Care Quality Commission

Chadwick Lodge

Quality Report

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We undertook an unannounced, focused inspection of forensic inpatient/secure wards following concerns identified at an independent care and treatment review carried out in January 2020. Members of the independent care and treatment review panel raised concerns about the staff's skills and knowledge to provide good quality care to a patient with learning disabilities. The independent care and treatment review panel also raised concerns about the use of long-term segregation with a patient with learning disabilities. This inspection was a focussed inspection so therefore did not provide a change to the existing rating.

During this inspection we found:

- Seclusion rooms were not designed in a way that assured patients privacy. Seclusion suites used for long term segregation did not meet the guidelines outlined in the Mental Health Act Code of Practice. Staff had used furniture to prevent a patient easily exiting a seclusion room.
- The hospital had not reviewed the long-term segregation for one patient in line with the Mental Health Act code of practice.
- Staff providing day to day care to a patient with a learning disability were not following national guidance based on best practice. For example, they were not delivering positive behaviour support based on an individual plan. Members of the wider

Summary of findings

multidisciplinary team had followed best practice advice, for patients with a learning disability, but they had not transferred this into care plans for the nursing staff to use.

- There was no discharge plan in place for a patient with a learning disability that the service felt needed a different service. There were no care plans detailing how a patient with learning disabilities could exit long-term segregation.
- Senior leaders had not ensured that staff had the skills to meet the needs of all patients with a learning disability admitted to the hospital, despite recommendations from external experts.

However:

- The provider followed the correct procedures when using seclusion. Managers provided support to staff following incidents.
- The provider was working with NHS England to identify a different placement for a patient with learning disabilities who needed a different service.

Summary of findings

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Care Quality Commission

Chadwick Lodge

Services we looked at
Forensic inpatient or secure wards

Summary of this inspection

Background to Chadwick Lodge

Chadwick Lodge hospital is situated in Eaglestone, Milton Keynes. It provides male and female forensic secure and long stay rehabilitation services for patients with mental health needs, who may also have related issues such as substance misuse. It offers care and treatment to patients with a dual diagnosis of mental illness/personality disorder and mild learning disabilities. It is located on two adjacent sites, called Chadwick Lodge and Eaglestone View.

The hospital has capacity for 113 patients, accommodated on eight forensic secure wards and two long stay rehabilitation wards. Avon, Berridale and Calder are medium secure wards for men with 10 beds each, and Deveron and Lymington are low secure wards for men with 14 and 11 beds respectively. Eden is a medium secure ward for women with eight beds and Jordan and Kenly are low secure wards for women with 11 and 10 beds respectively. Hope House and Isla House have 19 and 10 beds respectively and are rehabilitation wards for women experiencing mental ill health and specialising in the treatment of women with personality disorders, we did not inspect these wards.

Chadwick Lodge is registered to carry out the following regulated activities:

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Accommodation for persons who require treatment for substance misuse.

Our most recent comprehensive inspection of the hospital took place in December 2017. We rated the hospital as ‘good’ overall and good in all domains.

Our inspection team

The team that inspected the service comprised three CQC inspectors, a Mental Health Act reviewer and a specialist adviser who had experience in this area.

Why we carried out this inspection

In January 2020, following an independent care and treatment review, we received concerns that the staff lacked the skills and knowledge to provide care and treatment to some of the patients admitted to the hospital and that the hospital staff did not always follow good practice guidance in relation to treatment of people with needs related to a learning disability.

Concerns were also raised about the use of long-term segregation within the hospital. The Mental Health Act (MHA) Code of Practice defines long-term segregation as “a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis”. Concerns raised were that the appropriate reviews were not being carried out and the environment was not suitable to provide long-term segregation in a safe way to the patient.

This inspection was carried out to explore these concerns.

Summary of this inspection

How we carried out this inspection

As this was not a comprehensive inspection, we did not pursue all key lines of enquiry. We only focused on the issues identified in the independent care and treatment review, around staff skills and knowledge around the care of a patient with learning disabilities and the use of long-term segregation.

During the inspection visit, the inspection team:

- visited all five seclusion suites, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with two patients who were in seclusion or long-term segregation while using the service;
- spoke with the registered manager and a ward manager;
- spoke with 10 other staff members; including doctors, nurses, occupational therapists, psychologists and social workers;
- looked at three care and treatment records of patients; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with two patients who gave mixed responses about the care they received.

Both patients told us that staff were caring but they didn't get on with all staff.

Patients also told that us that staff did not always involve them in care planning and that not all their care plans were effective.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

As this was a focused inspection looking at concerns raised following an independent care and treatment review, we did not look at all the aspects of or rate the safe domain.

- Seclusion rooms were not designed in a way that assured patients privacy. Seclusion suites used for long term segregation did not meet the guidelines outlined in the Mental Health Act Code of Practice. Staff had used furniture to prevent a patient easily exiting a seclusion room.
- The hospital had not reviewed the long-term segregation for one patient in line with the Mental Health Act code of practice.

However:

- The provider followed the correct process when placing patients in seclusion and long-term segregation.

Staff were supported following serious incidents.

Are services effective?

As this was a focused inspection looking at concerns raised following an independent care and treatment review, we did not look at all the aspects of or rate the effective domain.

- Staff working with a patient with a with learning disability had not received the training needed to meet their needs.
- Care plans used by staff providing day to day care for a patient with a learning disability did not give clear direction of how staff should meet patients' needs. These care plans did not always follow best practice. Staff had not always read care plans when working with a patient with learning disabilities.

However:

- The occupational therapy team had a clear plan of how they worked with a patient with a learning disability.

Are services caring?

As this was a focused inspection looking at concerns raised following an independent care and treatment review, we did not look at all the aspects of or rate the caring domain.

- Patients were not always involved in planning their care.

Summary of this inspection

Are services responsive?

As this was a focused inspection looking at concerns raised following an independent care and treatment review, we did not look at all the aspects of or rate the responsive domain.

- Staff had not put plans in place to help a patient with a learning disability end their time in long term segregation and the patient did not have a discharge plan.
- The service did not always provide care that met the needs of a person with a learning disability admitted to the hospital.

However:

- Mangers were working with commissioners to identify a suitable placement for a patient with a learning disability.

Are services well-led?

As this was a focused inspection looking at concerns raised following an independent care and treatment review, we did not look at all the aspects of or rate the well-led domain.

- Leaders had not provided the training needed for staff to meet the needs of an individual patient with learning disability admitted to the hospital.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The seclusion suites used for long term segregation did not meet the standards of the Mental Health Act Code of Practice.

The provider used a seclusion suite for long term segregation and patients could not open the bedroom door without asking staff to open it for them.

The provider did follow the correct procedures when patients were in seclusion and long-term segregation.

Forensic inpatient or secure wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are forensic inpatient or secure wards safe?

Seclusion room

The seclusion rooms did not allow patients privacy when they were using the toilet. Patients could be observed by staff and CCTV cameras could record patients using the toilet as there was no door on the toilet areas. Some of the seclusion rooms were situated in the air lock at the entrance to the ward, this meant that all staff and visitors walked past the seclusion suite when entering the ward. Staff and visitors entering the ward could see the patient using the suite, because staff left the door open. During our inspection, we walked past seclusion suites and could see the patient clearly. Staff, patients and visitors walking past the seclusion suite could see the CCTV monitors.

Staff had used a table to block the door way of one seclusion suite used for the long-term segregation of a patient with a learning disability. We were told this was not to stop patients from leaving the area but to slow them down when they were unsettled. This was unsafe, and we discussed it with senior managers who said the table and chairs were for physical health reasons such as improving the patient's posture.

However, the seclusion rooms in the hospital allowed clear observations of the patient and two-way communication and had toilets and clocks.

Safeguarding

At the time of our inspection visit, there were three patients in long term segregation. We reviewed the records relating to this and saw that the provider had followed the correct procedure for monitoring and reviewing patients in long term segregation. However, the provider had changed their policy on who could provide the independent medical review carried out every three months and no longer used doctors from the provider's other hospitals. This meant that there had been a delay in two three-month reviews for a patient with learning disabilities. We discussed this with senior managers on the day of the inspection and they told us they had been unable to find an independent doctor to carry out the review. They had discussed the issue with the local forensic provider network and had requested an appropriate doctor to complete the review.

Reporting incidents and learning from when things go wrong

Managers debriefed and supported staff after any serious incident. Staff told us they were offered debriefs after serious incidents and there were monthly clinical supervision sessions.

Are forensic inpatient or secure wards effective?
(for example, treatment is effective)

Best practice in treatment and care

Staff did not always provide care and treatment based on national guidance and best practice. Care records we reviewed showed that the hospital had acted on advice around sensory processing, physical health, the development of communication passports for people with a learning disability and the use of functional analysis to inform positive behaviour support plans. However; we were not assured that staff providing direct day to day care to patients were following these plans. The ward staff we spoke to were unaware of a patient with learning disabilities care plans and how they could use these strategies when providing care to the patients.

Forensic inpatient or secure wards

Staff did not always follow the least restrictive approach when managing patient risk. For example, we found there was a lack of plans for reducing restrictions in long term segregation over time for a patient with learning disabilities.

Skilled staff to deliver care

Not all staff had the skills needed to work with all the patients admitted to the hospital. When we spoke with staff, they told us they did not have the skills or knowledge needed to work with a patient with a learning disability. Staff were unable to explain any communication strategies they might use with a patient or explain how they could help manage the patient's behaviour by reducing their exposure to known triggers. We discussed the lack of knowledge with senior managers at the hospital and they told us that patients with learning disabilities were only admitted if the learning disability was a secondary diagnosis. However, the provider is responsible for ensuring that the staff team has the skills needed to provide care and treatment to all the patients admitted.

Multi-disciplinary and inter-agency team work

We reviewed patients care plans and discussed them with senior staff and members of the wider multidisciplinary team and they could explain how they were trying to work with patients. However, staff providing direct day to day care did not always have care plans that clearly explained how they should work with a patient with learning disability and what their goals for treatment were.

Adherence to the MHA and the MHA Code of Practice

The seclusion suites used for long term segregation did not meet the standards of the Mental Health Act Code of Practice as they did not offer a distinct relaxing lounge area, separate to the bedroom. A patient with learning disabilities using a seclusion suite for long term segregation only had access to a bedroom and ensuite area. They had to carry out all their activities of daily living within their bedroom accommodation. The bedroom door could not be open from the inside and if the patient wanted the bedroom door closed, they could not open it again without asking staff to do it for them. Staff told us that they never left the door closed for longer than 20 minutes.

Are forensic inpatient or secure wards caring?

Involvement in care

Two patients told us that they had not been involved in their care planning. One patient told us how they could change their care plans to improve their care, but staff had not acted on this. We reviewed care plans and saw that patients were not always involved in their care planning.

Are forensic inpatient or secure wards responsive to people's needs?

(for example, to feedback?)

Access and discharge

The hospital was not able to find an appropriate service to discharge a patient with learning disabilities to. We discussed this with senior managers. They told us that they were unable discharge the patient or find a suitable placement for the patient, despite working closely with NHS England to identify possible placements and making numerous referrals to services. However, there was no treatment plan in place to help the patient meet the admission criteria of future placements.

The facilities promote recovery, comfort, dignity and confidentiality

A seclusion room that was being used for long term segregation of a patient with learning disabilities had been used by one patient for three years. There was no ready access to fresh air and only one room for the patient to sleep and relax in. The bathroom was fully visible to anyone walking past the room, because the door to the suite was left open.

Meeting the needs of all people who use the service

The service did not always respond to the needs of admitted patients. The service admitted patients with a dual diagnosis of mental illness/personality disorder and mild learning disability. When we discussed caring for a patient with a learning disability at the hospital with the senior leadership team, they referred to the learning disability as a secondary diagnosis. This meant that the

Forensic inpatient or secure wards

service did not view the treatment of the learning disability with equal importance as the patient's other mental health issues. We saw in one patient record that learning disability was the only recorded diagnosis.

Are forensic inpatient or secure wards well-led?

Leadership

Leaders at the hospital had not ensured that staff had the skills needed to provide care and treatment for a patient with a learning disability who had been admitted to the hospital.

Management of risk, issues and performance

Staff were aware of the need for relational security and teams worked well to share information related to risk. However, they were less aware of the impact of underlying issues such as secondary diagnoses of learning disability in relation to risk management.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure they protect the privacy of all patients in seclusion and long-term segregation.
- The provider MUST ensure patients have access to facilities that meet the standards outlined in the Mental Health Act Code of Practice.
- The provider MUST ensure they review all long-term segregations every three months in line with the Mental Capacity Act Code of Practice.
- The provider MUST ensure they do not use furniture to stop patients leaving rooms.
- The provider MUST ensure that staff receive the in-depth training needed to provide effective care and treatment to patients with a learning disability admitted to the hospital.
- The provider MUST ensure that all staff have access to and follow care plans based on national guidance and best practice advice for patients with a learning disability around positive behaviour support.
- The provider MUST ensure they continue to work with commissioners to plan for the discharge of the patient with a learning disability that is not suitable for the service.

Action the provider SHOULD take to improve

- The provider SHOULD ensure patients have plans in place to end long term seclusion.
- The provider SHOULD ensure all patients are fully involved in their care planning and record when this has not been possible.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that they protected the privacy of patients in seclusion and long-term segregation. The provider had not ensured that facilities used for long term segregation meet the standards outlined in the Mental Health Act Code of Practice. The provider has not reviewed long term segregation in line with the Mental Health Act Code of Practice. The provider had used furniture to prevent patients from leaving rooms while in long term segregation. Staff had not received the training needed to provide care to all patients admitted to the hospital. Nursing staff did not always follow care plans based on national guidance and best practice advice. This was a breach of regulation 12(1)(2)(c)(d)