Rushcliffe Care Limited

Rushcliffe Independent Hospitals Mill Lodge Hospital Kegworth

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Mill Lodge Kegworth is an independent acute mental health hospital. It is in the village of Kegworth between Leicester, Derbyshire, Nottinghamshire and Lincolnshire. Mill Lodge caters for female adults of working age who are experiencing acute episodes of mental health illness. The hospital has a total 26 beds across four wards.

Our rating of this location stayed the same. We rated it as good because:

- We looked at seven patient risk assessments and found all were thorough, comprehensive, personalised, up-to-date and reviewed regularly.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff received specialist training for their role, for example continence, wound care, personality disorder, bipolar affective disorder, trauma informed care, and leadership training.
- We saw staff involved patients in decisions about the service, when appropriate for example suggestions on the décor, menu choice and therapeutic activities. Staff and patients attended weekly community meetings where topics discussed included the environment, meals, patient involvement opportunities, achievements and celebrations and keeping in touch with family and friends.
- The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Wards were on the ground floor and supported disabled patients. We saw, where appropriate, patients had a personal evacuation plan in place.
- There was a transparent and open culture that encouraged creative thinking in relation to patients' safety.

However:

- We found open food in two ward fridges which was not labelled with either the date it was opened and when it should be consumed by.

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	Good 	Mill Lodge Kegworth is an independent acute mental health hospital. It is in the village of Kegworth between Leicester, Derbyshire, Nottinghamshire and Lincolnshire. Mill Lodge caters for female adults of working age who are experiencing acute episodes of mental health illness. The hospital has a total 26 beds across four wards. Our rating of this location stayed the same. We rated it as good because: • We looked at seven patient risk assessments and found all were thorough, comprehensive, personalised, up-to-date and reviewed regularly. • Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff received specialist training for their role, for example continence, wound care, personality disorder, bipolar affective disorder, trauma informed care, and leadership training. • We saw staff involved patients in decisions about the service, when appropriate for example suggestions on the décor, menu choice and therapeutic activities. Staff and patients attended weekly community meetings where topics discussed included the environment, meals, patient involvement opportunities, achievements and celebrations and keeping in touch with family and friends. • The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Wards were on the ground floor and supported disabled patients. We saw, where appropriate, patients had a personal evacuation plan in place. • There was a transparent and open culture that encouraged creative thinking in relation to patients' safety. However:

Summary of findings

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Summary of findings

Contents

Summary of this inspection

Background to Rushcliffe Independent Hospitals Mill Lodge Hospital Kegworth

Mill Lodge Kegworth is an independent acute mental health hospital managed by Rushcliffe Health Care Limited. It is in the village of Kegworth between Leicester, Derbyshire, Nottinghamshire and Lincolnshire. Mill Lodge caters for female adults of working age who are experiencing acute episodes of mental health illness. Mill Lodge accepts urgent referrals and patients who may be detained under the Mental Health Act. The hospital is commissioned via a block contract with two local NHS Trusts. The hospital has a total 26 beds across four wards; James ward 6 beds (not open at the time of the inspection), Alexander Ward 6 beds, Amrik Ward 7 beds and Jared Ward 7 beds. There were 16 patients at the hospital, 11 of which were detained under the Mental Health Act. The average length of stay was 20 days.

The hospital registered with Care Quality Commission in May 2019. It is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the mental health act 1983;
- Diagnostic and screening procedures.

There is a registered manager, nominated individual and controlled drugs accountable officer. The hospital was most recently inspected in November 2019 and was rated as good in all five domains.

What people who use the service say

We spoke with three patients face-to-face; two other patients and three carers were contacted by telephone.

One patient told us healthier lifestyle was promoted and encouraged, the ward was clean and warm, and they could open the windows for fresh air. One patient said they can get into their room whenever they want, and staff always knock before coming in and are polite and very caring.

One patient said staff were great, that they have got a care plan which is still being developed. There is a treatment plan the doctor wrote and they were shown this. They sat with the nurse, to look at the care plan and put it together collaboratively. There was a lot to do during the day and they had a busy activity programme and the Occupational Therapy (OT) staff are brilliant.

There is a multi-faith room the head of OT uses it for sensory purposes there is also a church in the village it is beautiful, they can go and ring family and friends if they need to.

However, one patient told us there was not enough therapy.

Carers told us staff were exceptional, they did all they can to make my loved one's life as good as it can be, staff love her and she loves them, it's genuine. She has her own iPad and watches films. The staff do a weekly ward round that they attend on teams they listen to me as well they are amazing, can't praise them enough.

The carer also said staff were very supportive and off the scale, it's a dream. If they don't know the answer to something they will find out and they are exceptionally polite. Happy helpful supportive staff.

Summary of this inspection

We have engaged with many hospitals over the last ten years this is the best place. It's small it has lovely grounds, and the staff are lovely. They looked after people very well at Christmas.

However, one carer told us there is the odd occasion at weekends when there is a shortage of staff and they use bank and agency staff.

How we carried out this inspection

Our inspection team was led by an inspection manager.

The team included two CQC inspectors, inspection manager, specialist advisor and an expert by experience.

To get to the heart of people who use services' experience of care, 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 we held about the location, asked other organisations for information and sought feedback from patients via an engagement meeting.

During the inspection visit, the inspection team:

- visited three wards at the hospital and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with three patients face-to-face, two over the phone and three carers over the phone
- spoke with the registered manager and four clinical nurse leads
- spoke with 19 other staff members including; doctors, nurses, occupational therapist, psychologist, social worker, mental health act administrator and healthcare support workers
- attended and observed one morning management meeting and one multi-disciplinary meeting
- looked at seven care and treatment records of patients
- carried out a specific check of the medication management and prescribing practice on three wards looking at 10 charts in detail
- looked at a range of policies, procedures and other documents relating to the running of the service.

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

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good

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

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

Good

Safe and clean care environments

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

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. There was an up-to-date ligature audit which included the large garden area.

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

The wards complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff always wore alarms on the wards and summoned help when needed.

Maintenance, cleanliness and infection control

Ward areas were clean, well-maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff were present throughout our inspection.

Staff followed the provider's infection control policy, including handwashing. We were assured staff were following safe infection prevention and control procedures to keep people safe. We saw anti-bacterial hand soap dispensers in all clinical areas. Staff wore masks in all areas of the wards we visited. There were clear signs up in reception and around the hospital to communicate the visiting arrangements and COVID-19 precautions. The hospital had a good supply of personal protective equipment (PPE), and staff had received extra training on handwashing and PPE use.

We found open food in two ward fridges that were not labelled with the date they had been opened or the date they needed to be used by.

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

Good

Seclusion room

The hospital did not have a seclusion room.

Clinic room and equipment

We checked three clinic rooms which were tidy, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly and recorded appropriately.

Staff checked, maintained, and cleaned equipment in the clinic room.

Safe staffing

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

Nursing staff

The service had enough nursing and support staff to keep patients safe. The hospital had an establishment of 16 qualified nurses. At the time of the inspection there was 13 in post, this equated to a 9% vacancy rate. The establishment for support workers was 38 at the time of the inspection and 34 were in post, this equated to a 10% vacancy rate.

The provider had an active and ongoing recruitment programme.

The service had reducing rates of bank and agency staff. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff understood the service before starting their shift and had a full induction where necessary.

The service had low turnover rates. During the 12 months prior to the inspection the rate was 15%.

Managers supported staff who needed time off for ill health. Levels of sickness were low at 2% against a provider target of 5%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants for each shift and reviewed this daily at the morning management meeting. If required, they could adjust staffing levels according to the needs of the patients.

Patients had regular one-to-one session with their named nurse. Staff told us they rarely cancelled these sessions due to short staffing, and patients confirmed this.

Patients told us they rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients took leave in line with their current risk status.

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

Staff shared key information to keep patients safe at handovers and during the morning management meeting.

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

Good

Medical staff

The service had enough daytime and night-time medical cover. Doctors were able to go to the ward quickly in an emergency. The hospital had one medical director, one responsible clinician, one doctor who specialised in psychiatry, one staff grade doctor, one locum psychologist working one day per week and one nurse prescriber.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. Overall training compliance rates were 93%. The mandatory training programme was comprehensive and met the needs of patients and staff and included professional boundaries, safety intervention, infection prevention and control and intermediate life support training.

Managers monitored mandatory training compliance rates and alerted staff when they needed to update their training by allotting time on the staff rota.

Assessing and managing risk to patients and staff

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

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using several risk tools. the tools included Short-Term Assessment of Risk and Treatability tool (START), Becks Suicide scale for hopelessness, depression and anxiety, Inventory of Statements About Self-injury (ISAS) and the Columbia Suicide severity scale.

Management of patient risk

Staff knew about the individual risks for each patient and acted to prevent or reduce them. Staff we spoke were aware of what strategies to use to minimise and manage risks and how to support individuals when they posed a risk to themselves, others or their environment. Staff communicated current patient risks in the ward handover. Accurate risk information was handed over and recorded in the morning management meeting.

Staff identified and responded to any changes in risks to, or posed by, patients.

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

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

Use of restrictive interventions

Levels of restrictive interventions were low, in the three months prior to the inspection there had been 38 instances where restraint had been used. An audit completed in January 2022 showed in all cases the reasons for use of the restraint were outlined in the patient's care plan, and there was evidence of consideration and application of alternatives to using restraint. There had been no use of rapid tranquilisation in the two years prior to the inspection.

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

Good

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

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

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 completed training in the use of restrictive interventions. Compliance rates were at 83% at the time of the inspection.

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

Safeguarding

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

Staff received training and kept up-to-date on how to recognise and report abuse. The training compliance of staff for mandatory level three for safeguarding adults and children training was 100%. The social worker and managers supported staff when reporting potential abuse, who ensured they reported to the local authority, CQC and the police when appropriate.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They gave clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood and took steps to protect patients when needed. All staff completed equality and diversity training

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them, compliance rates for safeguarding children was 89%.

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

Staff access to essential information

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

We looked at seven patient records, they were in an electronic format, comprehensive and all staff, including agency could access them easily. Staff made sure that the records were kept up to date.

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

Medicine management

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

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 10 medicine charts, all of which were completed correctly.

Staff regularly reviewed the effects of medicines on each patient's mental and physical health and recorded this appropriately. The service commissioned a private pharmacy to undertake regular audits and feedback and suggested actions to improve medicine management.

Staff reviewed patients' medicines regularly and provided specific advice in the form of comprehensive information leaflets to patients and carers about their medicines.

Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The use of 'as required' medicine was low. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The multi-disciplinary team reviewed the use of as required medicine at each ward round and patients and carers were involved in these discussions, where appropriate.

Staff reviewed the effects of each patient's medicine on their physical health according to National Institute for Health and Clinical Excellence (NICE) guidance. We found evidence in patient care records that electrocardiographs and blood tests were appropriately undertaken when indicated and records of regular physical health monitoring for example blood glucose monitoring for diabetic patients.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff accurately described what incidents to report and how to report them. Incidents in the preceding 24 hours were discussed and actions taken to prevent reoccurrence at the morning management meeting.

Staff reported serious incidents clearly and in line with the provider's policy.

The service looked at themes and trends of incidents on a monthly basis. They produced a 'learning from incidents' poster which described the type and number of incidents and reminders for staff regarding the completion of incident forms. It also praised staff for the quality of the information in the reports where appropriate and encouraged transparency when reporting incidents.

The service had no never events on any wards.

Staff described their responsibilities under duty of candour. We saw evidence in letters to both patients and their carers which were open and transparent and gave patients and families a full explanation when things went wrong.

Managers and psychology staff debriefed and supported staff and patients after any serious incidents.

Managers investigated incidents thoroughly. We saw the hospital had an investigating serious incidents policy which described how patients and their families could be involved in the investigations where appropriate.

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

Good

Staff received feedback from investigation of incidents via regular team meetings and emails.

Staff and patient representatives met to discuss the feedback and look at improvements to patient care in the ward community and clinical governance meetings.

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

Good

Assessment of needs and planning of care

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

Staff completed a comprehensive assessment of each patient either on admission or soon after. We looked at seven care records, all of which reflected patients' assessed needs and were holistic and recovery oriented. We saw staff assessed the physical and mental health of all patients on admission and developed care plans appropriate to the identified health need. Care plans were reviewed regularly through multidisciplinary discussion and updated as needed.

Best practice in treatment and care

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

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

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

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

Staff supported patients with their physical health and encouraged them to live healthier lives.

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

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

Skilled staff to deliver care

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

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

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers provided an induction programme for new staff and mentoring opportunities for all new starters.

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

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff received specialist training for their role, for example continence, wound care, personality disorder, bipolar affective disorder, trauma informed care, and leadership training.

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

Multi-disciplinary and interagency teamwork

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

Staff held weekly multi-disciplinary meetings to discuss patients and improve their care. We reviewed seven care records and saw that the meetings were well attended and all aspects to patient's individual care was reviewed to ensure it met their needs. We attended one multi-disciplinary meeting, the patient was in attendance and their parents contributed virtually. The out of area clinician from the Clinical Commissioning Group (CCG) where the patient resided was also present. We were told CCG representatives attended every meeting either in person or virtually. We saw evidence in an email of how much the CCG representative valued this.

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

We saw evidence that the social worker and local authority safeguarding teams worked together to provide high quality care for patients.

The service had effective working relationships with staff from services providing care following a patient's discharge and engaged with them early in the patient's admission to plan discharge.

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

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

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. Compliance training rates for relevant staff were at 95% at the time of the inspection.

We reviewed eleven patients' folders relating to their detention under the Mental Health Act 1983. The folders were well-organised, containing the relevant current information, and we were able to find the information we required. In addition to the statutory paperwork, ten patients' folders, had reports from the approved mental health professionals. In the remaining patient's folder, there was evidence of the MHA administrator requesting this report from the relevant approved mental health professional.

A system was in place for the receipt and scrutiny of the Mental Health Act detention paperwork. We saw evidence in an audit completed in December 2021 of the Mental Health Act administrator and medical staff scrutinising the detention paperwork.

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

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

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

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

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

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. We saw lead clinicians audited section 17 leave on the daily checklist.

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

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

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

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

Good

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

Good practice in applying the Mental Capacity Act

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

Staff received and were consistently up-to-date, with training in the Mental Capacity Act and demonstrated a good understanding of at least the five principles. Compliance training rates for appropriate staff were at 94% at the time of the inspection.

There were no deprivations of liberty safeguards applications made in the previous 12 months.

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

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

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

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

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

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

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

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

Good

Kindness, privacy, dignity, respect, compassion and support

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

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

Good

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

Staff gave patients help, emotional support and advice when they needed it. We observed staff supporting patients in group and individual therapeutic session, for example, the café group and craft group.

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

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

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

Involvement in care

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

Involvement of patients

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

Staff told us they introduced patients to the ward and the services as part of their admission and patients confirmed this.

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

There was evidence that changes had been made because of feedback, for example we saw the service had supplied a smoothie machine and addressed issues regarding decoration following patient feedback.

We saw staff involved patients in decisions about the service, when appropriate for example suggestions on the décor, menu choice and therapeutic activities. Staff and patients attended weekly community meetings where topics discussed included the environment, meals, patient involvement opportunities, achievements and celebrations and keeping in touch with family and friends. Patients also contributed to "employee of the month" whereby a staff member was identified and received a certificate to acknowledge their work. Staff supported and encouraged patients to complete a satisfaction survey to monitor their views and suggestions, this was then discussed at management meetings and action taken where applicable.

Staff supported patients to make decisions on their care for example where appropriate supporting them to cater for themselves and devise individualised therapeutic programmes.

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

Good

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

Involvement of families and carers

Staff informed and involved families and carers appropriately.

We reviewed seven care plans, all of which contained evidence that family members had been involved in multi-disciplinary, commissioner and care programme approach meetings. We spoke with three carers and they were unanimously positive about the care their family member received. One carer said that staff were exceptional, and they could not praise them enough. Another carer said communication was good and they attended ward rounds and had met staff and management. We were told the doctor explained in a way that they could understand and gave them all the information they needed.

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

Good

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

Bed management

The average length of stay was 29 days. Staff planned and managed patient discharges well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. We saw evidence that commissioners attended multi-disciplinary meetings. There was a weekly call between the hospital and commissioners to coordinate care. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason. We reviewed seven care records, all had evidence of active discharge planning with the involvement of the patient and external agencies.

Managers made sure bed occupancy did not go above 85%.

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

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

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

The service took referrals from the Coventry and Warwickshire area. The hospital worked with commissioners to facilitate discharge to these areas.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient, for example to safeguard them

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

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

Good

Discharge and transfers of care

The service had three patients in the last year and one current delayed discharge. The current delay was due to the unavailability of suitable accommodation to meet their needs.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

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

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

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

The three wards we inspected were bright, and airy. The furniture was in good condition and easy to clean. We were told the food was of good quality and patients could access hot drinks and snacks at any time. Patients who had been assessed as able to do so through a risk assessment could make their own hot drinks and snacks and were not dependent on staff.

Staff used a full range of rooms and equipment to support treatment and care.

The service had quiet areas and a room where patients could meet with visitors in private. The provider had a policy to ensure all visitors are made aware of the restricted items list before entering the ward environments. Posters were on display in reception areas listing restricted items and we saw visitors were reminded of these before entry to the wards.

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

The wards had outside spaces that patients could access.

Patients' engagement with the wider community

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

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

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

Staff encouraged patients to develop and maintain relationships both in the service and the wider community where possible, for example attending church services.

Meeting the needs of all people who use the service

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

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Wards were on the ground floor and supported disabled patients. We saw, where appropriate, patients had a personal evacuation plan in place.

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

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

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

The service provided a variety of food to meet the dietary and cultural needs of individual patients and where appropriate were encouraged and were appropriate supported to shop for themselves. One patient told us the vegan food on offer was of good quality.

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

Listening to and learning from concerns and complaints

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

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

Patients, relatives and carers knew how to complain or raise concerns. How to complain posters were displayed on ward noticeboards and leaflets were accessible. We spoke with two carers and five patients who all said they knew how to make a complaint and felt confident it would be dealt with appropriately.

Staff understood the policy on complaints and knew how to handle them.

The service had three complaints in the 12 months leading up to this inspection, all were not upheld. Each had been fully investigated and feedback and lessons learned had been shared with the complainant and ward teams.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

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

Good

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good

Leadership

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

Staff knew who the leaders were of the service and reported they were visible and approachable, not only to them but for patients too. Staff told us leaders often visited the wards and would work shifts to support the team and get a better understanding of the service. The registered manager held monthly informal coffee drop-ins with the healthcare support workers. They were encouraged to talk confidentially about how the service could be improved and what support they needed to achieve this. Staff told us that leaders were a "breath of fresh air "who went above and beyond to support them and were always available whenever for whatever they needed.

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

We spoke with the four clinical leads as well as other members of the multi-disciplinary team and they confirmed development opportunities for career progression were available and were encouraged to take these up.

Vision and strategy

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

Managers worked with staff to ensure they knew and understood the provider's vision and values and how they applied to the work of their team. We heard about the clinical pathway for patients and how they contributed to this. Staff were able to articulate that the hospitals vision was to "provide a positive experience for patients to enable a sustainable recovery, maximum potential and successful discharge". In addition, staff we spoke with explained how they were working to deliver high quality care within the budgets available.

Staff were very motivated by and proud of the service. There were consistently high levels of constructive engagement with patients, carers and staff. Managers had developed their leadership skills and those of others, to ensure they were empowered to positive changes.

Culture

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

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

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

Good

We were told that the registered manager had developed a culture where issues were openly discussed and challenged, and staff were held accountable for their actions. Staff also said they felt comfortable in challenging each other and were actively supported to do this and felt listened too. Support workers told us they could raise any concerns without fear and they were actively encouraged to speak up, if they felt they needed to raise an issue. We were told there was "always learning at Mill Lodge, we don't stand still, we always challenge ourselves."

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

We spoke with 23 members of the team who were overwhelmingly positive about the registered manager. Staff told us they felt extremely respected, supported and valued. They said leaders promoted equality and diversity in daily work and provided opportunities for development, for example training and career progression, and they felt very proud to work at Mill Lodge.

Governance

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

Mill Lodge had effective governance structures in place to monitor the safety of the ward environment, performance and risk. The service held monthly governance meetings which had an agenda including; safeguarding, health promotion, lessons learned and medicines management. The social worker produced a monthly highlight report to evidence assurance that safeguarding issues were managed and appropriate actions taken. We were told the ethos around governance at Mill Lodge was aiming to create an environment where clinical excellence would flourish.

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

Management of risk, issues and performance

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

Staff had access to the information they needed to provide safe and effective care and used that information to good effect. Clinical leads checked medicine charts daily to ensure safe administration and record keeping. Managers were supported to address performance issues in a timely way.

Effective multi-disciplinary meetings across the service helped to reduce patient risks and keep patients and staff safe. The service looked at themes and trends of incidents on a monthly basis. They produced a 'learning from incidents' poster which were displayed in ward offices that described the type and number of incidents and reminders for staff regarding the completion of incident forms, as well as acknowledging good practice

Staff notified and shared information with external organisations, for example the local authority and CCGs. Staff were open and transparent and explained to patients when something went wrong. We saw staff had good rapport with patients and said that staff were compassionate, and they felt safe.

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

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

Good

Staff said the service provided information governance systems to measure key performance indicators and to gauge the performance of teams which helped them provide consistent good quality care.

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

Information management

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

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

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

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

Information governance systems included confidentiality of patient records.

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

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

Staff made notifications to external bodies as needed.

Engagement

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

Managers engaged actively with other local and national health and social care providers to ensure an integrated health and care system was commissioned and provided to meet the needs of the local population. Commissioning group representatives attended multi-disciplinary meetings whenever possible and the service held weekly phone calls with commissioners to coordinate care. We saw evidence that commissioners had received several unsolicited compliments from patients and families about the quality of care they had received.

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

Learning, continuous improvement and innovation

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

Good

The service was very effectively monitored, through robust systems of governance. Clinical leads had delegated responsibility for specific areas of monitoring the service, something they took seriously. For example, one team member was responsible for overseeing training and other team members for medicines, the quality and completion of documents, including care records and reviews. This system helped ensure ownership of the service's performance by every member of the team. Staff felt involved, consulted and that their views were genuinely valued and acted upon.

There was a particularly strong emphasis on continuous improvement. The views of patients and staff were at the core of quality monitoring and assurance arrangements. Innovation was celebrated and shared.