Elysium Healthcare Limited

Arbury Court

Inspection report

Townfield Lane
Winwick
Warrington
WA2 8TR
Tel: 01925400600
www.elysiumhealthcare.co.uk

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**

Summary of findings

Overall summary

- The service provided safe care. Staff assessed and managed risk well. They minimised the use of restrictive practices and in the majority followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- The wards had enough nurses and doctors. Managers ensured that these staff received training, supervision and appraisal.
- Staff in the majority treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients in care decisions.

However

- The provider's policies did not outline all the safeguards required for patients who were segregated.
- The service had not implemented all the necessary safeguards for a minority of patients subject to restrictive interventions.
- Some patients and staff felt that the necessary balance between familiarity and professional boundaries was sometimes blurred.

What people who use the service say

- Patients gave mixed feedback about their experience of the service. Some patients felt very supported, that most staff were helpful, and that when restrictive interventions were used (such as restraint or seclusion) this was in the least restrictive way. Other patients were more critical of staff and did not agree with the care they received. Other patients gave a mixed view – they thought most staff were okay, but there were some who were less helpful. Some patients and staff described overfamiliarity and "banter" between some staff, and in some staff interactions with patients. This was not described as abuse, but that they did not like the attitude of some staff, and felt it was not appropriate and demonstrated a lack of professional boundaries.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Arbury Court

Arbury Court has 82 beds for women aged over 18 diagnosed with a mental illness or personality disorder. Some of the women have a learning disability in addition to a mental illness. All patients are detained under the Mental Health Act. Five of the wards provide forensic or secure services, and one ward is a psychiatric intensive care unit.

There are 44 low secure beds across three wards:

- Alderley - 15 beds
- Hartford - 14 beds
- Daresbury - 15 beds.

There are 27 medium secure beds across two wards:

- Delamere - 12 beds
- Oakmere - 15 beds.

There are 11 psychiatric intensive care beds on Primrose ward. Primrose ward has its own consultant psychiatrist, ward manager and nursing team, but is integrated within the rest of the service.

Patients are admitted from across the United Kingdom. Secure beds in England are commissioned by NHS England, and different authorities in Wales and Northern Ireland. Beds in the psychiatric intensive care unit are purchased on a case-by-case basis by individual NHS trusts and authorities.

Arbury Court is registered to provide the regulated activities: treatment of disease disorder or injury; assessment or medical treatment for persons detained under the Mental Health Act 1983; and diagnostic and screening procedures.

Arbury Court is provided by Elysium Healthcare Limited, and was registered with CQC in October 2016. Arbury Court has a registered manager.

Arbury Court has been inspected twice by the Care Quality Commission since this registration, and was rated as good on both occasions. Arbury Court was last inspected by the Care Quality Commission in July 2019. It was rated as good in all five domains: safe, effective, caring, responsive and well led; and there were no breaches of regulations.

We carried out this inspection following concerns being raised with CQC. During this unannounced inspection we focussed on two areas of the safe domain: staffing and restrictive practice.

How we carried out this inspection

Before the inspection visit we reviewed information that we held about the service.

During the inspection visit the inspection team:

- visited two wards, looked at the ward environment and observed how staff were caring for patients
- spoke with 16 patients
- spoke with two relatives of patients

Summary of this inspection

- spoke with the registered manager and other managers within the service
- spoke with 13 other staff
- spoke with two independent mental health advocates
- reviewed nine care records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

The onsite interviews with staff and patients, and the review of care records, was focused on two wards. However, discussions with managers and reviewing of documents covered all six wards.

You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

- The provider should ensure that their policies outline the safeguards required for all patients who are segregated.
- The service should ensure that the necessary safeguards are implemented for all patients subject to restrictive interventions.
- The provider should ensure its policies incorporate standards for the physical environment provided for all segregated patients, and how this will be monitored through governance at all levels of the organisation.
- The service should consider reviewing the culture on wards, to ensure that the potential positive and negatives aspects of familiarity are considered against the need for appropriate professional boundaries.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inspected but not rated	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Not inspected	Inspected but not rated

Inspected but not rated

Forensic inpatient or secure wards

Safe

Inspected but not rated

Are Forensic inpatient or secure wards safe?

Inspected but not rated

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. There were additional staffing challenges due to the COVID-19 pandemic in the community. However, no shifts had unsafe staffing levels. The managers adjusted staffing levels daily to take account of case mix. The service used bank and agency staff who were familiar with the hospital as much as possible.
- Staff had received and were up to date with appropriate mandatory training. The availability of training sessions had reduced due to COVID-19 restrictions, but this had since improved. Management of violence and aggression training was at 72% (this includes annual refresher training), but regular training sessions had restarted.
- Staff received supervision and appraisal.
- Staff assessed and managed risks to patients and themselves well and achieved the right balance between maintaining safety and providing the least restrictive environment possible to facilitate patients' recovery. Staff had the skills required to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed.
- The service had a comprehensive process to monitor the use of all restrictive interventions. Staff did a risk assessment of every patient prior to and on admission and updated it regularly, including after any incident. Staff used a recognised risk assessment tool. Patients at Arbury Court could be at risk of harming themselves or other people. The care and risk management plans were detailed about when and how restrictive interventions should be used, and these were routinely reviewed by the multidisciplinary team. This information was shared with each patient's external keyworker and/or commissioner of their care.
- Seclusion rooms allowed clear observation and two-way communication, and had toilet facilities and a clock. Some patients were in long term segregation. Each patient in long term segregation had an individual plan relating to when they had access to activities and other areas of the ward, including the lounge and outside space, although segregation was mostly in their bedroom with staff support. Patients were individually risk assessed and reviewed regularly and we saw that these restrictions were reduced or increased in response to the patient's mental state and behaviour.
- Most patients in seclusion and long-term segregation had regular reviews in accordance with the Mental Health Act code of practice to ensure that they were appropriately safeguarded and their rights were upheld. Not all patients who were restricted to their rooms had all the safeguards in place, although their care and risk plans were regularly reviewed. The provider took action to address this following the inspection.
- 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.
- Patients knew how to raise concerns. Some patients told us they would speak with staff or the complaints person. Most patients had spoken with an advocate, however, not all knew how to contact them directly. Patients could raise issues about the service through the weekly community meetings on each of the wards, and a monthly patients' council meeting with a patient representative. The latter had taken place during the COVID-19 outbreak but in a more restricted way. Issues raised were often about environmental issues or activities, and we saw that feedback was responded to and actioned, although this could take time (for example, if significant funding were needed).
- Some patients and staff described overfamiliarity and "banter" between some staff, and in some staff interactions with patients. This was not described as abuse, but that they did not like the attitude of some staff, and felt it was not

appropriate and demonstrated a lack of professional boundaries. Patients told us about specific incidents they had raised concerns about, and we saw that these had been addressed. Where potential abuse had been alleged/ occurred, this had been investigated and responded to including by contacting the local authority safeguarding team and/or the police.