rooms and equipment to support treatment and care, however there was no dedicated spaces for therapeutic activities which were undertaken in dining and lounge areas.
- We found left over medicines from a patient who had been discharged in cupboards on two wards. We brought this to the attention of the nurse in charge who disposed of the medicines immediately.
- We were concerned that governance systems and processes were not sufficiently embedded so that when the patient numbers and acuity increase, they remain effective to support the operational performance of the service.

Summary of findings

Our judgements about each of the main services

Service

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

Rating

Good



Summary of each main service

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Summary of findings

Long stay or rehabilitation mental health wards for working age adults

Good



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Summary of findings

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Summary of this inspection

Background to Magna House

Magna House is a 29-bed independent hospital in Lincolnshire, providing acute care, treatment, and rehabilitation services to people who are experiencing mental health issues.

It registered with the Care Quality Commission in August 2020 for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder, or injury.

The hospital comprised of Redwood ward, an 11 bedded male acute ward. There were also four smaller wards, Aspen, a 7-bed female acute ward. Beech 1, a 5 bedded female rehabilitation ward, Beech 2 a three bedded male rehabilitation ward, and Beech central which could accommodate either 3 males or 3 females.

All bedrooms have ensuite bathrooms. The cottages are located on the ground floor, and Redwood ward is over two floors, in a separate building.

Magna House has a registered manager. A full comprehensive inspection of Magna House took place in October 2022. We found the provider to be in breach of the Health and Social Care Act (regulated activities) Regulations 2014:

Regulation 12 - Safe care and treatment

Regulation 15 – Premises and equipment

Regulation 9 – Person-centred care

Regulation 18 – Staffing

Regulation 17 – Good governance

Regulation 10 – Dignity and respect

We served requirement notices and subsequently received an action plan from the provider which they completed. On the 26 and 27 April 2023, we undertook a focused unannounced inspection looking at two key questions, safe and well led. This was in response to concerns brought to our attention from members of the public, people using the service, the Integrated Care Board (ICB), as well as the police. Following this inspection, we took urgent civil enforcement action which consisted of placing 9 conditions upon their registration. This included that the service must not admit any new patients without the written permission of CQC.

We completed a specific inspection to check that the provider had taken immediate actions, as directed by CQC on 14 and 15 June 2023. Following this inspection improvements were noted, and the conditions placed upon the provider's registration were removed and therefore the provider is no longer in breach of regulations.

At the time of this inspection there were two patients receiving care at Magna House Hospital.

Summary of this inspection

What people who use the service say

We spoke with one patient during the inspection. They were very happy with level of care and support. They said staff were good and helped them with their day-to-day needs. They said the environment was very clean and furnished to a high standard. They attended the multi-disciplinary meetings and was happy that their carer could attend as well.

How we carried out this inspection

How we carried out this inspection

This was a comprehensive inspection and looked at all five key questions.

The inspection team consisted of one lead CQC inspector, two operational managers, one occupational therapist specialist advisor and one expert by experience working remotely.

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.

During the inspection visit, the inspection team:

Visited all areas of the hospital and looked at the cleanliness and quality of the environment.

Spoke with one patient who was using the service.

Spoke with one carer and one friend of patients using the service.

Reviewed community meeting minutes

Spoke with the advocate.

Spoke with the registered manager and the nominated individual

Spoke with 14 other staff members; including ward manager, nurses, healthcare support workers, psychologist, occupational therapist, activity co ordinator, patient safety officer, maintenance staff and a housekeeper.

Summary of this inspection

Observed one daily management meeting and one therapeutic activity session

Looked at six care and treatment records of patients.

Looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

Areas for improvement

Action the service **SHOULD** take to improve:

- The provider should consider the provision of dedicated rooms in which therapeutic activities can take place.
- The provider should ensure that all medicines are disposed of appropriately when a patient is discharged.
- The provider should consider how governance systems and processes remain sufficiently embedded so that when the patient numbers and acuity increases, they remain effective to support the operational performance of the service.

Our findings






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good 

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

Is the service safe?

Good 

Our rating of safe improved. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

We looked at four months of hospital environmental risk assessments. Staff reviewed all rehabilitation ward areas, and recorded where they removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Mirrors were in place to mitigate potential blind spots and provide clear lines of sight.

The ward complied with guidance and there was no mixed sex accommodation. All bedrooms were single and en- suite.

We looked at the ligature risk assessment for rehabilitation wards. Staff identified and recorded any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Whilst the hospital had two alarm systems in use, which were functional in all areas, we saw additional radios were in use should extra support be required throughout the hospital.

Maintenance, cleanliness, and infection control

We looked at cleaning records for each of the ward areas which were up to date and fully completed. We saw clinical areas were clean, well maintained, well-furnished and fit for purpose.

We saw staff followed infection control policy, including handwashing and use of protective equipment.

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

Good 

The hospital had a dedicated maintenance team, we saw all staff had access to an electronic log, where issues were prioritised, actioned in a timely manner and signed off on completion.

Clinic room and equipment

We looked at clinic rooms on Beech one. It was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We saw that staff had opened packs of emergency drugs which would have affected their efficacy. We brought this to the attention of ward staff who ensured packs of unopened emergency drugs were available.

Staff checked, maintained, and cleaned equipment; we saw I am clean stickers were used to indicate when items had been cleaned.

The hospital had a fully equipped physical health suite which was clean and fit for purpose.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

At the time of this inspection two patients were admitted to the hospital, managers had recruited to all vacant nursing and healthcare support worker posts. This was to ensure the service had enough nursing and support staff to keep patients safe as the occupancy increased. We reviewed staff rotas and saw appropriately qualified staff were allocated to each shift. Managers had employed over the establishment of healthcare support workers and at the time of the inspection there were no registered nurse vacancies.

Managers supported staff who needed time off for ill health or for family and carer responsibilities.

Levels of sickness were low, at the time of the inspection sickness rates were 2%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients.

Staff told us they had regular one to one sessions with their patients, this was confirmed by the patients we spoke with.

Patients rarely had their escorted leave or activities cancelled or rescheduled.

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

Staff shared key information to keep patients safe when handing over their care to others. We attended a morning meeting where each patient was discussed, risks reviewed, and physical and mental health needs evaluated.

Medical staff

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

Good 

The service had enough daytime and nighttime medical cover and a doctor available to go to the wards quickly in an emergency. The consultant psychiatrist worked full time at the hospital, there was a junior doctor on site 24 hours a day with an on-call consultant psychiatrist for support.

Mandatory training

Managers had ensured staff completed all training appropriate to their role.

At the time of the inspection 97% of staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included, Autism awareness, basic and intermediate life support, medicine administration, self-harm and suicide, positive behaviour support, health and safety, and dignity and respect.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to a mandatory training compliance report, which highlighted when individual staff training was going to expire or had expired.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating, and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We looked at six care records, staff documented the individual risks for each patient and acted to prevent or reduce them. The risk assessments outlined the strategies staff used with the individual to support them when their risk increased. For example, we saw staff had provided a quiet, low stimulus area for one patient to use when their agitation increased.

Management of patient risk

We looked at six care records, four paper records of patients recently discharged from the hospital and two electronic records for the current inpatients. Staff documented the individual risks for each patient and acted to prevent or reduce them. Staff we spoke were aware of what strategies to use to minimise and manage risks and how to support individuals when they posed a risk to themselves, others, or their environment. Accurate risk information was handed over and recorded in the morning management meeting.

Staff described how they identified and responded to any changes in risks to, or posed by, patients. This was demonstrated in the care records.

Staff told us how they followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

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

Good 

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We looked at three episodes where patients had received rapid tranquilisation. This was recorded in the care record and an incident form was completed. The hospital incident reporting system would not allow the incident to be closed unless all physical health checks had been completed and recorded appropriately.

Staff told us they only used restraint as a last resort. Patients confirmed this and one stated that staff regularly helped her calm down when she was agitated.

We looked at six care records, we saw every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff evidenced within the incident reporting system what de-escalation interventions had been attempted prior to using restraint techniques. Additionally, if staff had to restrain a patient to keep them safe, they recorded in the incident form, the specific hold they used and how long they patient was held for.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Compliance rates were at 95% at the time of the inspection.

Staff described their responsibilities regarding the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training and kept up to date on how to recognise and report abuse. The training compliance of staff for mandatory level three for safeguarding adults was 98%. Managers supported staff when reporting potential abuse, who ensured they reported to the local authority, CQC and the police when appropriate.

Staff described how to make a safeguarding referral and who to inform if they had concerns. They gave clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood and took steps to protect patients when needed. Managers ensured staff completed equality and diversity training, the compliance rate at the time of the inspection was 98%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them, compliance rates for safeguarding children was 95%.

Staff followed clear procedures to keep children visiting the ward safe. There was a dedicated visitor's room which was age appropriate.

Staff access to essential information

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

Good 

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

The hospital had purchased a bespoke electronic care record system. Staff told us it was very easy to navigate and so much better than the paper-based system previously in use. We saw staff completed the electronic patient observation record which automatically uploaded to the main care record. The system also alerted staff to patient allergies by means of intermittent flashing on the front page of the care record. We looked at two electronic patient records and four paper records. Staff ensured they were comprehensive, up to date and all staff could access them easily.

Managers told us when patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

The service had electronic prescribing systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health, this was evidenced in weekly ward rounds meetings. Staff provided specific advice in the form of comprehensive information leaflets to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, we found left over medicines in the clinic room on Redwood and Beech 1 for a patient that had left the service and stock medication that had not been disposed of. We brought this to the attention of the ward staff who disposed of the medicines immediately.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

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

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Clinical Excellence. We found evidence in patient case records that electrocardiographs were appropriately undertaken and records of regular physical health monitoring.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Good 

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff accurately described what incidents to report and how to report them. Incidents in the preceding 24 hours were discussed and actions taken to prevent reoccurrence at the morning management meeting. We saw incident forms were linked to the electronic care record and could only be closed once all actions had been completed.

Staff reported serious incidents clearly and in line with the provider's policy. There had been one serious incident in the three months leading up to the inspection. This involved a patient who had swallowed batteries and required physical restraint. This was fully investigated, lessons identified and shared with staff appropriately.

The service looked at themes and trends of incidents monthly at the governance meeting.

The service had not had any never events on any wards.

Staff described their responsibilities under duty of candour.

Managers and psychology staff debriefed and supported staff and patients after any serious incidents. This was clearly recorded in on the incident form.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive assessment of each patient either on admission or soon after. We looked at six care records, four paper records of patients recently discharged from the hospital and two electronic records for the current inpatients, all of which had detailed admission assessments which reflected patients' physical and mental health needs. This assessment informed the care of the individual patients and ensured that the care delivered was personalised, holistic and recovery orientated. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking, and quality improvement initiatives.

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

Good 

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychology, occupational therapy, cognitive behaviour therapy, coping strategies, trauma informed care planning and support for self-care.

Staff used Health of the Nation Outcome Scores to assess and record severity and outcomes. The occupational therapy team used Model of Human Occupation Screening Tool Self-Assessment (MOHOST) and the Occupational Self-Assessment (OSA) as part of their assessments.

The service participated in clinical audit, benchmarking and quality improvement initiatives which included daily clinical checklist. This included electronic observation form completion, security, staffing and ward walkarounds.

Staff supported patients with their physical health and encouraged them to live healthier lives. We saw one patient had learned to swim whilst an inpatient at the hospital.

Staff identified patients' physical health needs and recorded them in their care plans. Patients had access to physical health care and staff supported them to access specialists as required. Staff had access to a variety of physical health monitoring equipment which were regularly checked.

Staff assessed patients' dietary needs and assessed those needing specialist care for nutrition and hydration, we saw these were regularly reviewed at the multi-disciplinary meeting.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included, nurses, psychologists, activity coordinators and occupational therapists.

Managers ensured staff had the right skills, qualifications, and experience to meet the needs of the patients in their care, including bank and agency staff. Managers provided a comprehensive induction programme for new staff and mentoring opportunities for all new starters, this was endorsed by staff we spoke with.

Managers supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Staff supervision and appraisal rates were 100%.

Managers made sure staff attended regular team meetings and gave information via e mail to those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff received specialist training for their role, for example Oliver Mc Gowan training, diabetes, oral health and learning disability. Staff told us managers were supporting them to undertake a master's degree.

Managers recognised poor performance, could identify the reasons, and dealt with these with support from the providers human resource team.

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

Good 

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We saw carers had attend these meeting both virtually and in person.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Clinical staff and managers had effective working relationships with external teams and organisations. We spoke with a commissioner who said there was a good level of care and support and gave an example where staff had made reasonable adjustments to support the individual with learning disabilities. However, another commissioner said the hospital had limited knowledge around supporting transgender patients.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Compliance training rates for relevant staff were at 96% at the time of the inspection.

A system was in place for the receipt and scrutiny of the Mental Health Act detention paperwork. A dedicated Mental Health Act administrator was on site five days a week.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrator was and when to ask them for support. They told us the administrator reminded them when action needed to be taken reading patients their rights.

The service had clear, accessible, relevant, and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service. Posters were displayed on the wards and in the reception area.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We managers audited section 17 leave paperwork.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Good 

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Original detention papers were kept in the Mental Health Act administration office and scanned copies in the care records.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act, this section is used to support people who have been kept in hospital under the Mental Health Act to get free help and support after they leave hospital.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits, discussing the findings, and completing provider action plans with evidence following Mental Health Act review visits.

Is the service caring?

Good 

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive assessment of each patient either on admission or soon after. We looked at six care records, four paper records of patients recently discharged from the hospital and two electronic records for the current inpatients, all of which had detailed admission assessments which reflected patients' physical and mental health needs. This assessment informed the care of the individual patients and ensured that the care delivered was personalised, holistic and recovery orientated. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking, and quality improvement initiatives.

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Staff used Health of the Nation Outcome Scores to assess and record severity and outcomes. The occupational therapy team used Model of Human Occupation Screening Tool Self-Assessment (MOHOST) and the Occupational Self-Assessment (OSA) as part of their assessments.

The service participated in clinical audit, benchmarking and quality improvement initiatives which included daily clinical checklist. This included electronic observation form completion, security, staffing and ward walkarounds.

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

Good 

Staff supported patients with their physical health and encouraged them to live healthier lives. We saw one patient had learned to swim whilst an inpatient at the hospital.

Staff identified patients' physical health needs and recorded them in their care plans. Patients had access to physical health care and staff supported them to access specialists as required. Staff had access to a variety of physical health monitoring equipment which were regularly checked.

Staff assessed patients' dietary needs and assessed those needing specialist care for nutrition and hydration, we saw these were regularly reviewed at the multi-disciplinary meeting.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision, and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

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Multi-disciplinary and interagency teamwork

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

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Clinical staff and managers had effective working relationships with external teams and organisations. We spoke with a commissioner who said there was a good level of care and support and gave an example where staff had made reasonable adjustments to support the individual with learning disabilities. However, another commissioner said the hospital had limited knowledge around supporting transgender patients.

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Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received, and kept up to date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Compliance training rates for relevant staff were at 96% at the time of the inspection.

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Managers and staff made sure the service applied the Mental Health Act correctly by completing audits, discussing the findings, and completing provider action plans with evidence following Mental Health Act review visits.

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

Good 

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

At the time of the inspection there were two patients admitted to the hospital, this was a result of restrictions imposed by the CQC.

We looked at the length of stay for patients in the 12 months prior to the restrictions which was 46 days.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Patients did not have to stay in hospital when they were well enough to leave.

We saw examples where staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. One patient had successfully completed a programme of phased leave to slowly orientate them to their new accommodation was due to be discharged imminently.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

The wards we inspected were bright and airy. The furniture was either new or in good condition and easy to clean. We were told the food was of good quality and patients could access hot drinks and snacks at any time. The hospital had begun a process of providing small double beds across the wards to improve comfort for patients.

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

Good 

Staff used a range of rooms and equipment to support treatment and care. However, there was no dedicated spaces for therapeutic activities which were undertaken in dining and lounge areas.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private and were able to use their own mobile phones. The

wards had outside spaces that patients could access freely.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education, and family relationships.

Patients told us they had access to the internet to keep up-to-date and that staff supported them with this.

Staff helped patients to stay in contact with families and carers. Patients had use of their own mobile phones and carers were invited to meetings virtually or in person.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community where possible, for example attending church services and a local day support group and local amenities for physical activities, such as swimming

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

Three wards were on the ground floor and supported disabled patients. Redwood ward had bedrooms on the first floor. We saw, where appropriate, patients had a personal evacuation plan in place.

Staff made sure patients could access information on treatment, local service, their rights and how to complain, there were notice boards on all wards and in the reception.

The service had access to a wide range of information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious, and cultural support and a multi faith room was available.

Listening to and learning from concerns and complaints

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

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

Good 

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

How to complain posters were displayed on ward noticeboards and leaflets were accessible. We spoke with one carer and one patient who said they knew how to make a complaint. Staff understood the policy on complaints and knew how to handle them.

The service had four complaints in the four months leading up to this inspection, three of which were partially upheld and related to issues raised by a neighbour of the hospital. They had been fully investigated and feedback and lessons learned had been shared with the complainant and ward teams. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff we spoke with knew who the leaders were of the service and reported they were visible and approachable, not only to them but for patients too. Staff told us leaders often visited the wards and would work shifts to support the team and were always available whenever for whatever they needed. They also completed daily walk arounds to ensure that issues could be dealt with immediately. We were told the new leadership team had had a very positive impact and staff said they were proud to work at Magna House hospital.

Managers had the right skills, knowledge, and experience to perform their roles, including a good understanding of the services they managed.

We spoke with members of the multi-disciplinary team, and they confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Senior managers relayed the providers vision and values during mandatory induction for all staff. Staff knew that the provider aimed to provide safe and effective care. Staff were able to tell us that they are expected to be kind and caring. Staff placed emphasis upon the stabilisation of mental health, which aimed to support patients with transitioning into the community.

Staff were very motivated by and proud of the service. Managers had developed their leadership skills and those of others, to ensure they were empowered to positive changes.

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

Good 

Culture

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

There was a strong, visible person-centred culture. The service ensured staff in all roles were highly motivated and offered care and support that aimed to be compassionate and kind.

We were told that the registered manager had developed a culture where issues were openly discussed and challenged, and staff were held accountable for their actions. Staff also said they felt comfortable in challenging each other and were actively supported to do this and felt listened too.

Staff we spoke with were also keen to tell us about the leadership and development opportunities open to them.

We spoke with 14 members of the team who were positive about the registered manager. Staff told us they felt respected, supported, and valued. They said leaders promoted equality and diversity in daily work and provided opportunities for development, for example training and career progression, and they felt very proud to work at Magna House.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Magna House had effective governance structures in place to monitor the safety of the ward environment, performance, and risk. The service held monthly governance meetings which had an agenda including safeguarding, health promotion, lessons learned and medicines management. We were told the ethos around governance at Magna House aimed to create an environment where clinical excellence would flourish. It was clear at this inspection that the senior leadership had further developed their governance systems and process. The provider needs to assure themselves that these systems and processes are sufficiently embedded so that when the patient numbers and acuity increases, they remain effective and continue to support the operational performance of the service.

Managers had good oversight of clinical practice and performance. There were daily, weekly, and monthly audits in place which focussed on key areas such as infection prevention and control, restrictive practice, physical health, staffing and incident management.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The registered manager kept a hospital risk register which senior managers reviewed regularly and discussed. Appropriate action plans were in place to address all risks highlighted. Staff knew they could highlight areas of concern to senior staff who would discuss with the registered manager. The provider had contingency plans in place, in case of an emergency, for example, adverse weather conditions or a flu outbreak.

Managers ensured staff had access to the information they needed to provide safe and effective care and used that information to good effect. They had invested in the new electronic patient record which continued to be developed with staff input.

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

Good 

Managers offered staff the opportunity to give feedback and input into service development. They did this through regular health care assistant, nurses, team, and governance meetings.

The service had business continuity plans for emergencies for example, adverse weather or a flu outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

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Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Access to equipment and information technology, including the telephone and patient record systems, worked well, and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

Engagement






Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers engaged actively with other local and national health and social care providers to ensure an integrated health and care system was commissioned and provided to meet the needs of patients. Commissioning group representatives attended multi-disciplinary meetings whenever possible, and the service held weekly phone calls with commissioners to coordinate care.

Staff, patients, and carers had access to information about the work of the provider and the services they used through, bulletins and newsletters.

Long stay or rehabilitation mental health wards for working age adults

Good 

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

Is the service safe?

Good 

Our rating of safe improved. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

We looked at four months of hospital environmental risk assessments. Staff reviewed all rehabilitation ward areas, and recorded where they removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. Mirrors were in place to mitigate potential blind spots and provide clear lines of sight.

The ward complied with guidance and there was no mixed sex accommodation. All bedrooms were single and en- suite.

We looked at the ligature risk assessment for rehabilitation wards. Staff identified and recorded any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems. Whilst the hospital had two alarm systems in use, which were functional in all areas, we saw additional radios were in use should extra support be required throughout the hospital.

Maintenance, cleanliness, and infection control

We looked at cleaning records for each of the ward areas which were up to date and fully completed. We saw clinical areas were clean, well maintained, well-furnished and fit for purpose.

We saw staff followed infection control policy, including handwashing and use of protective equipment.

Long stay or rehabilitation mental health wards for working age adults

Good 

The hospital had a dedicated maintenance team, we saw all staff had access to an electronic log, where issues were prioritised, actioned in a timely manner and signed off on completion.

Clinic room and equipment

We looked at clinic rooms on Beech one. It was fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. We saw that staff had opened packs of emergency drugs which would have affected their efficacy. We brought this to the attention of ward staff who ensured packs of unopened emergency drugs were available.

Staff checked, maintained, and cleaned equipment; we saw I am clean stickers were used to indicate when items had been cleaned.

The hospital had a fully equipped physical health suite which was clean and fit for purpose.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

At the time of this inspection two patients were admitted to the hospital, managers had recruited to all vacant nursing and healthcare support worker posts. This was to ensure the service had enough nursing and support staff to keep patients safe as the occupancy increased. We reviewed staff rotas and saw appropriately qualified staff were allocated to each shift. Managers had employed over the establishment of healthcare support workers and at the time of the inspection there were no registered nurse vacancies.

Managers supported staff who needed time off for ill health or for family and carer responsibilities.

Levels of sickness were low, at the time of the inspection sickness rates were 2%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift.

The ward manager could adjust staffing levels according to the needs of the patients.

Staff told us they had regular one to one sessions with their patients, this was confirmed by the patients we spoke with.

Patients rarely had their escorted leave or activities cancelled or rescheduled.

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

Staff shared key information to keep patients safe when handing over their care to others. We attended a morning meeting where each patient was discussed, risks reviewed, and physical and mental health needs evaluated.

Medical staff

Long stay or rehabilitation mental health wards for working age adults

Good 

The service had enough daytime and nighttime medical cover and a doctor available to go to the wards quickly in an emergency. The consultant psychiatrist worked full time at the hospital, there was a junior doctor on site 24 hours a day with an on-call consultant psychiatrist for support.

Mandatory training

Managers had ensured staff completed all training appropriate to their role.

At the time of the inspection 97% of staff had completed and kept up to date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. It included, Autism awareness, basic and intermediate life support, medicine administration, self-harm and suicide, positive behaviour support, health and safety, and dignity and respect.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had access to a mandatory training compliance report, which highlighted when individual staff training was going to expire or had expired.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating, and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We looked at six care records, staff documented the individual risks for each patient and acted to prevent or reduce them. The risk assessments outlined the strategies staff used with the individual to support them when their risk increased. For example, we saw staff had provided a quiet, low stimulus area for one patient to use when their agitation increased.

Management of patient risk

We looked at six care records, four paper records of patients recently discharged from the hospital and two electronic records for the current inpatients. Staff documented the individual risks for each patient and acted to prevent or reduce them. Staff we spoke were aware of what strategies to use to minimise and manage risks and how to support individuals when they posed a risk to themselves, others, or their environment. Accurate risk information was handed over and recorded in the morning management meeting.

Staff described how they identified and responded to any changes in risks to, or posed by, patients. This was demonstrated in the care records.

Staff told us how they followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Long stay or rehabilitation mental health wards for working age adults

Good 

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. We looked at three episodes where patients had received rapid tranquilisation. This was recorded in the care record and an incident form was completed. The hospital incident reporting system would not allow the incident to be closed unless all physical health checks had been completed and recorded appropriately.

Staff told us they only used restraint as a last resort. Patients confirmed this and one stated that staff regularly helped her calm down when she was agitated.

We looked at six care records, we saw every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff evidenced within the incident reporting system what de-escalation interventions had been attempted prior to using restraint techniques. Additionally, if staff had to restrain a patient to keep them safe, they recorded in the incident form, the specific hold they used and how long they patient was held for.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Compliance rates were at 95% at the time of the inspection.

Staff described their responsibilities regarding the Mental Capacity Act definition of restraint and worked within it.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training and kept up to date on how to recognise and report abuse. The training compliance of staff for mandatory level three for safeguarding adults was 98%. Managers supported staff when reporting potential abuse, who ensured they reported to the local authority, CQC and the police when appropriate.

Staff described how to make a safeguarding referral and who to inform if they had concerns. They gave clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood and took steps to protect patients when needed. Managers ensured staff completed equality and diversity training, the compliance rate at the time of the inspection was 98%.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them, compliance rates for safeguarding children was 95%.

Staff followed clear procedures to keep children visiting the ward safe. There was a dedicated visitor's room which was age appropriate.

Staff access to essential information

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

The hospital had purchased a bespoke electronic care record system. Staff told us it was very easy to navigate and so much better than the paper-based system previously in use. We saw staff completed the electronic patient observation record which automatically uploaded to the main care record. The system also alerted staff to patient allergies by means of intermittent flashing on the front page of the care record. We looked at two electronic patient records and four paper records. Staff ensured they were comprehensive, up to date and all staff could access them easily.

Managers told us when patients transferred to a new team, there were no delays in staff accessing their records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

The service had electronic prescribing systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health, this was evidenced in weekly ward rounds meetings. Staff provided specific advice in the form of comprehensive information leaflets to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. However, we found left over medicines in the clinic room on Redwood and Beech 1 for a patient that had left the service and stock medication that had not been disposed of. We brought this to the attention of the ward staff who disposed of the medicines immediately.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

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

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Clinical Excellence. We found evidence in patient case records that electrocardiographs were appropriately undertaken and records of regular physical health monitoring.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Long stay or rehabilitation mental health wards for working age adults

Good 

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff accurately described what incidents to report and how to report them. Incidents in the preceding 24 hours were discussed and actions taken to prevent reoccurrence at the morning management meeting. We saw incident forms were linked to the electronic care record and could only be closed once all actions had been completed.

Staff reported serious incidents clearly and in line with the provider's policy. There had been one serious incident in the three months leading up to the inspection. This involved a patient who had swallowed batteries and required physical restraint. This was fully investigated, lessons identified and shared with staff appropriately.

The service looked at themes and trends of incidents monthly at the governance meeting.

The service had not had any never events on any wards.

Staff described their responsibilities under duty of candour.

Managers and psychology staff debriefed and supported staff and patients after any serious incidents. This was clearly recorded in on the incident form.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Staff completed a comprehensive assessment of each patient either on admission or soon after. We looked at six care records, four paper records of patients recently discharged from the hospital and two electronic records for the current inpatients, all of which had detailed admission assessments which reflected patients' physical and mental health needs. This assessment informed the care of the individual patients and ensured that the care delivered was personalised, holistic and recovery orientated. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed.

Best practice in treatment and care

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Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act, this section is used to support people who have been kept in hospital under the Mental Health Act to get free help and support after they leave hospital.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits, discussing the findings, and completing provider action plans with evidence following Mental Health Act review visits.

Good practice in applying the Mental Capacity Act

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

Staff received and were up to date, with training in the Mental Capacity Act and demonstrated a good understanding of at least the five principles. Compliance training rates for appropriate staff were at 100% at the time of the inspection.

There was one patient subject to deprivations of liberty safeguards at the time of the inspection.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. This was provided by the Mental Health Act administrator and lead clinicians at the hospital.

Staff described how they gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

We saw in the care records staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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

The service monitored how well it followed the Mental Capacity Act and made changes to practice when necessary.

Staff audited on an annual basis how they applied the Mental Capacity Act and identified and acted when they needed to make changes to improve. The audit was monitored at the hospital governance meeting.

Is the service caring?

Good 

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Good 

Our rating of caring improved. We rated it as good.

Kindness, privacy, dignity, respect, compassion, and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment, or condition.

We spoke with one patient who told that staff worked with them collaboratively to write their care plans and supported them to stay connected with their families and friends. Throughout the inspection we saw that staff treated patients with dignity and respect, offered choice of food and drinks, knocking on patient's bedroom doors before entering. We observed staff were discreet, respectful, and responsive when caring for patients. Staff were aware of the individual need of the patients and supported patients to understand and manage their own care treatment.

Staff gave patients help, emotional support and advice when they needed it. We observed staff supporting patients in a group therapeutic session.

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

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

We saw staff followed policy to keep patient information confidential, they ensured all confidential information was displayed out of patient lines of sight in ward offices.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

We spoke with one patient who told that staff worked with them collaboratively to write their care plans and supported them to stay connected with their families and friends.

Staff introduced patients to the ward and the services as part of their admission. We saw a partially refurbished room which was identified as a preadmission room. It was envisioned that patients would be welcomed to the hospital and undergo their initial admission assessment in a quiet environment.

We saw evidence that staff actively sought feedback from patients on the quality of care provided in the patient community meeting minutes. Staff ensured patients had easy access to advocates, advocacy posters were visible in lounges, dining, and reception areas.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties, for example easy read versions of information leaflets.

We saw "you said - we did" boards on all wards. Patients had provided feedback and suggestions which they recorded on the boards. Managers had acted upon feedback for example; we saw white boards had been installed in bedrooms

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Good 

where patients could write down the name of their nurse, and more evening activities had been planned and a new washer/dryer had been purchased. We saw staff involved patients in decisions about the service, when appropriate. For example, suggestions on the décor, menu choice and therapeutic activities. Staff and patients attended weekly community meetings where topics discussed included the environment, meals, patient involvement opportunities, achievements and celebrations and staying connected with family and friends.

Staff made sure patients could access advocacy services and facilitated weekly meetings.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We reviewed six care plans, all of which contained evidence that family members had been involved in multi-disciplinary, commissioner and care programme approach meetings. We spoke with one carer and one friend, one said staff were exceptional, and they could not praise them enough. They were happy with the discharge arrangements and staff kept them informed about medication and treat the patient with dignity and respect Another said communication could be improved and complaints were not handled in a timely way.

Is the service responsive?

Good 

Our rating of responsive improved. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Bed management

At the time of the inspection there were two patients admitted to the hospital, this was a result of restrictions imposed by the CQC.

We looked at the length of stay for patients in the 12 months prior to the restrictions which was 46 days.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Staff did not move or discharge patients at night or very early in the morning.

Discharge and transfers of care

Patients did not have to stay in hospital when they were well enough to leave.

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Good 

We saw examples where staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. One patient had successfully completed a programme of phased leave to slowly orientate them to their new accommodation was due to be discharged imminently.

Staff supported patients when they were referred or transferred between services.

The service followed national standards for transfer.

Facilities that promote comfort, dignity, and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

The wards we inspected were bright and airy. The furniture was either new or in good condition and easy to clean. We were told the food was of good quality and patients could access hot drinks and snacks at any time. The hospital had begun a process of providing small double beds across the wards to improve comfort for patients.

Staff used a range of rooms and equipment to support treatment and care. However, there was no dedicated spaces for therapeutic activities which were undertaken in dining and lounge areas.

The service had quiet areas and a room where patients could meet with visitors in private.

Patients could make phone calls in private and were able to use their own mobile phones. The

wards had outside spaces that patients could access freely.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education, and family relationships.

Patients told us they had access to the internet to keep up-to-date and that staff supported them with this.

Staff helped patients to stay in contact with families and carers. Patients had use of their own mobile phones and carers were invited to meetings virtually or in person.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community where possible, for example attending church services and a local day support group and local amenities for physical activities, such as swimming

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy, and cultural and spiritual support.

Three wards were on the ground floor and supported disabled patients. Redwood ward had bedrooms on the first floor. We saw, where appropriate, patients had a personal evacuation plan in place.

Long stay or rehabilitation mental health wards for working age adults

Good 

Staff made sure patients could access information on treatment, local service, their rights and how to complain, there were notice boards on all wards and in the reception.

The service had access to a wide range of information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious, and cultural support and a multi faith room was available.

Listening to and learning from concerns and complaints

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

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

How to complain posters were displayed on ward noticeboards and leaflets were accessible. We spoke with one carer and one patient who said they knew how to make a complaint. Staff understood the policy on complaints and knew how to handle them.

The service had four complaints in the four months leading up to this inspection, three of which were partially upheld and related to issues raised by a neighbour of the hospital. They had been fully investigated and feedback and lessons learned had been shared with the complainant and ward teams. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge, and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Staff we spoke with knew who the leaders were of the service and reported they were visible and approachable, not only to them but for patients too. Staff told us leaders often visited the wards and would work shifts to support the team and were always available whenever for whatever they needed. They also completed daily walk arounds to ensure that issues could be dealt with immediately. We were told the new leadership team had had a very positive impact and staff said they were proud to work at Magna House hospital.

Long stay or rehabilitation mental health wards for working age adults

Good 

Managers had the right skills, knowledge, and experience to perform their roles, including a good understanding of the services they managed.

We spoke with members of the multi-disciplinary team, and they confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

Senior managers relayed the providers vision and values during mandatory induction for all staff. Staff knew that the provider aimed to provide safe and effective care. Staff were able to tell us that they are expected to be kind and caring. Staff placed emphasis upon the stabilisation of mental health, which aimed to support patients with transitioning into the community.

Staff were very motivated by and proud of the service. Managers had developed their leadership skills and those of others, to ensure they were empowered to positive changes.

Culture

Staff felt respected, supported, and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

There was a strong, visible person-centred culture. The service ensured staff in all roles were highly motivated and offered care and support that aimed to be compassionate and kind.

We were told that the registered manager had developed a culture where issues were openly discussed and challenged, and staff were held accountable for their actions. Staff also said they felt comfortable in challenging each other and were actively supported to do this and felt listened too.

Staff we spoke with were also keen to tell us about the leadership and development opportunities open to them.

We spoke with 14 members of the team who were positive about the registered manager. Staff told us they felt respected, supported, and valued. They said leaders promoted equality and diversity in daily work and provided opportunities for development, for example training and career progression, and they felt very proud to work at Magna House.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Magna House had effective governance structures in place to monitor the safety of the ward environment, performance, and risk. The service held monthly governance meetings which had an agenda including safeguarding, health promotion, lessons learned and medicines management. We were told the ethos around governance at Magna House

Long stay or rehabilitation mental health wards for working age adults

Good 

aimed to create an environment where clinical excellence would flourish. It was clear at this inspection that the senior leadership had further developed their governance systems and process. The provider needs to assure themselves that these systems and processes are sufficiently embedded so that when the patient numbers and acuity increases, they remain effective and continue to support the operational performance of the service.

Managers had good oversight of clinical practice and performance. There were daily, weekly, and monthly audits in place which focussed on key areas such as infection prevention and control, restrictive practice, physical health, staffing and incident management.

Management of risk, issues, and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

The registered manager kept a hospital risk register which senior managers reviewed regularly and discussed. Appropriate action plans were in place to address all risks highlighted. Staff knew they could highlight areas of concern to senior staff who would discuss with the registered manager. The provider had contingency plans in place, in case of an emergency, for example, adverse weather conditions or a flu outbreak.

Managers ensured staff had access to the information they needed to provide safe and effective care and used that information to good effect. They had invested in the new electronic patient record which continued to be developed with staff input.

Managers offered staff the opportunity to give feedback and input into service development. They did this through regular health care assistant, nurses, team, and governance meetings.

The service had business continuity plans for emergencies for example, adverse weather or a flu outbreak.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities for example Health of the Nation Outcome Scores.

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Access to equipment and information technology, including the telephone and patient record systems, worked well, and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

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Good 

Staff made notifications to external bodies as needed.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Managers engaged actively with other local and national health and social care providers to ensure an integrated health and care system was commissioned and provided to meet the needs of patients. Commissioning group representatives attended multi-disciplinary meetings whenever possible, and the service held weekly phone calls with commissioners to coordinate care.

Staff, patients, and carers had access to information about the work of the provider and the services they used through, bulletins and newsletters.