Mundesley Hospital

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

The CQC is placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated Mundesley Hospital as inadequate because:

- The monitoring and recording of rapid tranquillisation was incomplete. Nurses did not consistently monitor the physical health of patients who had received this. There was a lack of recording of blood pressure, pulse, temperature, respirations and level of consciousness. One staff member had received advanced life support training, and a further three had undertaken immediate life support training. Due to the rural location of this hospital attendance by the emergency services, including ambulances could be delayed.
- The hospital had a poor record of reporting incidents to the Care Quality Commission; they had not reported any serious incidents since the hospital began admitting patients. There was evidence of a number of serious incidents having taken place. For example, a detained patient who had left the hospital, and was absent without leave and the police were involved. Reporting of notifiable safeguarding incidents to the Care Quality Commission did not take place on time. Staff did not record incidents fully. For example, incidents including those that involved restraint, which were documented in individual patient's clinical notes, were not always recorded on the provider's incident forms. The hospital had not reviewed their environmental ligature risk assessments since the hospital began admitting patients. The provider's risk register did not reflect the risk of patients tying ligatures.
- Examples of audits included infection control, care programme approach, searches, rapid tranquillisation and blood pressure monitoring. These did not effectively monitor the quality and effectiveness of

Summary of findings

care and treatment. For example, staff identified concerns around rapid tranquillisation in their audits, but no actions had been taken. There was a lack of action plans to reflect the outcomes of these audits.

- There was no clinical psychologist in post. This meant that patients did not receive input from a psychologist whilst in the hospital.
- Staff were not up to date with their mandatory training, which included the safeguarding of adults and children; the Mental Health Act (1983) and Mental Capacity Act (2005). .
- Care and treatment plans lacked detail and did not reflect the risks identified in individual risk assessments.
- There was minimal evidence of wide spread learning from incidents through the governance systems in place. The hospital did not follow their own policies and procedures regarding incident management. This increased risks to patient safety.
- Nursing staff did not always record when medication was administered, or why medication was omitted. We saw that two patients had not received physical health medications as they were out of stock. One patient had not received one medicine for four days.
- Some patients did not know about their rights as an informal patient. In-patient areas did not display information around this. Staff did not always explain detained patients their rights when they were well enough to understand these.
- Staff did not review long-term segregation in line with the Mental Health Act Code of Practice (2015).
- Individual patient freedom was restricted for reasons other than an assessment of individual risk. Staff escorted patients throughout the building due to the lay out of the building and the identified environmental risks as opposed to assessment of individual risk.

However:

- The hospital had medical cover throughout the 24-hour period. Each patient had received a full physical health assessment upon admission. The provider's general practitioner attended multi-disciplinary team meetings as required.
- Only 23% of staff were permanent employees and the vacancy rate for directly employed staff was high. However, the hospital had a recruitment strategy in place for permanent staff. The records seen showed us that the agency staff working in the hospital had the suitable skills and experience to work in this service.
- Care and treatment records were stored securely. Mental Health Act documentation was in place and correct.
- Staff were caring and responsive during interactions. New patients were orientated to the hospital by staff in a planned and informative way. Staff supported patients to meet their spiritual and cultural needs. Staff were aware of the need to promote patient confidentiality at all times.
- The hospital enabled patients to keep in touch with family and friends using current information technology.
- Staff and patients knew who the senior managers of the hospital were and could approach them.
- Staff received clinical supervision and attended regular staff meetings. They were happy in their roles and told us that they enjoyed working at the hospital.

Summary of findings

Contents

Inadequate

Mundesley Hospital

Services we looked at

Acute wards for adults of working age

Summary of this inspection

Background to Mundesley Hospital

The Mundesley hospital is a private mental health care facility in the North Norfolk countryside.

The hospital has 27 beds for adults who require assessment and treatment in an inpatient setting. Patients are either informal or detained under the Mental Health Act (1983).

It provides mental health acute care for patients assessed with high-level needs and acuity. For example, some patients are admitted directly from health-based places of safety into the service.

The hospital was registered to provide assessment or medical treatment for persons detained under the Mental Health Act (1983) and the treatment of disease, disorder or injury. There is a registered manager in post.

There are six wards located over two floors. On the ground floor, there are two adjoining in patient suites which the provider called wards, Middleton and Chrome. Both can accommodate up to six patients each and are designated male in-patient suites.

On the first floor, there are four in-patient suites. Thirtle, Stannard, Vincent and Bright. All can accommodate four patients each. Thirtle and Stannard are designated female in-patient suites.

Vincent and Bright are for either male or female patients.

The Care Quality Commission registered the hospital in December 2015 and patients were first admitted in February 2016. This was the first inspection undertaken by the CQC since this initial registration.

Our inspection team

The team that inspected the service was led by Peter Johnson - CQC inspection manager, two CQC inspectors and one Mental Health Act reviewer.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location and asked the provider to submit a range of information about the service.

During the inspection visit, the inspection team:

- visited each ward, looked at the quality of the care environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- interviewed the registered manager of the service
- spoke with 11 other staff members; including doctors, nurses, support workers, occupational therapist and mental health act administrator
- attended and observed five patient review meetings

Summary of this inspection

- collected feedback from 12 patients using comment cards
- reviewed in detail 15 care and treatment records of patients
- checked 15 medication charts
- examined a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Most patients told us that staff were friendly, caring and had time for them.
- They said there were different activities they could do if they wanted to.
- Patients said that there were enough staff on duty.
- They said that friends and family could visit them at the hospital.
- Three patients out of six we spoke with told us they had care plans.
- One detained patient said that they did not know why they were in hospital and could not recall having their rights explained. One informal patient spoke about having to be escorted everywhere within the hospital.
- Some patients did not know about their rights as informal patients.
- Two patients did not know about the independent advocacy service or that they could access this.

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?

Inadequate 

We rated safe as inadequate for Mundesley Hospital because:

- The monitoring and recording of rapid tranquillisation was incomplete. Nurses did not consistently monitor the physical health of patients who had received this. There was a lack of recording of blood pressure, pulse, temperature, respirations and level of consciousness for three patients. Four staff members had received immediate life support training. Due to the rural location of this hospital attendance by the emergency services, including ambulances could be delayed.
- Staff were not up to date with their mandatory training. For example, only 63% staff had completed training in safeguarding of adults and 7% in safeguarding children.
- Staff did not record incidents fully. For example, incidents including those that involved restraint, which were documented in individual patient's clinical notes, was not always recorded on the provider's incident forms. The senior management team had recognised the need to improve incident management procedures in July 2016. However, these improvements had not been made at the time of the inspection.
- The hospital reported safeguarding incidents to the local safeguarding authority, but not to the Care Quality Commission promptly.
- Individual patient freedom was restricted for reasons other than an assessment of individual risk. Staff escorted patients throughout the building due to the lay out of the building and the identified environmental risks as opposed to individual risk assessment. The hospital had not reviewed their environmental ligature risk assessments since the hospital began admitting patients.
- Nursing staff did not always record medication administration, or why medications had been omitted. We saw that two patients had not received physical health medications as they were out of stock. One patient had not received one medicine for four days. Regular pharmacy audits and the hospitals' action plans around medication management were in place.

However:

Summary of this inspection

- The hospital had a recruitment strategy in place for permanent staff. The records seen showed us that the agency staff working in the hospital had the suitable skills and experience to work in this service. They worked regular shifts to aid continuity of patient care.
- The hospital had appropriate medical cover throughout the 24-hour period.
- There were 23 reported incidents of physical restraint of patients between February and August 2016. Staff used deescalation techniques before resorting to restraint.

Are services effective?

Requires improvement

We rated effective as requires improvement for Mundesley Hospital because:

- All of the care plans examined lacked detail. For example, two patients had multiple incidents of self-harm which care plans did not address. One patient was having regular blood pressure monitoring. The care plan did state this but it did not give any guidance to staff or the patient as to why staff were monitoring, and what actions to take and when, if there were concerns.
- Staff had not completed clinical audits consistently.
- There was no clinical psychologist in post. This meant that patients did not receive input from a psychologist whilst in the hospital.
- Only 46% of staff had received training in the Mental Health Act (1983). Qualified staff had basic knowledge about the Mental Health Act. Only 33% of staff had received training in the Mental Capacity Act (2005).
- Patients were not always aware of the rights as informal patients. Staff did not always inform detained patients of their rights under the Mental Health Act when they were well enough to do so. Not all patients were aware of, or knew how to access independent advocacy services.
- There was no care certificate or equivalent training for support workers in place at the time of inspection. Subsequently, senior staff told us that six staff members would be completing this training.
- Staff did not complete the nutrition risk assessment for patients fully.

However:

- Patients received a full physical examination upon admission or shortly after.
- Patient records were stored securely and confidentiality maintained.
- Staff had received regular supervision.

Summary of this inspection

- Mental Health Act documentation was in place and fully completed.

Are services caring?

Good

We rated caring as good for Mundesley Hospital because:

- Staff were caring and respectful in their interactions with patients.
- Most patients interviewed spoke positively about the staff.
- New patients were orientated to the hospital by staff in a planned and informative way.
- Patients were able to keep in touch with friends and family.
- There was appropriate involvement of family in patients care.
- Patients were able to give feedback about the service.

However:

- Not all patients had signed their care plans.

Are services responsive?

Good

We rated responsive as good for Mundesley Hospital because:

- The hospital had admissions criteria to reflect the care and treatment they could offer.
- Staff worked collaboratively with placing NHS trusts to facilitate appropriate discharge of patients.
- The hospital was able to meet the needs of patients of different faiths and religions.
- Patients were able to make themselves hot, cold drinks, and snacks when they wanted.
- The hospital was able to access leaflets in different languages if required, and had an interpreting service available to use if needed.
- There was a range of therapy rooms to support the care and treatment of patients. A seven-day activity timetable offered a variety of activities. Examples of activities included current affairs and newspaper discussion groups, relaxation and complementary therapy groups.
- Patients received a leaflet upon admission explaining how to complain. Patients knew how to complain, and approached a member of staff if required. Community meetings were held weekly at which informal concerns were addressed.

Are services well-led?

Inadequate

We rated well led as inadequate for Mundesley Hospital because:

- The hospital was not reporting all notifiable incidents to the Care Quality Commission. The hospital had not reported any

Summary of this inspection

significant incidents since opening. We saw examples of serious incidents that had occurred. The reporting of notifiable safeguarding incidents to the Care Quality Commission did not take place on time.

- The hospital did not follow their policies and procedures regarding incident management. Staff did not record all incidents. Staff had not completed each incident form, and when there were, many were incomplete. Senior managers did not sign them all off. There was minimal evidence of learning from incidents through the governance systems in place. Senior staff had previously identified that the management of incident procedures needed improving. However, these improvements had not been made at the time of inspection. The hospital's risk register did not reflect all clinical risks including the risk of patients tying ligatures; staff had to escort patients throughout the hospital to mitigate this risk.
- Staff undertook audits which included infection control, care programme approach, searches, rapid tranquillisation and blood pressure monitoring. Staff had identified problems through audits. However, senior managers had taken no actions to address these.
- Mandatory staff training statistics were low. Senior staff were working on a training plan for staff to improve compliance.
- Not all patients were happy with being escorted by staff throughout the hospital. Patients were escorted due to identified environmental risks which managers were aware of.

However:

- Staff knew who the senior managers of the hospital were. They were visible and staff felt they could approach them.
- Patients and staff were able to give feedback about the service.
- Staff confirmed that they were happy in their roles and enjoyed working at 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.

- Only 46% of staff had completed training in the Mental Health Act. Qualified staff had basic knowledge about the Mental Health Act.
- The relevant responsible clinician completed consent to treatment forms. Copies of these were with the medication charts. The Mental Health Act administrator had a system that identified patients who had been in the hospital for more than three months and required a review of consent under the Act.
- Not all patients had their rights explained upon admission in a timely manner. Out of 15 files examined, we saw that there had been a delay in the informing of rights for two patients who were detained under section 2. A delay in informing patients of their rights could lead to a patient being unable to appeal against their detention due to the set time-scales for logging an appeal.
- Staff did not review long-term segregation in line with the Mental Health Act Code of Practice (2015).
- The hospital had a Mental Health Act administrator who worked four days a week. The administrator was available for staff to contact for advice. Local NHS teams supported the administrator as required. Audits were in place to monitor adherence to the Mental Health Act. Detention paperwork was completed, up to date and stored securely.
- The hospital had policies and procedures whose content correctly reflected the MHA code of practice. However, the records seen demonstrated that staff lacked an understanding of these in practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

We do not rate responsibilities under the Mental Capacity Act 2005. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Only 33% of staff had completed training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of what the Mental Capacity Act was broadly about but could not explain the five key principles of the Act.
- The hospital had made one deprivation of liberty application since opening.
- The hospital had a Mental Capacity Act and Deprivation of Liberty Safeguards policy, which staff could refer to if necessary.

Multi-disciplinary team meeting discussions took place when staff identified concerns about patient capacity. None of these discussions had led to individual capacity assessments being carried out in those care and treatment records reviewed.

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	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Good	Inadequate	Inadequate

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

Inadequate

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

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Inadequate

Safe and clean environment

- Staff could not observe all parts of the ward due to its lay out. They attempted to mitigate risks by the use of nursing observations and closed circuit television in communal areas. Patients were encouraged to use the communal areas of the hospital on the ground floor where a staff member was present.
- The hospital had not reviewed their environmental ligature risk assessments since the hospital began admitting patients. There were ligature points identified throughout the hospital in communal areas.
- The hospital's risk register did not reflect the risk of patients tying ligatures. Staff escorted patients around the hospital to mitigate this risk.
- Wards within the service complied with guidance for same-sex accommodation. However, the hospital had a lift which was accessible through Middleton ward (the male ward), and opened up onto the female ward above (Thirtle). Staff kept the lift locked, and escorted patients if they needed to use it.
- The wards were clean and records showed that staff maintained the equipment used. There were effective cleaning schedules in place.
- Staff adhered to infection control principles. Hand gel wash was available and there were adequate hand washing facilities for staff.
- Senior staff had worked with the fire brigade and had completed a recent fire risk assessment. The hospital had evacuation plans in place in the event of a fire.
- Staff and visitors carried personal alarms, which they used to summon help in an emergency. There were patient call bells in bedrooms.

Safe staffing

- The provider set the core staffing levels for the service. There were four trained nurses and six vacancies. There were ten support staff in place, with 13 vacancies. 23% of staff were substantive employees. The service had an ongoing recruitment plan to increase the number of staff. Managers booked 46 agency staff to ensure that the service had the required number of staff to meet the needs of the patients.
- The hospital had a recruitment strategy in place for permanent staff. Those records sampled showed us that the agency staff working in the hospital had the suitable skills and experience to work in this service. Hospital based induction had taken place and they worked consistent shifts.
- Managers based safe staffing numbers on the number of patients in the service and the need for staff to escort patients. Managers had recently reviewed the staffing levels and had decided that during the day two nurses would cover three inpatient wards between them, with two support workers on each. An additional nurse dispensed medication to every patient, and undertook other tasks related to medication management. At night, there was one support worker on each in-patient ward and one qualified nurse allocated to each of the two floors. Managers reported that they had the required numbers of staff on duty to meet the needs of the patients. This was due to the use of agency staff to support permanent staff.

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

Inadequate

- Senior nursing staff discussed additional staffing requirements with senior managers as and when required. Staff told us that the hospital supplied additional staff when a patient required enhanced observations. However, this was likely to be an agency staff member. We found that there were enough staff to carry out restraint if necessary. Staff attended from other wards to support colleagues and patients as required.
- The staffing levels enabled nurses to have regular one to one time with patients. However, staff did not record this consistently.
- Escorted leave or ward activities were rarely cancelled due to short staffing.
- There was psychiatrist cover throughout the 24-hour period based on an on-call system. The multi-disciplinary team (MDT) included a general practitioner (GP) who worked Wednesday through to Friday. The hospital had a contract with a local GP surgery, which provided cover throughout the rest of the week. A doctor could attend the wards quickly in the event of an emergency.

Assessing and managing risk to patients and staff

- Safeguarding training was mandatory. However, only 63% of staff had received training in safeguarding adults, and only 7% had received training in safeguarding children. The training figures show the hospital was not meeting their own target.
- Staff we spoke with told us what constituted a safeguarding concern, and explained they escalated to senior staff. Senior staff had not been sending safeguarding notifications through to the CQC in a timely manner. On two occasions, notifications were received several weeks following the incident.
- There was a spacious fully equipped clinic room on the ground floor from where staff dispensed all medication. Emergency drugs were available. Resuscitation equipment including a defibrillator was available in the main nursing office, in a bag that staff could grab quickly. This contained all emergency equipment that would be required in the event of a medical emergency. All staff had access to this. Nursing staff checked this daily. However, the hospital did not offer training in immediate life support so staff may not know how to use the equipment provided. Four staff members had received immediate life support training in previous roles. Guidance from the resuscitation council states that immediate life support training should be provided for healthcare professionals who may have to act as the first responders and treat patients while awaiting a response from the emergency services. Due to the rural location of this hospital attendance by the emergency services, including ambulances could be delayed.
- There were no seclusion facilities. Staff told us that they could not seclude patients as a result. However, staff had secluded one patient in their bedroom for three hours and forty-five minutes. Staff had followed the Mental Health Act Code of Practice (2015) with monitoring and reviewing the patient throughout this time.
- There had been two incidents of long-term segregation reported since the hospital opened, one of which was ongoing at the time of inspection. Care plans were in place but lacked detail. A clear re-integration plan was not available for staff. The multidisciplinary team and staff from the patient's NHS trust met and reviewed the patient's care and treatment regularly. However, records seen did not reflect requirements set out in the Mental Health Act Code of Practice (2015). Patients in long-term segregation should have daily reviews by the responsible clinician and weekly reviews by the multi-disciplinary team. In addition to this, the hospital should provide periodic reviews by a senior professional who was not involved in the care of the patient.
- There were 23 reported incidents of physical restraint of patients between February and August 2016, involving seven patients. Of these, eleven resulted in prone restraint (face down). Staff explained what techniques they used in attempts to deescalate patients who were showing signs of distress. The hospital had a policy around the management of violence and aggression. This included guidance for the consideration and administration of rapid tranquillisation. The policy was in line with the National Institute for Health and Care Excellence (NICE) guidance. Staff did not consistently monitor the physical health of patients following the administration of rapid tranquillisation. For example, for three patients, staff did not record the patients' blood pressure, pulse, respirations and levels of consciousness. This presented a risk to the safety of patients.
- The risk assessment tool used by staff was unique to the hospital and was clear. Nursing staff undertook a risk

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

Inadequate

assessment of every patient on admission. However, staff did not update individual risk assessments following incidents. Risk management plans were in place but these were not detailed or updated regularly.

- Individual patient freedom was restricted for reasons other than an assessment of individual risk. Staff escorted patients throughout the building due to the lay out of the building and the identified environmental risks as opposed to individual risk assessment.
- Policies were in place for the observation of and searching of patients. Trained staff searched patients on admission and then subsequently based on risk.
- The service had a policy in place for medication management and the pharmacist completed regular audits. There was a nurse allocated to administer medication daily. We reviewed 15 medication charts. We found there were five missing signatures with no explanation. These related to two different patients. On six occasions, staff were unable to administer physical health medications due to this being out of stock. This related to two patients. One patient had not been administered one medicine for four days. The nurse on duty told us that they had ordered it. Nurses were not always recording why medications were omitted. One patient had one medication omitted on eight occasions with no explanation.
- The hospital had an identified family room, as well as other private rooms, used if children visited. If a patient wanted children to visit, the multi-disciplinary team would carry out a risk assessment.

Track record on safety

- The hospital had not reported any serious incidents to the Care Quality Commission since opening. However, we identified some serious incidents had taken place. For example a detained patient who had gone absent without leave. This led to police involvement.

Reporting incidents and learning from when things go wrong

- Staff did not report all incidents in line with the hospital policy. There was minimal evidence of wide spread learning from incidents through the governance systems in place. The hospital did not follow their own policies and procedures regarding incident management.
- We found several incidents recorded in individual care and treatment records that staff had not reported via the internal incident reporting policy. This included an incident where a detained patient tried to abscond and incidents of patient self-harm.
- Duty of candour training was part of the corporate induction programme and 71% of staff were compliant with this at the time of inspection.
- Staff had replaced wooden window restrictors with metal fittings, as a patient had managed to break the previous wooden ones when trying to get out of a window. This was an example of how they made a change in response to an incident. However, staff had not reflected this in the hospital's environmental risk assessment.
- Senior managers informed us that staff were debriefed following incidents. Staff confirmed that they would be offered a debrief if they were involved in a serious incident.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Staff completed a 72-hour care plan following admission. This was based on the initial risk assessment. Initial care plans were holistic and recovery focussed.
- Doctors carried out physical examinations of patients upon admission where possible. If a patient refused to co-operate, the doctors documented this and attempted to repeat the following day. Staff monitored the physical health of patients routinely and regularly for patients who had physical health problems identified. Care plans reviewed were recovery focused. However, staff did not ensure that care plans fully reflected the risks highlighted in the patient's risk assessments.
- All of the care plans examined lacked detail, for example, one patient was having regular blood pressure monitoring. The care plan did state this but it did not give any guidance to staff or the patient as to why staff

were monitoring, and what actions to take and when, if there were concerns. Two patients had multiple incidents of self-harm, which their care plans did not address.
- Care and treatment records were stored securely.

Best practice in treatment and care

- Care and treatment records demonstrated that doctors followed the national institute for health and care excellence (NICE) guidelines when prescribing anti-psychotic medication. For example, by following guidance regarding drug dosage and frequency of administration.
- Staff provided some therapeutic sessions to patients on a one to one, or group basis. They also completed solution focused brief therapy with patients.
- Patients had access to physical healthcare. If specialist advice were required, a referral was made by the hospital's GP. However, we saw that one patient had been waiting two weeks for an urgent dental appointment despite reporting that they were in pain. We bought this to the attention of staff who addressed this immediately.
- Staff undertook a malnutrition universal screening tool (MUST) for patients as part of the admission process. However, some of these were incomplete.
- Front line staff participated in clinical audits. For example, infection control, care programme approach, searches, rapid tranquillisation and blood pressure monitoring. However, staff had not completed these consistently and some scored below 80%.

Skilled staff to deliver care

- The multi-disciplinary team consisted of doctors, nurses, support workers, activity staff and an occupational therapist to provide care and treatment to patients. The hospital did not have a clinical psychologist. Recruitment was on going.
- Records seen showed us that each member of new staff had received an induction to the service. Staff received a staff handbook. Agency staff completed a hospital orientation checklist.
- The provider reported that six staff members were scheduled to start their training in the care certificate.
- Staff attended regular staff meetings on a monthly basis. Minutes were taken, which were shared with those who could not attend.
- Staff had regular supervision. Senior staff managed poor performance through one to one meetings with staff, supervision, and with guidance from a human resource consultant as and when required.

Multi-disciplinary and inter-agency team work

- Weekly multi-disciplinary meetings took place to discuss patient care and treatment. Staff from the patient's community teams attended wherever possible. Each patient's progress was discussed initially, and the team then saw the patient. Staff gave clinical updates to external teams who were unable to attend, via telephone or email.
- Staff reported that handovers between shifts were effective and covered the whole service. Although they also reported that, these frequently ran over the allotted time-scale of thirty minutes. This meant that staff finished their shift late.
- The records seen demonstrated that staff had established good working relationships with community teams, care co-ordinators, GP services and crisis teams with the purpose of effective discharge planning.

Adherence to the MHA and the MHA Code of Practice

- Only 46% of staff had completed training in the Mental Health Act. This fell below the provider's own target.
- The responsible clinician (RC) completed consent to treatment forms. Copies of these were with the medication charts. The Mental Health Act administrator had a system that identified patients who had been in the hospital for more than three months and who required a review of consent under the Act.
- Not all patients had their rights explained upon admission in a timely manner. Out of 15 files examined, we saw that there had been a delay in the informing of rights for two patients who were detained under section 2 . A delay in informing patients of their rights could lead to a patient being unable to appeal against their detention due to the set time-scales for logging an appeal.
- During the inspection, there were 14 informal patients. There was no written information available or posters on the in-patient wards; to explain the rights of informal patients.
- The hospital had a Mental Health Act administrator who worked four days a week. The administrator was available for staff to contact for advice. Local NHS teams

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

Inadequate

supported the administrator as required. Audits were in place to monitor adherence to the Mental Health Act. Detention paperwork was completed, up to date and stored securely.

Good practice in applying the MCA

- Only 33% of staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The hospital had made one deprivation of liberty application since opening.
- The hospital had a Mental Capacity Act and DoLS policy that staff could refer to if necessary.
- Multidisciplinary team meeting discussions took place when staff identified concerns about patient capacity. None of these discussions had led to individual capacity assessments being carried out in those care and treatment records reviewed.
- Patients had access to an independent mental health advocate, although two patients spoken with were unaware that they could use this service.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

Good

Kindness, dignity, respect and support

- We observed caring and respectful interactions between staff and patients.
- Staff reported that that patients were treated with kindness and respect and those patients spoken with supported this.
- Patients were positive about the staff and felt that they had time for them.

The involvement of people in the care they receive

- The hospital had an admission pack. The admitting nurse worked through the details of this with the patient where possible. This included a leaflet for the patient with details around the hospital mealtimes; medication times etc. Staff told us that they gave each patient a tour of the hospital as soon as was practical after their admission.
- Information leaflets were available in the hospital. This included an information leaflet on advocacy and how to access.
- Staff told us that patients were involved where possible in the care planning process. We saw that most patients had signed their care plans. In the 15 records viewed, 12 had a patient's signature.
- Staff involved family and carers in the patient's care when appropriate. We saw that some family members had attended patient reviews. The hospital was able to offer relatives overnight accommodation if required.
- The hospital had a computer system, which enabled patients to have video contact with family and friends.
- Patients were able to give feedback about the service via weekly community meetings and at the point of discharge with a questionnaire.
- A number of patients were on escorted leave during the inspection.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The hospital accepted admissions from three NHS trusts. The average length of stay for patients was 10 days. Patients would be at the hospital on a short-term basis. This was due to pressures upon acute bed capacity within the trusts. Most patients were newly admitted from trust community based services. They were transferred directly to the hospital with prior arrangements in place. Trusts could recall patients when a local bed became available.
- The hospital confirmed that they had one delayed discharge at the time of inspection, which was due to housing issues. Staff were working with the relevant agencies to address this. The multidisciplinary team discussed discharge planning during patient reviews. Often patients were admitted for a short period prior to returning to their placing NHS trust and then would be discharged from that service.

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

Inadequate

- There had been two transfers of patients out to psychiatric intensive care units since February. Staff told us that this transition ensured the needs of these patients were met in a more appropriate setting.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital had a range of rooms and equipment to support treatment and care. This included a consultation room for physical health care checks. A large dining room was used as an activity room. There were other smaller rooms available within the hospital, which staff used for activities, or with patients on a one to one basis. There was also a multi-faith room. There were dedicated visiting rooms.
- Patients had their own mobile telephones. If a patient did not have a mobile telephone, the hospital had a portable ward phone, which patients could use in private.
- Patients had access to secure courtyards.
- Patients were able to make themselves hot, cold drinks, and snacks at all times. The dining room had drink making facilities, as well as a fridge with a selection of snacks and sandwiches.
- Patients were able to personalise their bedrooms if they wanted.
- There was a secure cupboard space for patients to store possessions in their bedrooms.
- A seven-day activity timetable offered a variety of activities. Examples of activities included current affairs and newspaper discussion groups, relaxation and complementary therapy groups.

Meeting the needs of all people who use the service

- The service was accessible for people requiring disabled access. There was a disabled shower room and toilet on the ground floor. Staff kept these areas locked due to potential ligature risks.
- Patients had access to a range of leaflets displayed in the dining area. These included information around different mental illnesses, substance misuse and the recovery programme. There was a poster in the dining room informing patients how to access independent advocacy. Leaflets were in English, however staff could access leaflets in different languages if required. The hospital had access to a translating service.
- The hospital provided a variety of meals for patients, who chose what they wanted from the menu.
- Patients had access to spiritual support via the multi faith chaplain who visited the hospital weekly.

.Listening to and learning from concerns and complaints

- The hospital confirmed that they had received two formal complaints since opening. Senior staff were investigating these. Patients received a leaflet upon admission explaining how to complain. We saw these leaflets on display in the dining room. Patients knew how to complain, and approached a member of staff for help if required. Staff informed us they tried to address complaints on an informal basis wherever possible. Community meetings were held weekly at which informal concerns were addressed
- Staff knew the hospital's complaints policy and procedure.
- Some patients completed questionnaires upon discharge. This enabled the hospital to get feedback about the services provided.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Inadequate

Vision and values

- Staff reported that the values of the hospital included offering person centred care tailored to individual need of patients.
- Staff knew who the senior managers within the hospital were. Staff told us that senior managers were visible, and staff felt that they could approach them to discuss any concerns or ideas. Staff told us that senior managers often attended the daily hand-over meetings.

Good governance

- Governance structures were not robust throughout the hospital. For example, incidents were not recorded in full and serious incidents were not always reported. There was minimal evidence of wide spread learning from incidents through the governance systems in place. The hospital did not follow their own policies and procedures regarding incident management. This increased risks to patient safety.

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

Inadequate

- Compliance with mandatory training for the service was below 75% with some training attendance falling below 50%. Senior staff acknowledged that training compliance needed improvement. Subsequently senior staff informed us that they were putting together a training programme for all staff to address this.
- Examples of audits included infection control, care programme approach, searches, rapid tranquillisation and blood pressure monitoring. These did not effectively monitor the quality and effectiveness of care and treatment or lead to improvement. For example, staff identified concerns around rapid tranquillisation in their audits, but no actions had been taken to improve this. There was a lack of action plans to reflect the outcomes of these audits.
- Staff told us that they discussed any risk issues with the hospital manager, who would then take action in terms of adding the concern to the risk register if appropriate. However, not all clinical risks including the risk of patients tying a ligature were on the hospital risk register. The managers had not undertaken required action to eliminate the environmental risks. This meant that patient's movement was restricted as staff escorted patients around the hospital to mitigate the environmental risks.
- Staff had not received an appraisal, as the hospital had not been open for 12 months.

Leadership, morale and staff engagement

- The overall sickness rate was 7%.
- Staff knew the whistle-blowing process. Staff were able to tell us who the lead for this was. The whistle-blowing phone line went through to a staff member who worked at the hospital. This may put staff off using this system as the call handler may recognise the caller and therefore concerns would not be anonymous.
- Staff appeared happy in their roles and there was a strong sense of team working.
- Staff provided feedback about service provision, in staff meetings, during supervision, or on an ad hoc basis with senior staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are up to date with mandatory training, which includes the safeguarding of adults and children; the Mental Health Act (1983) and the Mental Capacity Act (2005).
- The provider must ensure that all qualified staff receive immediate life support training.
- The provider must ensure that incident forms are completed in full and signed off by a senior manager.
- The provider must ensure that restraint forms and rapid tranquillisation forms are fully completed as necessary.
- The provider must ensure there are appropriate systems in place to learn from incidents and share that learning with all staff.
- The provider must ensure that staff monitor and record the physical health of patients who have received rapid tranquillisation.
- The provider must report notifiable incidents to the Care Quality Commission in a timely manner.
- The provider must complete an environmental risk assessment that addresses ligature and other risks. This should be updated regularly and identified risks mitigated.
- The provider must ensure that the escorting of patients around the building is based on a clinical assessment of individual risk.
- The provider must ensure that staff record when medications have been administered, or why medications are omitted.
- The provider must ensure that care plans are completed fully and are detailed, and based upon individual risk assessment. The risk assessments must be updated regularly, with clear management plans in place.
- The provider must ensure that all clinical audits have an action plan in place to address concerns identified.
- The provider must ensure that the Mental Health Act Code of Practice (2015) is adhered to in the respect of caring for patients in long-term segregation; informing informal and detained patients of their rights, and ensuring that all patients are aware that they can access the independent advocacy service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff were not up to date with their mandatory training and there was no provider plan to address this. **This was a breach of Regulation 18 2 (a) (b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not comply with all the policy and practice to meet the requirements set out in the Mental Health Act code of practice. **This was a breach of Regulation 17 (2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The hospital had not reported incidents to the Care Quality Commission in a timely manner. This meant that the Commission had not been informed of some notifiable incidents as required. **This was a breach of Regulation 18(1)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Patient care plans were not completed fully, lacked detail, and were not based upon individual risk assessment. • **Escorting of patients was not based on a clinical assessment of individual risk** • **Some incidents were not reported on the provider's incident reporting system or updated on individual risk assessments and care plans.** • **Immediate life support training including use of a defibrillator was not provided for staff.** • The recording of rapid tranquillisation and restraint was incomplete and nurses did not consistently monitor the physical health of patients who had received this. • Nursing staff did not always record when medications had been administered, or why medications had been omitted. Some medications had run out of stock. **This was a breach of Regulation 12– (1) and (2) (a),(b),(f),**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • **Some clinical audits did not have an action plan in place to address the concerns identified by these.**

This section is primarily information for the provider

Enforcement actions

- Incident forms were not always being completed by staff as expected, and when they were – many were incomplete and not all were signed off by senior managers.
- Staff were not recording incidents of restraint consistently.
- There was no formal structure for staff to learn lessons from incidents.
- There was not always an accurate, complete of contemporaneous record of care and treatment.
- Were audit had been undertaken there was not always evidence of action to address the issues found.
- The hospital's environmental ligature risk assessments had not been reviewed since the hospital began admitting patients.
- The risk register did not reflect all risks found at the hospital.

This was a breach of Regulation 17 (2)(a)(b)