

Elysium Healthcare (St Mary's) Limited

# St Mary's Hospital

## Inspection report

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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

Inspected but not rated



Are services safe?

Inspected but not rated



Are services effective?

Inspected but not rated



Are services responsive to people's needs?

Inspected but not rated



# Summary of findings

## Overall summary

We did not rate this service following this inspection as this was a focused inspection to look at specific areas of service quality.


- Both wards were safe and clean. Activities were available for patients as part of their recovery. The hospital had a gym and cafe that patients could use.
- Each patient had care plans that met their specific mental and physical health needs. Staff reviewed patients' needs on a regular basis.
- Patients had access to a range of specialists required to meet their needs. This included a patient liaison officer who was available to offer support to patients with wider social needs such as housing and access to financial support.
- Managers ensured staff received training relevant to their roles.
- The service managed access and discharge well. If patients faced delays in their discharge this was due to wider issues within the local integrated care system. Where patients faced barriers to discharge staff were assertive in addressing issues.
- Staff worked well together and with those outside the ward who were involved in patients care.

However:

- Some areas of the service were still developing and required further time to ensure best practice had been embedded. This included the reintroduction of the service's psychotherapy offer and implementing the use of specific patient outcome measures appropriate to the service.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inspected but not rated 	

# Summary of findings

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# Summary of this inspection

## Background to St Mary's Hospital

St Mary's Hospital is based in Warrington it provides services for people with acute mental health needs and specialist services for people with acquired brain injury, autistic spectrum conditions or both. It is part of the Elysium Healthcare group, which also has other mental health hospitals across England.

At the time of our inspection there were 6 wards open within the hospital for male patients. The acute mental health inpatient services were provided on 2 of these wards;

- Eve ward a 4 bedded ward
- Leo ward a 12 bedded ward

The two wards were managed as one. They were managed by the same ward manager and had access to the same multi-disciplinary team. Patients on Eve ward could access the same facilities as patients staying on Leo ward and some spaces, such as the visiting room, were shared between the two wards.

Leo ward had previously been an inpatient ward supporting people with a learning disability and or autism. This service had closed in May 2023 and the ward had reopened as an acute mental health service in July 2023.

At the time of our inspection there was a registered manager in post.

### What people who use the service say

We spoke with 2 patients using the service, one relative of a patient and an independent advocate.

Overall, the feedback we received about care that patients received was positive. Patients felt staff were supportive and respectful.

We observed respectful and caring interactions between patients and staff on the day of our inspection.

We reviewed results from a patient survey completed in May 2023. The results showed 90% of patients felt supported in their recovery and 100% either 'strongly agreed' or 'agreed', that they received high quality care that met their individual needs.

We reviewed meeting minutes that showed staff responding to patient's feedback at weekly community meetings and through the patient forum. For example, where patients had said they felt the ward was too cool or didn't like the food available, staff had responded by offering different meal options and providing portable heaters, where appropriate.

A concern was raised about delays in one patient's discharge due to issues in the wider care system. We found examples where the staff had supported patients to raise concerns about their care to commissioners and other decision makers in the local care system.

# Summary of this inspection

## How we carried out this inspection

We carried out this inspection because we had received information of concern that may affect the care and safety of patients. During this unannounced, focused, inspection we looked at specific areas of our safe, effective and responsive key questions. We did not review all our key lines of enquiry and we did not rate key questions during this inspection.

During the inspection we:

- visited Eve and Leo wards and observed how staff were caring for patients
- spoke with the Hospital Director (who was the registered manager) and the ward manager for both wards
- spoke with 7 other staff members delivering care and treatment including recovery workers, registered nurses, the patient liaison officer and speciality doctor
- looked at care and treatment records relating to 8 patients
- spoke with 2 patients using the service and one relative of a patient.
- spoke with other relevant stakeholders including commissioners and an independent advocate who visited the service
- looked at a range of other information and data about 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 a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

- The provider should ensure that patients have access to psychological therapy that follows national guidance.
- The provider should continue to develop the service in line with best practice guidance. This includes implementing the use of specific patient outcome measures appropriate to the service.
- The provider should improve the quality of record keeping to ensure there are accurate records of one to one sessions and patients accessing therapeutic activity.
- The provider should ensure that delays to improvements to the ward environment do not impact on the quality and safety of care.

# 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	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Not inspected	Inspected but not rated

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

Inspected but not rated 

Safe	Inspected but not rated 
Effective	Inspected but not rated 
Responsive	Inspected but not rated 

## Is the service safe?

Inspected but not rated 

We did not rate how safe the service was.

### Safe and clean care environments

**Wards were safe, clean, well furnished, well maintained and fit for purpose.**

#### Safety of the ward layout

Staff were deployed to the wards to keep them safe.

Staff observed patients on the wards and followed procedures to minimise risks where they could not easily observe patients.

Staff were aware of blind spots and convex mirrors were in place to mitigate these areas. CCTV was in use on the ward. Only authorised members of staff had access to the CCTV footage.

The service was for male patients only. There was no mixed sex accommodation on the wards.

Staff knew about potential ligature anchor points and mitigated the risks to keep patients safe. Managers completed ligature risk assessments. Simulation training was provided for staff about how to remove a ligature.

Staff had easy access to alarms and patients had easy access to nurse call systems. Alarms were tested weekly.

Eve ward was accessed through Leo ward but had its own separate side entrance that was used when needed.

Over 95% of staff completed training in fire, food and general health and safety.

Security checks were completed daily and recorded in a logbook for each ward, this included checks on the environment.

### Maintenance, cleanliness and infection control

Both wards were clean and tidy. Cleaning staff visited both wards daily. Over 98% of staff had completed infection control training. Staff followed good hand hygiene processes and hand sanitiser was available on both wards.

Ward areas were well-furnished and fit for purpose.



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

Inspected but not rated 

Senior managers completed monthly walk rounds to look at the condition of the wards and made improvements when needed. For example, Eve ward had recently been redecorated following feedback from patients.

Some repairs and upgrades to the environment had been delayed due to external contractors. For example, on Eve ward a patient had damaged a wardrobe in a bedroom. A temporary repair had been put in place which was safe, but the service was awaiting a full repair. On Leo ward, the communal bath had been closed until a new anti-ligature bath could be sourced. The hospital director kept a log of all maintenance repairs and required works that were outstanding and reviewed this regularly.

## Seclusion room

There was a new seclusion room on Leo that had not opened at the time of our visit.

It had been designed to allow clear observation and two-way communication. It had a toilet and a clock.

The Provider had informed local commissioners that the seclusion room had not yet opened and the referral criteria for the service reflected this.

There was an existing seclusion room available off the ward.

## Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Over 95% of staff had completed basic or immediate life support training dependent on their role.

## Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff had completed and kept up to date with their mandatory training. All staff had completed Oliver McGowen training on Learning Disability and Autism.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training provided ensured staff had the skills to keep patients safe. The service was exploring further training requirements to ensure staff could further meet individual needs. For example, managing self-harm was going to be made mandatory across the hospital in 2024 to reflect the changing needs of patients using the service.

## 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 assessed and managed risks to patients and themselves well.

Staff completed risk assessments for each patient on admission, using a standardised tool, and reviewed this regularly.

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

Inspected but not rated 

Staff knew about specific risks to individual patients and acted to prevent or reduce risks. Patients had specific care plans in place that addressed these risks.

Changes in risks to, or posed by, patients were identified and responded to.

Policies and procedures were in place to support staff when they needed to search patients or their bedrooms to keep them safe from harm.

Personal emergency evacuation plans (PEEPs) were in place for individual patients in case of an emergency evacuation.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training.

## Use of restrictive interventions

Staff received training in breakaway techniques and/or the Safe and Therapeutic Management of Violence and Aggression (STMVA). Over 97% of staff had completed STMVA training. This included de-escalation techniques and approved restrictive practices such as physical holds.

Staff worked with patients to de-escalate and manage challenging situations. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff told us they did not routinely complete positive behaviour support (PBS) plans for patients within the acute mental health service. Positive behaviour support (PBS) plans help provide longer term support to people with a learning disability and/or autism who have, or may be at risk of developing, behaviours that challenge. However, the multidisciplinary team had the skills, knowledge and capacity to create specific PBS plan if they felt it was beneficial for an individual patient. We also found elements of PBS care planning in some care plans, for example, where staff had identified specific behavioural triggers for individual patients.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Managers monitored the use of restrictive practices and reported them to commissioners and other relevant stakeholders.

## Staff access to essential information

**Staff had easy access to clinical information and it was easy for them to maintain clinical records, although there were gaps in records of one to one sessions.**

The service used an electronic record keeping system.

Patient notes were up to date and all staff could access them easily.

Records were stored securely.

We found the recording of one-to-one sessions between patients and staff was not always apparent. Although leaders were confident these were taking place, they were aware that staff were not always recording these sessions in patients' care records and had plans in place to address this.

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

Inspected but not rated 

Leaders monitored the quality of care records kept and had identified areas for improvement. For example, the ward manager had worked with staff to introduce a standardised format for staff to use when writing the daily notes for each patient. This had improved the consistency of daily records kept.

## Is the service effective?

Inspected but not rated 

We did not rate how effective the service was.

### Assessment of needs and planning of care

**Staff assessed the physical and mental health of 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.**

Staff assessed the physical and mental health of all patients on admission. Staff completed a mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The National Early Warning Score 2 (NEWS2) tool was used and staff completed training in this. Over 95% of staff had also completed training in epilepsy awareness.

Staff monitored the prescribing of High dose antipsychotic therapy (HDAT) in line with national guidance.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs.

The multidisciplinary team regularly reviewed and updated care plans when patients' needs changed.

Care plans reflected patients' assessed needs and were recovery-orientated. Some care plans included standard phrases. However, when we spoke to staff they understood the individual needs of patients. It was also recorded where patients had been offered copies of their care plans and patients were invited to attend weekly reviews of their care plans at the multidisciplinary team meeting.

### Best practice in treatment and care

**Patients did not have access to the full range of treatment and care based on national guidance and best practice. Staff did not consistently use rating scales to assess and record severity and outcomes. However, they ensured that patients had good access to physical healthcare and supported them to live healthier lives. They also participated in clinical audit and quality improvement initiatives.**

Patients could not always access a full range of treatment and care, however, what was available for patients was based on national guidance.

Leo ward had opened as an acute mental health ward in July 2023. Since this expansion leaders recognised there were areas to develop to ensure the service reflected up to date best practice.

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

Inspected but not rated 

For example, at the end of November 2023, the service had paused the group programme and planned to relaunch an improved offer in January 2024. The new psychology offer included group therapy sessions which were more flexible and included cognitive behavioural therapy and compassion focused therapy techniques. Patients had been involved in the redesign of the psychology offer. However, this meant at the time of our visit patients were unable to access group psychotherapy sessions temporarily. Patients were still able to access one to one sessions with psychologists.

A training needs analysis had been scheduled to consider the further learning needs of staff in order to ensure the effective provision of an acute mental health service. This was due to take place following our visit. Staff had already identified that training in supporting people with an Emotionally unstable personality disorder would be beneficial. In the meantime, lunch and learn groups had been available for staff to attend as informal learning and reflective practices. The service also planned to implement a more formal trauma informed approach to care.

Patients were supported to access physical healthcare and staff supported them to live healthier lives. Staff identified patients' physical health needs and recorded them in their care plans.

Staff planned care to ensure patients' dietary needs were met and assessed those needing specialist care for nutrition and hydration. For example, staff referred patients to dieticians when needed.

Staff helped patients live healthier lives by supporting them to take part in programmes or by giving advice. Patients were encouraged to access the onsite gym and staff helped to support patients with healthier eating options. The provider had offered a weekly walking group, but this has paused over the winter months. Patients were also offered support with smoking cessation.

Staff reviewed data about the service to check if it was effective, this included patients' length of stay. However, specific rating scales to assess and record treatment outcomes had not been embedded yet. For example, the service did not use Health of the Nation Outcome Scales (HoNOS). Although this had not impacted the quality of care, the introduction of specific outcome measures may help the service identify further areas for improvement over time.

Staff took part in clinical audits. Managers used results from audits to make improvements.

Leaders also attended acute clinical networks to drive quality improvement and share best practice with other hospitals run by the provider.

## Multi-disciplinary and interagency team work

### **Staff from different disciplines worked together as a team to benefit patients.**

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included psychologists, occupational therapists and a patient liaison officer. Other professionals such as dieticians and physiotherapists were accessible when needed.

Staff held weekly multidisciplinary meetings to discuss patients and improve their care. Patients and their advocates, families or carers were invited to attend these when appropriate.

The ward team had effective working relationships with other relevant teams within the organisation and with relevant services within the local integrated care system.

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

Inspected but not rated 

External stakeholders gave positive feedback about the service. We also found examples where the service had worked with other organisations to improve to benefit the patient. This included information sharing about patients specific physical health needs prior to their admission.

## Is the service responsive?

Inspected but not rated 

We did not rate how responsive the service was.

## Access and discharge

### Bed management

**Staff managed bed availability and occupancy well. Discharge was rarely delayed for other than clinical reasons.**

Managers regularly reviewed length of stay for patients. Managers and staff worked to make sure they did not discharge patients before they were ready.

A bed was available when a patient needed one. When patients went on leave there was always a bed available when they returned.

Patients were not moved between wards except for their benefit. Due to the different sizes and layouts of the two wards, some patients had found it beneficial to move between the two wards. For example, some patients had been moved to Eve ward from Leo ward as the smaller, quieter ward atmosphere better met their individual needs.

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

Two psychiatric intensive care units in the local area were available if a patient needed more intensive care.

### Discharge and transfers of care

Staff planned patients' discharges and worked with care managers and coordinators to make sure this went well. Staff did not create separate discharge care plans but did plan for discharge and this was evident in patient care and treatment records.

When patients left the service staff shared a discharge summary with the relevant stakeholders, including their GP.

Managers monitored the number of patients whose discharge was delayed and took action to reduce them.

At the time of our inspection there were 3 patients whose discharges had been delayed. Wider pressures in the local integrated care system had contributed to these delays. For example, patients did not always have an allocated care coordinator in the external community teams to facilitate their discharge. For other patients, there was not always a suitable discharge placement available that met their needs. There was evidence showing staff had worked with system partners to address these delays.

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

Inspected but not rated 

When discharges were delayed, the provider escalated concerns and worked with local commissioning bodies to monitor and manage these delays. They had also supported patients to raise concerns about their delays in their care to commissioners and other decision makers in the local care system.

Staff worked with patients to minimise the potential impact of delays to their discharge. For example, where appropriate, staff supported patients to take home leave and utilise unescorted leave in the community.

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

Where patients had been admitted to the wards a long distance from their homes, staff worked with commissioners to repatriate these patients as soon as possible.

## 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. A store of donated items was available to ensure patients could access essential items, such as clothes, if they arrived on the ward with no personal belongings.

Staff had access to a range of rooms and equipment to support patients' treatment and care. This included ward based activities such as games, books, DVDs and arts and crafts. The hospital also had a café, wood workshop and small tuck shop on site. Patients on Eve and Leo wards were invited to take part in other activities and events going on in hospital.

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

Some facilities, including the visitors room, were shared between the two wards. This was not raised as an issue during the inspection and staff found ways to mitigate potential impacts to patients. For example, an alternative visitor's room off the ward was available for patients to use. Staff also encouraged patients and their families to utilise unescorted leave, when appropriate, to spend time with one another.

The service had an outside space that patients could access easily. As Eve ward was located on the first floor, patients did have to ask staff to access outside space. This was not raised as a concern to us during the inspection and patients from Eve ward were able to leave, when appropriate, without unnecessary restrictions.

Staff noted they could move patients from Leo to Eve ward if they felt it was appropriate and met their needs. Some patients preferred the smaller layout of Eve ward and found it to be quieter.

Patients could make phone calls in private.

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food.

There were therapeutic activities available for patient to partake in as part of their treatment. These included a music group with a local musician, karaoke, and access to the gym. A therapy dog also visited the service. Staff encouraged patients to access local amenities whilst on leave. The Occupational Therapist also worked with individual patients completing assessments to support life skills such as money management and traffic awareness.

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

Inspected but not rated 

Some patients chose not to engage with activities available. Concerns were raised to us regarding this prior to our inspection. During our visit staff described how they encouraged and supported them to partake in activities whilst respecting their individual choices.

However, it was not always recorded how staff had explored some patient's personal interests and worked with patients to explore what activities could be offered in line with these. We found examples where the staff had worked with individual patients to provide activities that matched their interests but as this had not been recorded for other patients it was difficult to know if this was being done consistently.

## Patients' engagement with the wider community

### **Staff supported patients with activities and life outside the service.**

A patient liaison officer worked with patients on both wards to help support them access appropriate financial, housing and benefit support where applicable.

Staff helped patients to stay in contact with families and carers.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. A regular ward based community meeting took place for patients on Eve and Leo wards. A most valuable person award was also in place where staff and patients could nominate one another to share their appreciation for one another.

Patients had access to an independent advocate.

## 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 made sure patients could access information on their treatment, local services, their rights and how to complain.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had specific communication needs.

Information displayed on the ward was available in easy read format to make it accessible to all patients. Staff addressed accessibility issues when patients had arrived on the ward without specific communication aids such as a hearing aids.

The service had information leaflets available in languages spoken by the patients and local community. 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.

Staff gave carers information on how to find the carer's assessment.

Staff involved patients in decisions about the service, when appropriate, to ensure it reflected their individual needs. Patients could give feedback on the service at the ward community meeting and at the patient forum.

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

Inspected but not rated 

Patients were supported to access independent advocacy services.

## Listening to and learning from concerns and complaints

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

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

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

Managers investigated complaints and identified themes. We reviewed a sample of recent complaints and found they were responded to appropriately. Patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints and concerns with staff and learning was used to improve the service. For example, concerns were raised that the lights being used by staff completing night checks were disrupting patients' sleep. In response the service purchased new torches that were dimmer and less disruptive for patients.

The service used compliments to learn, celebrate success and improve the quality of care.

We also reviewed meeting minutes that showed staff responding to patients' feedback at weekly community meetings and through the patient forum. For example, where patients had said they felt the ward was too cool or didn't like the food available, staff had responded by offering different meal options and providing portable heaters, where appropriate.