Richmond House

Quality Report

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Date of inspection visit: 17 February 2016
Date of publication: 20/07/2016

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	Requires improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

Overall summary

We rated Richmond House as requires improvement because:

- There were multiple ligature points (things to which patients intent on self-injury might tie something to harm themselves), in the bathrooms and bedrooms. The provider completed ligature risk assessments, but had no plans to remove or update ligature risks in these areas. There were multiple blind spots around the unit and on all floors, which were not risk managed. There was no nurse call system in any bedrooms or bathrooms, and staff did not carry alarms.
- There was a breach of the Mental Health Act (MHA) code of practice and CQC regulations regarding single sex accommodation. There was no female only lounge.
- Staffing levels at weekends and evenings was not sufficient to manage any serious control and restraint procedures that may be required, or other emergencies.

However:

- The service employed appropriately trained staff and covered vacancies by using regular bank or agency staff. Most staff were up to date with mandatory training, and those who were not had training dates booked. All staff either had, or were studying for, the British Institute of Learning Disability (BILD) care certificate or a diploma in health care. Supervision and appraisals were all up to date.
- All staff had received MHA training. Staff understood the MHA, the revised code of practice and the guiding principles. Staff completed capacity and consent to treatment requirements and reviewed these regularly. Staff explained patients' rights on admission, and they repeated this information at patients' reviews. Patients had access to Independent Mental Health Advocates (IMHA's). Richmond House had no incidents of seclusion, segregation, or deprivation of liberty safeguard applications.
- Robust arrangements were in place for staff to manage admissions and discharges in the hospital. Staff undertook pre-admission assessment visits and patients were encouraged to visit the service prior to admission.
- Patients' risk assessments were up to date. Staff had completed crisis plans for all patients to address any mental health deteriorated. Care records showed that staff carried out comprehensive risk assessments including physical health care needs. Staff encouraged patients to contribute to their own recovery. Patients had access to an independent advocacy service.
- The hospital had a good track record for managing safeguarding and complaints. The manager used the partnerships in care dashboard to monitor activity on the unit including MHA reviews and section 17 leave. Clinical audits were regularly undertaken by the manager and outcomes shared with other staff. The provider's policies met best practice guidance. Staff told us they were able to raise concerns without fear of victimisation. Staff told us they were unaware of any bullying or harassment cases.
- Staff knew about and agreed with the organisation vision and values. Staff used clinical practice as recommended by National Institute of Health and Care Excellence (NICE) guidelines. Multidisciplinary team working and information sharing was good. Staff worked closely with external agencies and existing care co-ordinators to identify suitable accommodation, employment, and voluntary opportunities for patients. The provider offered smoking cessation support.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	

Summary of findings

Contents

Requires improvement

Richmond House

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Richmond House

Richmond House is part of the Partnerships in Care Limited care pathway in Norfolk and Suffolk which, taken together, provides 98 beds at different levels of therapeutic security in four linked specialised residential units.

Richmond House is one of the two community locked rehabilitation units. The hospital provides psychiatry, psychology, rehabilitation, and wellbeing therapies and is part of the Partnerships in Care group. The hospital provides these services for men and women of working age with a history of offending behaviour who have learning disability and other mental health conditions.

The hospital has eight inpatient beds. At the time of this inspection there were seven patients, all detained under the Mental Health Act 1983.

Richmond House is regulated by the Care Quality Commission (CQC) for:

- Assessment and medical treatment for persons detained under the Mental Health Act 1983.
- Treatment for Disease, Disorder, and Injury.

The provider had a registered manager and controlled drugs accountable officer.

The CQC first registered Richmond House hospital in December 2010. The CQC inspected Richmond House on four occasions. The last inspection on 15 August 2013 showed that the hospital was compliant with all the regulations inspected at the time.

Our inspection team

The team that inspected the service consisted of two CQC inspectors.

The team would like to thank all those who met and spoke with inspectors during the inspection. People were open with the sharing of their experiences and their perceptions of quality of care and treatment at the hospital.

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 a range of other organisations for information. We provided comment boxes for patients, carers, and staff to express their opinions confidentially if they wished.

During the inspection visit, the inspection team:

- Looked at the quality of the hospital environment and observed how staff cared for patients.
- Spoke with seven patients who were using the service.

Summary of this inspection

- Interviewed the service manager and deputy unit manager.
- Spoke with twelve other staff members, including the responsible clinician, nurses, psychologist, occupational therapist, social worker, complaints officer, and healthcare workers.
- Carried out one patient focus group.
- Received feedback about the service from three carers.
- Reviewed one comment card.
- Reviewed in detail seven care and treatment records of patients, including Mental Health Act paperwork.
- Reviewed 13 staff records.
- Carried out a specific check of medication management and the clinic room.
- Examined a range of policies, procedures and other documents about the running of the service.

What people who use the service say

Patients told us they felt cared for at Richmond House. They told us there were a wide range of activities and a choice of staff they could talk to, in addition to their named nurse. Doctors and other senior staff were approachable, and staff overall were kind.

Patients told us the food was good. They could personalise their bedrooms and commented on how clean and comfortable the hospital was. Patients said they were included in decisions about their care and treatment.

However, two patients told us they did not think there were enough staff on duty at evenings and weekends. One patient told us staff cancelled activities because there were not enough staff to escort them. This was in contrast to the evidence we saw, including a table showing the number of activities planned versus the number of activities cancelled, and entries staff had made in the patients' care notes when activities had taken place.

All the carers interviewed, said Richmond House hospital offered a safe and caring environment for their relatives.

We had one completed comment card which referred to:

- Short staffing at Richmond House, and frequent use of temporary staff who were not known to patients.

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 requires improvement for Richmond House because :

- There were multiple ligature points in the bathrooms and bedrooms. Ligature points are things to which patient's intent on self-injury might tie something to harm themselves. There were multiple blind spots around the unit and on all floors, which were not risk managed. Blind spots are areas of the building that staff could not see clearly.
- There were no nurse call systems in any bedrooms or bathrooms. Therefore, patients and staff would not be able to summon help in an emergency.
- There was a breach of the Mental Health Act code of practice and CQC regulations regarding single sex accommodation. A male bedroom was located on the same floor as the female sleeping accommodation and next to the female toilet and bathroom. There was no female only lounge.
- Staffing levels were not adequate at evenings and weekends if three or more person physical interventions were required while maintaining the remaining patients safety. During the period from May 2015 to November 2015, data provided by Richmond House showed that there had been 35 incidents of patients needing restraint.
- The manager confirmed that that Monday to Sunday daytime they planned for one qualified nurse and three healthcare workers. However, there were occasions when these numbers were lower due to unplanned absences or lowered patient occupancy. While staff and patients said there were usually three staff on duty at weekends. In the evenings staffing was one qualified nurse and one healthcare worker. Furthermore, and because the main nursing office was located in the former cellar of the building, nurses working in the office might not be aware of staff or patients requiring support in other areas of the building.

However:

- All areas were clean and tidy.
- The service employed appropriately trained staff and covered vacancies by using regular bank or agency staff. However, a comment made by a patient suggested bank and agency staff were not known to patients.

Summary of this inspection

- All staff completed most of their mandatory training, including safeguarding, equality and diversity and first aid training.
- Patients' risk assessments were up to date. All patients had crisis plans in place if their mental health deteriorated.
- The hospital had a good track record for managing safeguarding and complaints. We saw examples of how systems and practice had changed in response to safeguarding incidents and complaints.

Are services effective?

Good

We rated effective as good for Richmond House because :

- Staff completed comprehensive risk assessments, which included physical health care needs. Care plans reviewed were detailed, thorough, and complete and included the patients' views. Staff encouraged patients to complete their "My Shared Pathway" documents as part of their one to one sessions.
- Staff used clinical practice as recommended by NICE guidelines. Patients registered with the local GPs, opticians, dentists, and podiatrists, and staff gave them support to attend appointments. The team included nurses, doctors, an occupational therapist, a psychologist, a social worker, and healthcare workers. Staff worked closely with external agencies and existing care co-ordinators to identify suitable accommodation, employment, and voluntary opportunities for patients.
- The manager used the partnerships in care dashboard to monitor activity on the unit including, Mental Health Act 1983 (MHA) reviews and section 17 leave. Medical staff reviewed patient leave weekly. Multidisciplinary team working and information sharing was good.
- Supervision and appraisals were all up to date.
- All nursing staff received MHA training. Staff understood the MHA, the code of practice and the guiding principles.
- Staff completed capacity and consent to treatment requirements and reviewed these regularly. Staff explained patients' rights on admission, and they repeated this information at patients' reviews.
- We found evidence of two capacity assessments and one best interest meeting having taken place. We observed how staff encouraged patients to make their own decisions as far as possible.
- Data for the period from 17 May 2015 to 17 November 2015 showed that Richmond House had no incidents of seclusion, segregation, or deprivation of liberty safeguard applications.

Summary of this inspection

Are services caring?

Good

We rated caring as good for Richmond House because :

- Staff showed a good understanding of the individual care and treatment needs of patients.

Staff we spoke to demonstrated a commitment to providing high quality care and treatment within the least restrictive practices. Patients were encouraged to be involved with their care plans. We saw signed and individualised care plans in all the patients' records we checked.

- Carers told us that they had seen staff treating their relatives with kindness and respect. Patients told us that staff were kind and understood them well. Staff addressed patients in their preferred way and were polite at all times.
- Staff undertook pre–admission assessment visits and patients were encouraged to visit the service prior to admission. Family contact was encouraged where appropriate and families and other carers were involved in discharge planning.
- There were weekly house meetings, when patients could feedback their views, make suggestions, and influence change about the unit.
- An independent advocacy service was available to patients.

Are services responsive?

Good

We rated 'responsive' as good for Richmond House because :

- Robust arrangements were in place to manage admissions and discharges in the hospital. The provider had clear arrangements in place for assessing new referrals. The provider planned all admissions. All patients had discharge plans and carers were involved in discharge planning.
- The hospital was homely with quiet and private areas for patients to use. There was a pay phone, but all patients had access to their own personal mobile phone. Bedrooms were personalised by the patients and classed as private areas. Patients had input into the choice of food available. There was access to snacks and drinks throughout the day.
- The provider had a secure outside area for access to fresh air. Patients negotiated the times they wanted to smoke. The provider offered smoking cessation support and, staff understood how to support patients when they wanted to make a complaint.
- A range of activities was available including walking groups, arts and crafts, and visits to leisure amenities such as bowling. Patients had opportunity to do unpaid community work.

Summary of this inspection

Patients could access their chosen place of worship with staff support if needed. Staffs' work shifts were often adapted to meet the needs of those patients who preferred to capitalise on their higher energy and motivation levels in the early evening.
- Staff acknowledged that some patients benefitted from easy read information and staff made this available if required.

Are services well-led?

Requires improvement

We rated 'well-led' as requires improvement for Richmond House because :

- Management was aware of the breach of single sex regulations.They had put plans in place to rectify the situation, however it was doubtful if these plans were always being followed.
- Management had not appeared to give due attention to the potential for harm to patients' from ligature risks in bathrooms and bedrooms. Neither had management given consideration to managing the risk to staff and patients' from blind spots on all floors of the building.
- Management had not taken into consideration the lessons learned from an incident occurring in one of their other locations to Richmond House.

However:

- The manager explained that staff worked hard to maintain the homely feel of the unit, and were committed to positive risk taking and recovery-focussed interventions. Staff knew about and agreed with the organisation vision and values. Policies met best practice guidance.
- Staff told us that senior managers were approachable and they were able to raise concerns without fear of victimisation. Staff told us they were unaware of any bullying or harassment cases. Staff morale was good and many staff had been with the provider for several years. One carer we spoke to talked positively about the leadership at Richmond House.
- Clinical audits were regularly undertaken, and while there were processes in place to share the learning within Richmond House, this did not extend to the wider providers services.
- There was a commitment from senior managers to support staff with achieving the highest level of qualification for their grade.

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.

Richmond House had been subject to two Mental Health Act (MHA) review visits in October 2014 and November 2015. The findings from these visits showed that Richmond House had been following MHA policy and guidance.

At our inspection we found evidence that:

- All nursing staff had received MHA training. Staff understood the MHA, the revised code of practice and the guiding principles.
- Staff completed capacity and consent to treatment requirements and reviewed these regularly. Patients told us their doctor or nurse talked to them about their medication and explained the effects and side effects of their medication before they consented to treatment.
- Staff explained patients' rights on admission and repeated at patient reviews. Information given to patients included their legal status, right of appeal, the roles of CQC and independent mental health advocate (IMHA). Most of the patients we spoke with were clear about their legal status and rights. Those who were not clear about their rights knew that they could ask their named key worker.
- Medical staff reviewed patient leave weekly. Standardised leave forms, which included conditions and escort arrangements, were completed and stored in patient records for staff reference.
- Staff told us they knew where to get MHA advice if required. .
- Section papers were stored safely and made available when required.
- All the documents we looked at were complete and appeared to be in good order. Ministry of Justice (MoJ) authorisations for transfers in to the hospital were on the relevant files.
- Patients had access to independent advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Data for the period from 17 May 2015 to 17 November 2015 showed that Richmond House had no incidents of seclusion, segregation, or Deprivation of Liberty and Safeguarding (DoLS) applications.
- Data submitted following our inspection showed that seven out of eleven eligible staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) training. Four staff had MCA training booked.
- Staff we spoke to had a reasonable understanding of the MCA and DoLs, and their responsibilities under the Act. Consent to treatment and capacity assessments were completed.
- We found evidence of two capacity assessments and one best interest meeting having taken place. Staff told us that capacity assessments and best interest meetings were on an individual and needs led basis.
- We observed how staff encouraged patients to make their own decisions as far as possible. Staff knew how to access further advice if needed.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Good	Good	Good	Requires improvement	Requires improvement
Overall	Inadequate	Good	Good	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Inadequate

Safe and clean environment

- There were multiple ligature points (things to which patients intent on self-injury might tie something to harm themselves) throughout the hospital. The provider had an environmental risk plan and a current ligature risk audit. However, there were no further plans to remove or mitigate the risk of serious incidents. Staff told us they relied on previous knowledge of their patients. However, as the service had accepted patients outside of the Partnerships in Care (PiC) service pathway, we were not assured that this form of mitigation was adequate given the unpredictable nature of the patient's mental health conditions.
- There were multiple blind spots around the unit and on all floors, which were not risk managed. This put staff and patients at risk of harm.
- Richmond House had no recorded incidents of seclusion. Staff had received mandatory training in the use of safe physical restraint and they told us that when it was necessary to restrain patients they used safe holds. Staff told us that rapid tranquilisation was rarely used and they never used prone restraint.
- There were no nurse call systems in any bedrooms or bathrooms. Given the layout of the building over three floors and that bedroom or bathroom doors may be closed, patients' shouts would not necessarily be heard and they would not be able to summon help in an emergency.
- The clinic room was clean and tidy and emergency resuscitation equipment was present and well maintained, however, at 27 degrees the room was too hot. This was discussed with the staff who confirmed that they did record the temperature, usually in the morning when it was cooler. We bought this to the attention of staff and were advised that they would explore how the room could be kept cooler throughout the daytime. However, the high temperature of the room had not affected the temperature of the fridge.
- There was a breach of the Mental Health Act code of practice and Department of Health guidance regarding single sex accommodation. There was no female only lounge and a male bedroom was located on the same floor as the female sleeping accommodation and next to the female toilet and bathroom. We observed how females would have to pass the male occupied room to access the bathroom. The manager advised us that this was a temporary arrangement and she explained their plans for the unit to become a female only unit in the near future. However, we noted that a recently reported serious incident had involved an alleged sexual assault by a male on a female patient. This gave us further cause for concern about the potential delay on the provider's behalf in rectifying this situation. Furthermore, during the inspection, we observed a male patient coming out of the female bathroom having used it for his shower. We advised the nurse in charge and she immediately went to speak to the patient. We were concerned that this might not be the first time this situation had occurred.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Communal areas were clean, well maintained, and comfortably furnished. Cleaning records were up to date. Staff were up to date with infection control training.

Safe staffing

- The established level of staffing Monday to Sunday daytime was one qualified nurse and three healthcare workers. Then one qualified nurse and one healthcare worker in the evenings. However, the manager confirmed that staffing at weekends could drop to three staff in the case of unplanned absence, or lower patient occupancy. While staff and patients told us there were usually only three staff on duty at weekends. This meant that staffing levels may not be adequate at weekends or evenings should three or more person physical interventions be required, while maintaining other patient's safety. During the period from May 2015 to November 2015, data provided by Richmond House showed that there had been 35 incidents of patients needing restraint.
- Guidelines state that restraint procedures usually require three staff members to attend with a further staff member ensuring the safety of the remaining patients. Due to low levels of staffing particularly at evenings and weekends, we did not consider the service had sufficient staff on duty at these times to safely manage situations requiring physical interventions, or other emergencies. The manager told us that if the nurse in charge felt more staff were needed, they could either contact the on call manager or bring in staff from neighbouring units, between four and eleven miles away. This was considered to be too far away to mitigate the risk.
- The provider has four (WTE) qualified nurse vacancies. New staff had completed pre-employment checks. The provider was actively recruiting to improve staffing levels.
- There was doctor on site once weekly with additional drop in clinics as required. Staff had access to the on call doctor at all other times.
- The service employed appropriately trained staff and covered vacancies by using regular bank or agency staff. All new, bank and agency staff had completed induction training.
- Staff knew whom to contact for medical advice out of hours and emergency procedures.
- Most staff were up to date with mandatory training and those who were not had training dates booked. This included safeguarding of children and vulnerable adults, equality and diversity and first aid training.

Assessing and managing risk to patients and staff

- Staff did not use personal alarms while on the unit and there would be times when staff would be out of hearing range of other colleagues, particularly as the nursing office was located in the former cellar of the building. Staff told us that following discussion in a team meeting they did not think personal alarms were required. However, as the service was now accepting patients outside of the Partnerships in Care service pathway, we were not assured that this form of mitigation was adequate given the unpredictable nature of the patient's mental health conditions.
- Staff had reviewed most risk assessments. However, there were two occasions when staff had not updated the records following two incidents of patients bringing lighters and cigarettes onto the unit after periods of unescorted leave.
- Staff knew what constituted abuse, and how to report safeguarding concerns.
- Medications were stored securely, and records showed daily checking of the fridge temperature, which was correct. There were no controlled drugs. A pharmacist visited monthly to check medications.

Track record on safety

- Data for the period from January 2014 to May 2015 showed that the manager had dealt with and closed eight safeguarding concerns.
- The most recent concern related to the alleged sexual abuse of a patient by another patient. The provider had implemented an action plan following this incident, to minimise the likelihood of this happening again.
- Systems were in place to monitor any risks to patient safety. We found examples of changes made in response to previous safety concerns.

Reporting incidents and learning from when things go wrong

- Staff made us aware that following a serious incident at another similar site to Richmond House, central management had taken a decision not to admit patients

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

to that long stay / rehabilitation unit from outside of the PiC mental health pathway. The manager was not sure why this decision had not been extended to include Richmond House.
- Records showed that staff reported and recorded incidents.
- Staff used team meetings and clinical handovers to share learning. Staff told us that these opportunities were helpful to ensure a consistent approach towards incident management.
- Specific de-brief sessions were offered by the psychologist to staff and patients where required.

Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Care records showed comprehensive risk assessments had taken place and that these included physical health care needs.
- Care plans were detailed and thorough and included the patient's views.
- Care and treatment records were in electronic format.
- Physical health care plans were current and in place for each patient

Best practice in treatment and care

- Patients were registered with the local GP practice and staff gave them support to attend appointments. They had access to opticians, dentists, and podiatrists as needed.
- Patients were encouraged to complete their "My Shared Pathway" documents and discuss this as part of their one to one nurse sessions. All patients received a Recovery folder to keep their care plans and other recovery focussed documentation in. All patients received an information file on arrival at the unit.
- Staff to monitor Section 17 leave used outcome measures including Health of the Nation Outcome Scales for learning Disability, and the partnerships in care dashboard and Mental Health Act reviews.
- Staff worked with patients to enable them acquire life skills and achieve personal goals. They used practice as recommended by National Institute for care Excellence guidelines.
- Patients were encouraged to contribute to their weekly activity schedule. These were discussed in daily handover meetings and staff allocated appropriately throughout the shift.
- Therapy programs' and support plans were personalised and reflected the patient's unique needs and challenges.

Skilled staff to deliver care

- Most new healthcare workers had a care certificate and all staff either had completed, or were in the process of completing either their British Institute of Learning Disability care certificate or a diploma in health care.
- Staff told us that they were encouraged to undertake additional role specific training where appropriate.
- Managers and senior staff were available via an on call rota to provide additional support to staff.

Multi-disciplinary and inter-agency team work

- The team consisted of nurses, doctors, occupational therapist, psychologist, social worker, and healthcare workers.
- All staff worked together to provide care and treatment for patients. Staff received comprehensive handovers to keep up to date with patients' physical and mental health care needs.
- Staff worked closely with external agencies and existing care co-ordinators to identify suitable accommodation, employment, and voluntary opportunities for patients. Staff and patients had good relationships with local services including, medical centres, social groups, leisure centre, shops, and cafes.

Adherence to the MHA and the MHA Code of Practice

- All nursing staff had received Mental Health Act 1983 (MHA) training. Staff understood the MHA, the code of practice and the guiding principles.
- Patients told us their doctor or nurse talked to them about their medication and explained the effects and side effects of their medication before they consented to treatment.
- Staff explained patients' rights on admission, and this information repeated at patients' reviews. Information given to patients included their legal status, right of

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

appeal, the roles of CQC and independent mental health advocate (IMHA). Most of the patients we spoke with were clear about their legal status and rights. Those who were not clear about their rights knew that they could ask their named key worker.

- Medical staff reviewed patient leave weekly. Standardised leave forms, which included conditions and escort arrangements, were completed and stored in patient records for staff reference. Four patients told us that they had copies of their leave forms.
- Staff told us they knew where to get MHA advice if required.
- Section papers were kept safely and available when required.
- All the documents we looked at were complete and appeared to be in good order. Ministry of Justice (MoJ) authorisations for transfers in to the hospital were on the relevant files.
- Patients had access to advocacy services.

Good practice in applying the Mental Capacity Act

- Data for the period from 17 May 2015 to 17 November 2015 showed Richmond House had no incidents of seclusion, segregation, or Deprivation of Liberty and Safeguarding (DoLS) applications.
- Data submitted following our inspection showed that seven out of eleven eligible staff had completed Mental Capacity Act (MCA) and DoLS training.
- Staff we spoke to had a reasonable understanding of the MCA and DoLS, and their responsibilities under the Act. Staff knew how to access further advice if needed.
- We found evidence of two capacity assessments and one best interest meeting having taken place. Staff told us capacity assessments and best interest meetings were on an individual and needs led basis. Staff completed capacity and consent to treatment requirements and reviewed these regularly.
- We observed how staff encouraged patients to make their own decisions as far as possible.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

- Staff undertaking 1:1 and 2:1 patient observations did so in a caring manner. They showed a good understanding of the individual care and treatment needs of patients.
- Staff addressed patients in their preferred way and were polite at all times.
- Staff we spoke to demonstrated a commitment to providing high quality care and treatment within the least restrictive practices.
- Front line staff ate with patients and provided additional support at meal times if required.
- Patients told us that staff were kind and understood them well.
- Carers told us that they had seen staff treating their relatives with kindness and respect.

The involvement of people in the care they receive

- Staff undertook pre–admission assessment visits and patients were encouraged to visit the service prior to admission.
- Consultations with two carers about care and treatment of their relatives had taken place.
- Patients were encouraged to be involved with their care plans. We saw signed and individualised care plans in all the patients' records we checked.
- Patients had weekly one to one meetings when they were encouraged and supported to formulate their individual weekly activity plans. There were weekly house meetings, when patients could feedback their views, make suggestions, and influence change about the unit.
- An independent advocacy service was available to patients.
- Two carers commented that communication between the hospital and themselves was good, and staff at Richmond House hospital had made special efforts to help their relatives maintain contact with family.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- The provider had clear arrangements in place for assessing new referrals. The provider planned all admissions. Family contact was encouraged where appropriate and families and other carers were involved in discharge planning. The average length of stay was two years.
- Robust arrangements were in place to manage discharges. All patients had discharge plans, this included an enhanced care programme approach and close working with care co-ordinators and patients' families where applicable, and carers were involved in discharge planning.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital was homely with quiet and private areas for patients to use. There was a pay phone, but all patients had access to their own personal mobile phone.
- Patients had input into the choice of food available. There was access to snacks and drinks throughout the day.
- Bedrooms were personalised by the patients and classed as private areas, meaning that anyone entering the room had to request permission from the patient. Patients had helped to decide upon the colour schemes in some rooms.
- The provider had a secure outside area for access to fresh air. Patients negotiated the times they wanted to smoke. The provider offered smoking cessation support.

Meeting the needs of all people who use the service

- A range of activities was available including walking groups, arts and crafts, and visits to leisure amenities such as bowling. Patients had opportunity to do unpaid community work.
- There was a games room including pool table available on site.
- Patients could access their chosen place of worship with staff support if needed.
- Staff acknowledged that even when required, patients did not always get easy read information.
- Leaflets and information were available about local services and activities, but again not always in easy read format.
- One patient told us that staff often cancelled some of their weekly activities. However, examination of the care records for the previous two weeks showed that staff had cancelled 14 activities out of a possible 32. Three due to low staffing levels, four had been rescheduled and seven declined by the patient. Examination of the records showed that for the same two-week period, and across all patients, 136 activities had been planned, however, 161 activities had actually taken place.
- Staffs' work shifts were often adapted to meet the needs of those patients who preferred to capitalise on their higher energy and motivation levels in the early evening.

Listening to and learning from concerns and complaints

- Data for the period from February 2014 to July 2015 showed that Richmond House had received three complaints. Staff had investigated all complaints and none had been upheld. There were robust systems in place for dealing with complaints. Staff shared feedback from complaints in handover and made changes where necessary.
- Information on how to make a complaint was available on notice boards. Staff understood how to support patients when they wanted to make a complaint.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Vision and values

- Staff knew about and agreed with the organisation vision and values. Daily handover meeting and written care plans demonstrated the use of these values in practice.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Staff told us that senior managers were approachable.

Good governance

- Management was aware of the breach of single sex regulations, and the recent incident of an alleged sexual assault by a male patient on a female patient, and while they had put in place plans to prevent similar allegations occurring again, given the occasions when staffing was lowered, and nurses were either carrying out other duties around the hospital or working in the basement office, we could not be sure that staff were always able to follow the safeguarding plan.
- Management had not appeared to give due attention to the potential for harm to patients' from ligature risks in bathrooms and bedrooms. Neither had management given consideration to managing the risk to staff and patients' from blind spots on all floors of the building.
- Staff shared learning from internal incidents in handover meetings. However, management appeared to have not taken into consideration the lessons learned from an incident occurring in one of their other locations. The manager told us she did not why the decision had not applied to Richmond House.
- Staff were encouraged to take part in clinical audit and clinical audits were regularly undertaken with the learning from the audits being shared with staff.
- The service used the PiC dashboard to monitor activity across the unit, including staff sickness and absence rates.
- Partnerships in Care policies and procedures followed good practice, however, given the above concerns Richmond House may not be following them closely enough.

Leadership, morale and staff engagement

- Supervision and appraisals were all up to date.
- All staff knew the senior management team and felt they were approachable. Staff felt that the senior management listened to their concerns and responded positively.
- Staff told us they were able to raise concerns without fear of victimisation.
- Staff told us they were unaware of any bullying or harassment cases.
- One carer we spoke to talked positively about the leadership at Richmond House.
- Staff morale was good and many staff had been with the provider for several years.
- The provider took all possible steps to meet the needs of staff in terms of flexible working, situational management, and staff welfare.

Commitment to quality improvement and innovation

- The manager explained that staff worked hard to maintain the homely feel of the unit, and were committed to positive risk taking and recovery-focussed interventions.
- There was a commitment from senior managers to support staff with achieving the highest level of qualification for their grade.
- Care and treatment plans demonstrated the involvement of the multidisciplinary team.
- Care and treatment plans were in depth and demonstrated that the patient was actively involved in the planning of their care and treatment.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the environment is safe and monitored. They must ensure that ligatures in the bedrooms and bathrooms are removed or replaced to reduce the risk. The provider must ensure that all blind spots on all floors are recorded and risk assessed.
- The provider must address the single sex guidance regarding accommodation on the female floor at Richmond House and identification of a female only lounge.
- The provider must ensure that staffing levels at all times are adequate to manage three or more person restraint procedures that may arise, or other emergencies.

Action the provider SHOULD take to improve

- The provider should consider installing nurse call alarms in bedrooms or bathrooms to enable patients and staff summon help in an emergency.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social care Act 2008 (Regulated Activities) Regulations 2014 **Safe care and treatment** There were multiple ligature points (things to which patients intent on self-injury might tie something to harm themselves), in the bathrooms and bedrooms.The provider had an environmental risk plan and a current ligature risk audit. However, there were no further plans to remove or mitigate the risk of serious incidents. There were multiple blind spots around the unit and on all floors, which were not risk managed. The service had breached the single sex accommodation at Richmond House; there was a male bedroom located on the same floor as the female sleeping accommodation and next to the female toilet and bathroom. There was no identified female only lounge area. This is a breach of regulation 12(2)(a)(b)

This section is primarily information for the provider

Requirement notices

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 Regulation 18 Health and Social care Act 2008 (Regulated Activities) Regulations 2014 **Staffing** There was insufficient staff on duty particularly at evenings and weekends to manage any full restraint procedures that may be required, or other emergencies. This is a breach of regulation 18(1)