The Chimneys Limited

The Chimneys Clinic

Inspection report

Rougham
Bury St Edmunds
IP30 9LR
Tel: 01284220210
www.elysiumhealthcare.co.uk

Date of inspection visit: 8 - 17 March 2022
Date of publication: 18/05/2022

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	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The Chimneys Clinic is a 12-bedded rehabilitation unit for adult women with a personality disorder and disordered eating or high functioning autistic spectrum disorder.

This was the first inspection of this service. We rated it as requires improvement because:

- The service had completed a fire risk assessment in March 2021 that identified significant actions required to meet fire safety standards. However, these actions had not been completed.
- The service had completed an environmental risk assessment but had not identified that the clinic room door was not secure enough to prevent patients accessing the clinic room.
- The clinic room was visibly dirty.
- Staff had not completed checks to ensure equipment in the emergency bag was working and equipment had been moved from the clinic room.
- Managers had not completed clinical audits.
- Staffing levels on the ward were safe. However the provider had not considered the gender mix of staff to ensure that female staff were allocated to observations. This is particularly important for patients who have experienced trauma and/or express a preference to be supported by female staff.
- There were not enough specialist staff in place. There was no occupational therapist in post, no locum cover for the psychologist post and the therapist posts were part time.
- Supervision and appraisal levels were low but improving. The provider was implementing a plan to improve this.
- Staff could not be released from the ward to attend specialist training and reflective practice sessions.
- Patients could not access drinks without staff providing them.
- Patients could not lock their bedroom doors and did not have safe storage facilities in their bedrooms. Staff stored patients' valuable possessions in a safe in the nursing office. however, patients had possessions go missing from both their bedrooms and the safe.
- Provider governance systems had not identified the risks we found on inspection and where risks had been identified action had not been taken to reduce these.

However:

- Staff regularly reviewed the effects of medications on each patient's physical health.
- Staff followed national guidance about 'Stopping over medication of people with a learning disability or autism' and had successfully reduced medicines for some patients.
- Staff assessed and managed clinical risks to patients and themselves. Staff completed thorough assessments of patient risks and updated these regularly.
- 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 assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed.
- 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.
- Patients told us that they were involved in their treatment and were kept informed about changes in their medication and care.

Summary of findings

- Staff supported patients to maintain relationships with family and friends, and the integrated therapist worked with family members and patients to improve their relationships.

A warning notice was served to the provider due to their failure to ensure the safety of their premises and the equipment within it. The provider had identified several failures of fire regulations in March 2021 and had not acted to rectify this. This put patients, staff and visitors at risk.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to The Chimneys Clinic

The Chimneys Clinic is a 12-bedded rehabilitation unit for adult women with a personality disorder and disordered eating or high functioning autistic spectrum disorder. The service was in the process of moving to a personality disorder with learning disability and autism treatment pathway at the time of inspection and a new operational policy was being drafted in line with psychologically informed environment model of care. However, patients were already being admitted using this criteria before the operational policy was ratified and implemented.

The Chimneys Clinic has been registered with the Care Quality Commission under its current owner since 14 March 2018 for:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury

The service had a registered manager who commenced in post since 17th February 2022, replacing the previous Registered Manager.

This was the first inspection undertaken of the service.

How we carried out this inspection

The team that inspected the service comprised of one CQC inspection manager, two CQC inspectors, one CQC Mental Health Act Reviewer and an Expert by Experience.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with three family members of patients;
- spoke with the registered manager and regional services director;
- spoke with eight other staff members; including doctors, nurses, psychologist, therapist and healthcare support workers;
- spoke with an independent advocate;
- reviewed four care and treatment records of patients;
- reviewed five patients Mental Health Act detention paperwork;
- carried out a specific check of the medication management; and
- reviewed 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.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that they comply with fire safety standards. (Regulation 12)
- The service must ensure that all areas of the hospital including the clinic room are clean. (Regulation 12)
- The service must ensure that equipment is checked and calibrated regularly. (Regulation 12)
- The service must ensure that mandatory training in meets the provider compliance target. (Regulation 12)
- The service must ensure that patients have access to drinks without requiring staff assistance. (Regulation 9)
- The service must ensure patients have safe storage for possessions. (Regulation 10)
- The service must ensure that they have sufficient numbers of specialist staff to deliver therapeutic activity and meet the needs of patients. (Regulation 18)
- The service must ensure they complete clinical audits. (Regulation 17)
- The service must ensure that all staff receive regular supervision, appraisal and specialist training (regulation 18)

Action the service SHOULD take to improve:

- The service should ensure that the gender mix of staff on shift allows for female staff to complete observations.
- The service should ensure that patient views are recorded in care plans.
- The service should ensure all staff knew who the identified safeguarding lead was.
- The service should ensure that all identified staff complete the Level 3 Safeguarding training.
- The service should ensure that staff provide updated information when a patients' detention is renewed.

Our findings

Overview of ratings

Our ratings for this location are:

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Inadequate

We rated safe as inadequate.

We issued a warning notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were not complying with the requirements of Regulation 12: Safe Care and Treatment. The warning notice we served has limited the rating in safe to inadequate.

Safe and clean care environments

The ward was safe, clean, well equipped, well furnished, well maintained and fit for purpose, however identified risks had not been removed.

Safety of the ward layout

Staff had not completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Staff had completed a risk assessment of the environment but had not identified that the door to the clinic room was not secure enough to prevent a patient accessing the room. This was raised with the provider at the time of inspection and an action plan to replace the door was put in place.

The service had completed a fire risk assessment in March 2021 that had identified areas where significant action was required, including; the fire doors within the building not meeting fire safety regulation standards, combustibles in bedrooms, a lack of emergency lighting in some rooms, lack of signage for fire exits, and fire drills not taking place regularly but no action had been taken to address this.

This was raised with the provider and a new fire risk assessment was completed following the inspection with an action plan to reduce the risks and undertake the work required. However, we had serious concerns that actions identified as part of the risk assessment had not taken place for a year and patient safety in the event of a fire could not be guaranteed until all work had been completed.

Staff could observe patients in all parts of the wards. The provider had fitted mirrors and closed-circuit television to monitor blind spots in communal areas on the ward.

The ward complied with guidance and there was no mixed sex accommodation. The ward was female only.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The provider had completed a risk assessment of all potential ligature anchor points and taken action to remove these where possible.

Staff had easy access to alarms and patients had easy access to nurse call systems. Patient rooms had call bells to raise assistance if needed.

Maintenance, cleanliness and infection control

Ward areas were mainly clean, well maintained, well-furnished and fit for purpose. However, the clinic room was visibly dirty despite records showing it had been cleaned that day. The housekeeping staff could not access the medicines fridge, and this was also dirty inside. There was no process in place to ensure areas that only specific staff could access were regularly cleaned. Managers did not complete checks to ensure cleanliness of the service.

Staff made sure cleaning records were up-to-date and the premises were clean, apart from the clinic room. The service employed housekeeping staff

Staff followed infection control policy, including COVID-19 guidance and handwashing. Masks and hand gel were available at the ward entrance and staff followed personal protective equipment guidelines.

Clinic room and equipment

Clinic rooms were equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, staff had moved the level three personal protective equipment bag from the clinic room where it should be stored with the emergency resuscitation bag, to the nurses office. As not all staff may be aware of this, it could cause a delay with appropriate responses to an emergency.

Staff had not checked, maintained, and cleaned equipment. Staff had not checked equipment was in working order as several items in the emergency bag including the blood glucose meter and thermometer did not have working batteries and there were several blood pressure monitors that weren't working. The weighing scales had also been removed from the room and not returned.

The clinic room was based outside the main ward and so its location meant that staff had to leave the ward to collect and return items and to bring medication in to dispense to patients.

Safe staffing

The service had enough nursing and medical staff, who knew the patients but had not received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. We reviewed staffing rotas for the six weeks prior to inspection and saw that shifts were covered by the required number of staff. This was also evident during the inspection.

The service had reducing vacancy rates. The service was actively recruiting to vacant posts and had taken steps such as increasing healthcare workers' salaries to encourage additional applications. The service had recently employed two additional nurses and six healthcare workers who were being inducted into the service.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had reducing rates of bank and agency nurses due to the recruitment of two new nurses, however there were still six vacant posts. The service had reducing rates of bank and agency nursing assistants, however there were still vacancies that were covered by agency staff.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service had long term contracts with the agency to provide continuity for patients.

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

Managers supported staff who needed time off for ill health.

Levels of sickness were low, however there had been three outbreaks of COVID-19 among staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. However, whilst the gender mix of staff was more female staff during day shifts night shifts tended to have equal mix or higher number of male staff. Patients told us that they were uncomfortable having male staff complete their observations.

Managers could adjust staffing levels according to the needs of the patients. Managers could increase numbers of staff when patient observation levels increased.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled. Staff and patients told us that leave cancellations were a last resort and the activities co-ordinator and assistant psychologist would act as additional escorting staff when required.

We were not assured the service had enough trained staff on each shift to carry out any physical interventions safely. We found 50% of staff were not up to date with physical intervention training.

Staff shared key information to keep patients safe when handing over their care to others. Staff completed handover meetings between each shift to discuss patient care and risk.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. The service employed a consultant and an associate specialist doctor. The consultant provided an on-call cover for out of hours emergencies, along with a consultant from another service.

Managers could call locums when they needed additional medical cover. A consultant from another provider site was also available to help if needed.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Training compliance was at 76% overall. Five courses had compliance below the provider target with Management of Violence and Aggression at 41%, Conflict Resolution at 43%, Breakaway at 43%, Security at 69%, and Safeguarding Adults level 3 at 66%. Face to face training had been paused during the COVID-19 lockdowns at the service to reduce transmission and the service had booked additional training sessions to bring the compliance with these sessions up to date.

The mandatory training programme was comprehensive and met the needs of patients and staff. Training included basic and immediate life support, infection control and professional boundaries for working with people with a learning disability and/or autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. The provider used an e-learning system that sent reminders via email to any staff who were out of date with training. However, training compliance was 76% so further work remained to be fully compliant.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff 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 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 a recognised tool, and reviewed this regularly, including after any incident. We reviewed four risk assessments and saw that staff had completed thorough risk assessments for each patient on admission and updated them regularly including after an incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We reviewed four risk assessments and saw that they were individualised and comprehensive.

Staff identified and responded to any changes in risks to, or posed by, patients. Staff reviewed risk assessments including observation levels regularly and after any incident.

Staff followed procedures to minimise risks where they could not easily observe patients. Access to high risk areas such as the garden and kitchen were individually risk assessed and patients escorted by staff where risks were indicated.

Staff followed provider 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. The service had recorded 148 incidents of restraint in the six months prior to the inspection, with the majority being low level, guiding hand interventions.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The provider was an accredited trainer under the terms of the Restraint Reduction Network certification scheme.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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. The provider had a policy on 'The safe and therapeutic management of violence and aggression' that set out the expectation for staff of how to de-escalate potential incidents and how to support patients if restraint was used.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation. We reviewed five incidents involving rapid tranquilisation and saw that guidance was followed and the incident was recorded fully.

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 on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training. Training for levels 1 and 2 safeguarding were at 100% completion with level 3 safeguarding at 66% with refresher training booked in for all staff.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff made a referral to the independent advocate to support the patient when a safeguarding referral was made.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Not all staff knew who the safeguarding lead was within the service but staff knew the process of how to raise a concern on the ward.

Managers took part in serious case reviews and made changes based on the outcomes. The hospital director liaised with the Local Authority Safeguarding Team about any serious case reviews and ongoing safeguarding investigations.

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.

Patient notes were comprehensive and all staff could access them easily. The provider used an electronic patient record system that was easy to use and accessible for all staff and we saw that records were updated in a timely manner.

Records were stored securely.

Medicines management

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

Staff followed systems and processes to prescribe and administer medicines safely. The service used stock medicines rather than individually labelled medicine and had sufficient amounts of medicine in stock.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

We reviewed seven patient medicines charts and saw that prescribed medicines were administered safely, however there were unexplained gaps in administration of homely remedies such as multivitamins.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The consultant psychiatrist reviewed patient medicines during their monthly review meetings.

Staff completed medicines records accurately and kept them up-to-date. The provider used an independent pharmacy to audit medicines which had picked up some errors which were then logged on a live system, however staff did not always record actions and outcomes following errors.

Staff stored and managed all medicines and prescribing documents safely.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff followed national guidance about 'Stopping over medication of people with a learning disability or autism' and had successfully reduced medicines for some patients.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

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 knew what incidents to report and how to report them. The service used an electronic incident reporting system and we saw that staff reported incidents appropriately. The service had reported 475 incidents in the six months prior to inspection.

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

The service had no never events in the 12 months prior to the inspection.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw an example of when staff had sent a duty of candour letter following a medicine error.

Managers debriefed and supported staff after any serious incident. The provider policy on managing incidents included a debrief after any incident, however some staff told us that there was not always time for a full debrief but that they did receive support from senior staff on site.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We saw examples of where serious incidents had been investigated by managers both within the service and external managers when required.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff received feedback from investigation of incidents, both internal and external to the service. Managers provided feedback via email and in team meeting about incidents across provider services where lessons were learnt. These were also displayed in staff areas as a lessons learned bulletin.

There was evidence that changes had been made as a result of feedback. Staff had made changes to the gate in the courtyard following a serious incident where a patient absconded from the service.

Managers shared learning with their staff about never events that happened elsewhere. We saw an example of learning shared from another site where a patient had seriously harmed themselves.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Requires Improvement

We rated effective as requires improvement.

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 mental health assessment of each patient either on admission or soon after. We reviewed four patient records and saw that a full assessment was completed prior to admission and this was reviewed on admission.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Patient records showed that physical health was assessed on admission or the day after admission. This included blood tests and electrocardiogram tests.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff developed care plans that included building patient skills, staying well and moving on.

Staff regularly reviewed and updated care plans when patients' needs changed. We reviewed four patient records and saw that staff updated care plans regularly.

Care plans were personalised, holistic and recovery-orientated. Staff included patients' skills and plans for moving on from the service.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged 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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff provided a range of care and treatment suitable for the patients in the service. The service operated to a psychologically informed model of care in line with best practice and national guidance. The service was in the process of changing its treatment pathway to accommodate patients with learning disability and autism and had booked staff in for training in positive behaviour support. However, the service had begun to make these changes prior to the operational policy being agreed.

Staff identified patients' physical health needs and recorded them in their care plans.

Staff made sure patients had access to physical health care, including specialists as required. The service employed a physical health co-ordinator to manage physical health monitoring and patients were registered with a local GP surgery and dentist.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration. The service employed a dietician one day per week who worked with patients to encourage healthy eating and contributed to meal planning. The service had implemented a restricted eating plan for patients with obesity who did not have the capacity to make choices regarding food intake. There were no patients at the hospital who required assisted feeding at the time of inspection and the service did not plan to accept patients with disordered eating in the future.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The dietician gave advice to patients on healthy living and encouraged them to participate in exercise such as gym and swimming.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. The service used Health of the Nation Outcome Scales and an occupational therapy outcome scale.

Staff did not take part in regular clinical audits, benchmarking and quality improvement initiatives. The service had completed a closed cultures self-assessment audit and a blanket restrictions audit but had not completed any other clinical audits in the six months prior to inspection. An audit inspection schedule was in place for future audits. The closed culture audit had identified a low risk of closed culture at the service.

Skilled staff to deliver care

The ward team did not have access to the full range of specialists required to meet the needs of patients on the ward. They did not support staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service did not have access to a full range of specialists to meet the needs of the patients on the ward. The occupational therapist post had been vacant for over three months, although the service was proactively recruiting. The service employed a part time psychologist and full time assistant psychologist however the psychologist was about to go on maternity leave and there was no cover arrangements for the post. The service employed a part time systemic therapist and part time integrated therapist, part time dietician and a full time activities co-ordinator. However, the specialist provision was not sufficient for staff to work with all of the patients and was prioritised dependant on need.

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Managers gave each new member of staff a full induction to the service before they started work. The service delivered a two week induction process including shadowing opportunity on the ward. Staff told us that they did not feel the induction training was sufficient as it consisted of online training and did not prepare them for working with the patient group in a therapeutic way.

Managers had not supported staff through regular, constructive appraisals of their work with 43% of staff having an up to date appraisal completed.

Managers had not supported non-medical staff through regular, constructive clinical supervision of their work with an average of 51% of staff receiving supervision between November 2021 and January 2022 although this had increased to 78% in February 2022.

Managers made sure staff attended regular team meetings or gave information from 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. The service gave healthcare support workers the opportunity to complete nurse and associate nurse training and paid them full time whilst completing their training.

Managers did not make sure staff received any specialist training for their role. The therapy team had written training packages to deliver to ward staff as part of reflective practice meetings, however staff were unable to get away from the ward to attend. However, the service had recently provided training on autism and positive behaviour support for two staff members to deliver to the rest of the staff team.

Multi-disciplinary and interagency team work

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. They had effective working relationships with staff from services providing care following a patient's discharge.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service held monthly care review meetings and weekly medical review meetings.

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

Ward teams had effective working relationships with external teams and organisations. Managers held meetings with the Local Authority safeguarding team to review referrals, and commissioners to review patient care.

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 that 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 with Mental Health Act training was 100%.

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The Mental Health Act administrator was based at the service one day per week and was available for staff to contact throughout the week for support.

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. Staff displayed details of how to access the independent advocate and referred patients after any safeguarding incident.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, however staff did not always provide updated information when patients' detention was renewed.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. We saw that staff followed processes around section 17 leave appropriately.

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.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The Mental Health Act administrator had systems and audits in place and we saw where improvements had been made as a result of audit.

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 kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Compliance with Mental Capacity Act training was 71% and staff we spoke with had a clear understanding of the Act and its principles.

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.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. We reviewed five patient records and saw good examples of capacity assessments in regard to specific decision making.

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 and acted when they needed to make changes to improve.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Good

We rated caring as 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.

Staff were discreet, respectful, and responsive when caring for patients. We observed staff interactions with patients that were kind and supportive.

Staff gave patients help, emotional support and advice when they needed it. Patients told us that generally staff were helpful when they needed support.

Staff supported patients to understand and manage their own care, treatment or condition. Patients told us that they had been supported to manage their care and could see improvement in their wellbeing.

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

Patients said staff treated them well and behaved kindly. We spoke with four patients who told us that they generally got on well with staff and staff treated them well. However, patients told us that having agency staff who didn't know them wasn't helpful. Some patients also told us that having male staff on their observations was uncomfortable for them.

Staff understood and respected the individual needs of each patient. Staff provided individualised activities for patients dependent on their needs and preferences.

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

Staff followed policy to keep patient information confidential.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

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

Staff introduced patients to the ward and the services as part of their admission. Staff gave patients a tour of the ward on admission. The service had a welcome booklet with information however this was out of date and so was not used at the time of inspection and patients told us they had not been provided with an information booklet.

Staff involved patients and gave them access to their care planning and risk assessments. Patients told us that they were involved in their care plans and risk assessments and that the doctors and nurses discussed their care plans with them. Patients had signed their care plans and were offered copies, however staff did not record patient views in the care plans.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. Patients told us that they did understand their care and treatment and were given reasons for any changes in their care, such as changes to observations or leave access. The integrated therapist worked with patients who had communication difficulties.

Patients could give feedback on the service and their treatment and staff supported them to do this. The service held a weekly community meeting chaired by patients with the advocate present where patients could give feedback and discuss any concerns. Patients gave examples of changes they had suggested in community meetings that had been actioned, such as getting pets and visiting a local farm.

Staff made sure patients could access advocacy services. The service provided an independent advocate for seven hours per week and patients spoke positively about the support they had received from the advocate.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. We spoke with four patients' family members who told us that they were supported and involved in care but that communication could be improved. Two family members told us that they had previously received fortnightly update calls from staff but that these had ceased.

The systemic therapist contacted the family members of all patients on admission to offer support and at the time of the inspection was working with five families and patients to improve their relationships.

Staff helped families to give feedback on the service. The service sent out a carer audit annually and set an action plan as a result of feedback received.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Requires Improvement

We rated responsive as requires improvement.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Access and discharge

Staff planned and managed patient discharge well. They worked well with services providing aftercare and managed patients' move out of hospital. As a result, patients did not have to stay in hospital when they were well enough to leave.

Managers made sure bed occupancy did not go above 85%. The bed occupancy was 83% with 10 patients in treatment at the time of the inspection.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Staff agreed the expected length of stay for a patient on their admission.

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.

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

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. The service had one patient whose discharge was delayed while a placement was found and staff were proactive in trying to find a suitable placement.

Patients did not have to stay in hospital when they were well enough to leave.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well. Staff commenced discharge planning on admission and agreed an expected date of discharge.

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 but were unable to keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality, however patients did not have free access to hot or cold drinks. When clinically appropriate, staff supported patients to self-cater.

Each patient had their own bedroom, which they could personalise. All patients had a single bedroom with en-suite bathroom and patients could personalise their bedroom.

Patients did not have a secure place to store personal possessions. Patients did not have a key to their bedroom door due to the risk of self-harm using a key but the provider had not explored any other options for patients to be able to unlock their doors themselves, this meant patient bedrooms were often left unlocked during the day.

Staff provided a safe in the nurse's office for patients to store valuable possessions. However patients reported that items had gone missing from both the safe in the nurse's office and their own bedrooms.

Staff used a full range of rooms and equipment to support treatment and care. The service had a full range of rooms including large lounge area, therapy rooms and an assisted daily living kitchen for patients to cook whilst supervised by staff. The service were considering setting up a sensory room for patients.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

The service had quiet areas and a room where patients could meet with visitors in private. The service had a quiet lounge and a visitors room.

Patients could make phone calls in private. Patients could have their personal mobile phones subject to risk assessment and any patient not able to keep their mobile phone had access to the ward phone to make calls. However, three family members and two patients told us that they would like to have more telephone contact.

The service had an outside space that patients could access easily. The service had a large garden that patients could access with staff supervision.

Patients could not make their own hot drinks and snacks and were dependent on staff to provide them. Staff told us that there had been a cold water fountain in the dining area but that it had not been replaced after being damaged during an incident.

The service offered a variety of good quality food. Staff offered patients two choices for each meal. We saw patients involved in choosing what to cook for themselves in the assisted daily living skills kitchen.

Patients' engagement with the wider community

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

Staff helped patients to stay in contact with families and carers. The systemic therapist worked with patients and families to improve relationships, however three family members and two patients told us they would like more telephone contact.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

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. The service had ground floor bedrooms available for patients with reduced mobility, and the integrated therapist worked with patients who had communication needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. Staff displayed information on noticeboards on the ward and in the patient welcome booklet.

The service had 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. Staff could access an interpreter or signer if required.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The service could offer food to meet the needs of most patients including gluten free, vegetarian or vegan, however one patient told us that the dietician had given them a meal plan that could not be provided.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Patients had access to spiritual, religious and cultural support. Patients could access spiritual and religious services locally if required.

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.

Patients, relatives and carers knew how to complain or raise concerns. The service provided details of how to make a complaint in the patient and carer information booklets.

The service clearly displayed information about how to raise a concern in patient areas.

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

Managers investigated complaints and identified themes. The service had received three complaints in the previous six months. Two complaints were about COVID-19 outbreak lockdowns and one was about a staff member.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were allocated to an investigating officer and acknowledged promptly.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers shared lessons learnt with staff and we saw an example where this had happened following the patient complaint about staff response to distress.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Requires Improvement

We rated well-led as requires improvement.

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.

Local leaders at ward and directorate level had good knowledge and understanding of the service they managed and were visible on the ward for staff and patients. Staff told us that the hospital managers were approachable and supportive.

The hospital director had been in post since October 2021. The service had moved into a different regional management team and the new regional senior manager had visited the service regularly since then and was actively involved in governance meetings.

The provider had identified that there was a level of leadership missing at ward level and was in the process of starting recruitment for a ward manager who would have more day to day oversight of the ward including cleanliness of the clinic room, checks of equipment and audits.

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

Vision and strategy

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

Staff were aware of the provider values of 'Kindness, Integrity, Teamwork and Excellence' and demonstrated these values in their day to day work.

Culture

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

Staff told us that they felt supported and valued and generally had good levels of job satisfaction and morale. However, some staff told us they were not always able to attend training opportunities and reflective practice sessions as they couldn't leave the ward as this would mean staffing levels would not be safe.

Staff felt they could raise the above issues with managers but due to the staff vacancies nothing had been actioned and this was frustrating for them.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level but that performance and risk were generally managed well.

The provider governance systems had not identified the concerns we found during inspection around cleanliness of the clinic room, security of the clinic door, lack of audits and the outstanding actions arising from the fire assessment completed in March 2021.

The provider had not considered least restrictive practice when considering patient privacy to lock bedrooms, safe storage of possessions, and patient access to drinks.

Managers had been proactive in trying to recruit staff to reduce the number of vacancies including recruiting overseas nurses and increasing salaries for staff. However, the service had not considered the gender mix of staff when booking agency staff or taken into account patient views on this.

The service held a monthly clinical governance meeting that fed up into a regional clinical governance meeting and then into the provider's board governance meetings.

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.

The service had a risk register in place that identified the risks to the service, including fire risk, staffing and COVID-19 infections. The service did have plans in place to reduce the risks however most of the actions required from the fire risk assessment had not been completed in the past year.

Information management

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

Long stay or rehabilitation mental health wards for working age adults

Requires Improvement

All staff including agency staff had access to the electronic patient record system and there were sufficient numbers of computers and laptops for staff to complete records in a timely way.

Managers had access to information on service performance, staffing and patient care through the electronic dashboard system.

Staff made notifications to external bodies including the Care Quality Commission, Safeguarding team and Clinical Commissioning Groups.

Engagement

Managers sought feedback from patients in community meetings and through a comments box on the ward. Managers had used patient suggestions to make improvements to the service and patient wellbeing that included local trips out and the provision of pet guinea pigs that patients took care of.

The service issued an annual carers questionnaire to gain feedback from families and carers.

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 10 HSCA (RA) Regulations 2014 Dignity and respect The service did not provide patients with safe storage for possessions.

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 • The service did not comply with fire safety standards • The clinic room was visibly dirty • Staff had not completed checks to ensure equipment in the emergency bag was working or that equipment was stored in the clinic room. • Mandatory training sessions compliance did not meet the provider target

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients did not have access to drinks without staff assistance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	The service did not complete clinical audits

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 • The service did not ensure that they had sufficient numbers of specialist staff to deliver therapeutic activity and meet the needs of patients. • Staff did not receive regular supervision, appraisal and specialist training