Annesley House

Quality Report

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

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.

Overall summary

The service was rated as requires improvement overall in May 2017. It was not rated at this inspection.

The Care Quality Commission (CQC) carried out a follow up inspection of Annesley House on 17 July 2017 to ensure improvements were made following our inspection in May 2017. This followed CQC issuing a warning notice on 25 May 2017 to the provider requiring them to make sure patients received the required level of observation to maintain their safety and the safety of others.

We found the provider made the following improvements:

- Staff on Oxford ward completed patient observations in communal areas of the ward and documented patient observations on the provider's observation and engagement record form.
- The provider had implemented a new observation and engagement policy, delivered a training programme for all staff based on this new policy and completed an audit that reported into the provider's clinical governance processes.

Summary of findings

- We saw completed and up to date care plans, risk and physical health assessments.
- Documentation relating to the Mental Health Act 1983 was in order, however we observed a patient was not read their rights under section 132 Mental Health Act in a timely manner. This was rectified by the nurse in charge.

However

- We saw three staff members were not following the provider's observation and engagement policy as they had included information about the patients' mental state. One staff member did not record patient observations intermittently but recorded patient observations every 15 and 30 minutes.
- One care plan we saw did not focus on patient discharge although the patient had unescorted section 17 leave.

Summary of findings

Contents

Summary of this inspection

Page

Background to Annesley House 5

Our inspection team 5

Why we carried out this inspection 5

How we carried out this inspection 6

What people who use the service say 6

The five questions we ask about services and what we found 7

Detailed findings from this inspection

Mental Health Act responsibilities 8

Outstanding practice 11

Areas for improvement 11

Annesley House

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

Summary of this inspection

Background to Annesley House

Annesley House is an independent mental health hospital, which is part of the Priory Partnership in Care Group. The hospital is divided into three separate wards that aim to provide care, treatment and rehabilitation for up to 28 female patients with a primary diagnosis of mental illness and personality disorder.

Annesley House aims to provide a range of clinical therapies and individual treatment programmes for women detained under the Mental Health Act (1983). Annesley House is a single building divided into three wards; Durham ward is a nine bed low secure service, Cambridge ward has 11 beds and is an admission ward and Oxford ward has eight beds and is a locked rehabilitation service.

Annesley House was registered with CQC in 2010 to carry out the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- treatment of disease, disorder and injury.

The hospital had a hospital director in post who was in the process of obtaining registration with CQC. There had been seven inspections at Annesley House since registration with CQC; the last responsive inspection was on the 16 May 2017.

Our inspection team

Team leader: Sarah Bennett

The team that inspected the service comprised two CQC mental health hospital inspectors.

Why we carried out this inspection

At our previous inspection on 16 May 2017, we issued a warning notice to the provider as we identified a breach of Regulation 12 in relation to patient observations. At that inspection we rated Annesley House as requires improvement overall with safe as inadequate, effective and well–led as requires improvement. We did not look at caring and responsive so they remained as good from our inspection in August 2015.

During our focused inspection on 16 May 2017 we found the following issues:

- Staff did not observe patients on Oxford Ward as often as needed to make sure patients were safe.
- Staff did not consistently store medicines at safe temperatures and emergency equipment was not always in date.
- There were eight vacancies for registered nurses and agency staff were used to cover. The provider did not make sure that the estimated number and grades of staff worked on each ward on every shift.
- The provider did not offer psychological therapies to each patient to meet their assessed need.
- The provider did not offer specialist training to all staff to help them support patients.
- There had been two changes of managers within the last nine months, which had unsettled the hospital. There was no registered manager in post at the time of our inspection. An acting manager was in post.
- Audits did not always identify the risks to the health, safety and welfare of patients.

Following this inspection, we issued a warning notice. Our inspection on 17 July 2017 was to follow up the warning notice and ensure the provider had made the necessary improvements.

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited Oxford Ward and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with one patient who was using the service.
- Spoke with three staff members including a ward manager.
- Interviewed the hospital director who had responsibility for the service.
- Looked at two patient care and treatment records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During this inspection, we spoke with one patient. The patient said she was aware observation levels had changed and staff would talk to her about her wellbeing. The patient said the nurse in charge would increase observation levels if needed.

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?

- Staff observed patients on Oxford ward in the ward communal and bedroom areas.
- Records showed staff completed patient care plans and risk assessments in a timely manner.
- We saw staff recorded patient observations on the provider's observation and engagement form and handover of patient observations.

However:

- We saw one patient's care notes did not have evidence of discharge planning although the patient was having unescorted section 17 leave.
- Some staff did not record information on patients' mental state and patients' observations intermittently as required in the provider's observation and engagement policy.

Are services effective?

- We saw all patient records contained up to date care plans, risk and physical health assessments.
- Paperwork pertaining to the Mental Health Act was in order and stored securely.

However:

- One patient did not have their rights read under the Mental Health Act in a timely manner.

Are services well-led?

- The provider wrote a new policy and delivered a training programme based on patient observation and engagement.
- Ward managers reviewed the quality of observations recorded by staff.
- The provider wrote a development plan, which documented the progress of applying the observation and engagement policy.

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.

We saw two Mental Health Act records were in order and stored securely. Renewals of detentions and hospital managers' hearings were timely and well recorded. We saw copies of consent to treatment forms accompanying the medication charts. Staff explained patients' their rights under the Mental Health Act every three months. We found in one patient care records a patient did not have their rights explained to them within three months. The nurse in charge made sure that they explained to the patient their rights during this inspection.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Well-led	

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

Safe and clean environment

- During the inspection on 16 May 2017, we observed staff on Oxford Ward, completed patient observations from the nursing office. Staff did not physically go and check on the patients. At this inspection, we observed staff completed patient observations in communal and bedroom areas of the ward as per policy.
- We completed a tour of the ward and saw the provider had installed convex mirrors fitted on the ceiling in the corridors outside the patient bedrooms. Staff said they used convex mirrors to view patients who may be in areas of the ward where there were blind spots.

Assessing and managing risk to patients and staff

- During this inspection, we saw staff undertook a risk assessment of every patient on admission. All records we saw were regularly updated. The multidisciplinary team reviewed risk assessments on a monthly basis and following an incident.
- We saw the provider had implemented a new policy to complete patient observations safely. We read the new observation and engagement policy. The policy was written in June 2017 and to be reviewed in June 2020.
- We observed staff on duty followed the new observation and engagement policy. Each patient had an observation and engagement record form where staff recorded patient observations. Attached to the form was a copy of the observation and engagement policy for staff to read if required. We saw a handover of patient observations between staff.
- Some staff did not record patients' mental state as indicated in the observation and engagement policy. We saw staff indicated which level of observation the patient was receiving, date, time, and behaviour, patient's mental state and staff handover of patient observations. However, we looked at 20 observation and engagement records dated from 16 to 30 June 2017 and saw on 48 separate occasions, staff did not document patient's mental state and behaviour.
- From the 16 to 30 June 2017, we saw on one occasion, a member of staff did not record a patient observation for a one-hour period. The hospital director was informed of this.
- One staff member did not record patient observations intermittently. We spoke to one staff member who said recording observations was confusing as it was difficult to record different intermittent times of observations for the same patient.

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- At this inspection, not all care plans we saw were focused on patient discharge. We saw a range of care plans focused on the individual needs of two patients. For example, care plans covered patient's relationships with their family, friends and significant others. The multidisciplinary team completed monthly care plan reviews on a computerised patient record system. All the care plans were up to date and signed by all individuals involved. However, we found in one patient's record, there was no evidence of discharge planning even though the patient had regular unescorted section 17 leave.
- Care records we looked at showed staff carried out patients' physical examinations. Staff completed on going monitoring of patient's physical health problems. All care records we saw showed evidence of patients receiving monthly physical examinations.

Adherence to the MHA and the MHA Code of Practice

Long stay/rehabilitation mental health wards for working age adults

- At this inspection, documentation we saw in respect of the Mental Health Act was in order. Mental Health Act paperwork relating to detentions was up to date and stored securely. Renewals of detention, hospital managers' hearings were timely and well recorded. We saw copies of consent to treatment forms accompanying the medication charts relating to two patients.
- We saw staff explained to patients their rights under the Mental Health Act repeated every three months. However, we found, one patient had not had their section 132 Mental Health Act rights read within the three-month period. The nurse in charge made sure they explained to the patient their rights at the time of our inspection.

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

Good governance

- Following our previous inspection on 16 May 2017, senior hospital management prioritised training for all staff in skills and knowledge on patient observations. Senior management developed and implemented a training programme, which focussed on the new observation and engagement policy. This programme was delivered to all members of the multi-disciplinary team. On completion of the training, all staff completed an assessment of competency, which assessed their understanding of the new policy and procedure.
- The provider developed an audit tool, which monitored the effectiveness of the new observational and engagement policy. The hospital director added this audit to the provider's monthly audits, which then reported to the provider's clinical governance system. We saw ward managers reviewed the quality of observations recorded by staff on a daily basis, which reported into the monthly audit system.
- At this inspection, we saw the provider implemented a development plan. This plan showed actions the provider followed during the implementation of this policy. The plan documented factors such as actions required, progress to date and completion date.
- We spoke with the hospital director who said the implementation of patient observation and engagement training was in the process of being reviewed as part of the clinical governance process.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider discharge planning during the care review meetings.