Sturdee Community Hospital

Quality Report

52-62 Runcorn Road
Leicester
LE2 9FS
Tel:0116 2786991
Website:www.inmind.co.uk

Date of inspection visit: 04 May 2017
Date of publication: 03/07/2017

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

We found the following issues that the service provider needs to improve:

- Doctors prescribed medication on more than one medication chart. We found that the same types of medication had been prescribed on both charts. If staff had administered the medication in the same 24 hours period it would have resulted in an overdose for the patient.
- Staff recorded the monitoring of patients physical health in four separate documents. However, staff did not ensure that all four documents were fully completed specifically the National Early Warning Score form. Due to the duplicated records we found it difficult to ascertain baseline observations for patients and if staff had fully addressed all physical health concerns.
- Staff did not seek medical intervention after monitoring a patient's physical health and found that the patients' blood sugar was outside of the normal limits.
- Whilst managers had a clear oversight of incidents that had taken place within the hospital they did not have a robust system in place to ensure that incident forms were fully completed. We found incident forms were not completed fully or reviewed by a senior member of

Summary of findings

staff. In addition we could not be assured that incidents were recorded within patients care notes or discussed in ward rounds as ward round summaries were missing from patients' case records.

- Following a serious incident, managers had put measures in place to count cutlery. Whilst staff were following this new process, we found that the records showed a spoon had been missing for over five days. When we spoke with managers they were aware of this but no action had been taken to address it.
- Senior managers did not have access to the services ligature audit during the inspection.
- Managers had developed a red, amber green (RAG) rating system to assess patient's risk. However, there was no guidance or procedures in place for staff to use the system.
- Managers did not have a robust system to ensure that patients detained under the Mental Health Act had their rights explained to them and that the paperwork remained in order and up to date.
- Mental Health Act papers were not examined by a suitable trained member of staff. The most up to date section 132 had not been filled correctly. Staff did not have immediate access to detention paperwork. Managers had partially addressed the concerns highlighted in regards to the two unlawful detentions. However, we found that the action plan was not robust and did not fully address the concerns.
- The management of incident reporting was unclear. Managers could not fully explain why they continued to use a process that duplicated incidents forms which we found to be incomplete. Managers did not have processes in place to ensure that all incidents were fully recorded within the patient case notes.
- There was no alert in place at the beginning of the patient's case records to inform staff that the patient had physical healthcare issues that needed to be closely monitored. Whilst case records held this information we found it difficult to locate it quickly.
- Whilst weekly multi-disciplinary meetings took place to discuss patient care and treatment this was not always recorded within the patients case notes.
- Staff reviewed care plans on a monthly basis and recorded the review on a separate document. However, it was not clear that the patients had been involved in the reviews.
- Policies and procedures were in place for staff to follow and were available online. However, the manager had not kept the paper copies of polices in date. This increased the risk of staff not adhering to the most up to date policies.
- Managers did not have a robust recording system in place for monitoring patient's physical health. Although staff had comprehensive discussions about the physical health needs of the patients the paperwork was duplicated and incomplete.
- Managers had formulated an action plan to address issues that were identified from the last CQC inspection in November 2016. We reviewed this during the inspection. We found that although some actions were highlighted as achieved this was not the case.

However:

- Since the last inspection carried out in November 2016 managers had adapted rooms on a closed ward so that patients had space to have one to one time in a private, quiet area of the hospital.
- Throughout the inspection we observed positive team working and mutual support for staff. Staff commented that they felt supported by all members of the team from the clinical staff to housekeeping.
- Patients we spoke with told us that staff were supportive with their mental health issues and any physical health issues. They felt that staff understood their individual needs.
- Multidisciplinary handovers and briefing meetings between shifts were effective. The notes taken in handover were comprehensive, and showed that staff had discussed staffing levels, the physical health care needs of patients and specific nursing duties that needed to carried out during the shift.
- 80% of staff had received regular in line with the services policy of four supervision sessions per year. In addition to this the managers provided supervision to regular bank staff that worked at the hospital.
- Managers carried out investigations into serious incidents and highlighted areas of practice that need to be improved.

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		No rating given as the inspection was an unannounced focussed inspection.

Summary of findings

Contents

Sturdee Community Hospital

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

Summary of this inspection

Background to Sturdee Community Hospital

Sturdee Community Hospital is part of the Inmind Healthcare Group. Located in Leicester, the hospital provides both locked and open rehabilitation for female patients with complex mental needs, some of whom are detained under the Mental Health Act 1983.

At the time of the inspection 15 patients were receiving care and treatment.

Albert Chelliah is the current registered manager. However, Charles Stima began working at the service on 01 May 2017 will take over as the register manager when the registered processes are completed. Lyn Barnes was the nominated accountable officer for controlled drugs.

Since September 2016, the hospital has been operating as an all-female hospital. They have two wards:

- Rutland Ward – 16 bedded
- Aylestone Unit – nine support self-contained flats.

The service uses a closed ward, Foxton as a rehabilitation therapy unit.

Sturdee Community Hospital is registered to provide the following regulated activities:

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

Sturdee Community Hospital first registered with the CQC in April 2011.

Since this date there have been four Mental Health Act reviews and four CQC comprehensive inspections. The last comprehensive inspection was carried out in November 2016. Following this inspection the CQC identified actions that provider should take to improve the service:

- The provider should ensure that the ligature audit contains sufficient detail to show how ward staff will manage the specific ligature points.
- The provider should ensure all staff understands the purpose of supervision and that supervision records are easily accessible if required.
- The provider should ensure they advise CQC of all changes to their statement of purpose in a timely manner.
- The provider should put in place measures to ensure that the nurse administering routine medications can do so without interruption or distraction.

We found during the inspection that provider had addressed all issues with the exception of the ligature audit.

This inspection was an unannounced focused inspection to review risk management processes, patient's case records, detention paperwork and actions that the provider had taken to improve care and treatment for patients. We also reviewed the action plan that was submitted to the CQC after the last comprehensive inspection.

Our inspection team

Team leader: Sarah Duncanson, Inspection Manager

The team that inspected the service comprised of two CQC inspection managers, one inspector and one Mental Health Act reviewer.

Why we carried out this inspection

We carried out this focused inspection following specific concerns which related to two unexpected death and Mental Health Act detention paperwork. We also had concerns after we received an internal investigation report which highlighted issues in relation to care planning, risks management and multidisciplinary case records.

Summary of this inspection

How we carried out this inspection

We carried out this inspection as a focused unannounced inspection to review the risk management processes, patient's case records, detention paperwork and actions that the provider had taken to improve care and treatment for patients. We also reviewed the action plan that was submitted to the CQC after the last comprehensive inspection.

- 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 information that was submitted to us by the provider.

During the inspection visit, the inspection team:

- visited all areas wards at the hospital and observed how staff were caring for patients
- spoke with three patients who were using the service
- interviewed eight staff including, nurses, occupational therapist, psychologist
- attended and observed the morning multidisciplinary meeting and briefing meeting
- reviewed six care records, including six risk assessments and 36 care plans
- reviewed Mental Health Act papers which included section 17 and section 132 rights
- carried out a specific check of the medication management
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

- Patients we spoke with told us staff were supportive with their mental health issues and any physical health issues. They felt staff understood their individual needs.
- Patients reported that they had been involved in their care planning and staff would give them copies of the care plans if they wanted them.

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?

- Doctors prescribed medication on more than one medication chart. We found that the same types of medication had been prescribed on both charts. If staff had administered the medication in the same 24 hours period it would have resulted in an overdose for the patient.
- Managers had a system in place to report incidents. . However, the system meant that incidents forms were duplicated. We found incident forms were not completed fully or reviewed by a senior member of staff. In addition we could not be assured that incidents were recorded within patients care notes or discussed in ward rounds as ward round summaries were missing from patients' case records.
- Senior managers did not have access to the services ligature audit during the inspection.
- Staff did not seek medical intervention after monitoring a patient's physical health when they found that the patients' blood sugar was outside of the normal limits.
- Following a serious incident, managers had put measures in place to count cutlery. Whilst staff were following this new process, we found that the records showed a spoon had been missing for over five days. When we spoke with managers they were aware of this but no action had been taken to address it.
- Managers had partially addressed the concerns highlighted in regards to the two unlawful detentions. However, we found that the action plan was not robust and did not fully address the concerns.

However:

- Compliance with mandatory training for the service was 93%.
- 83% of staff were trained in safeguarding and knew how to make a safeguarding alert.
- Managers carried out investigations into serious incidents and highlighted areas of practice that need to be improved.

Are services effective?

- Staff recorded the monitoring of patients physical health in four separate documents.However, staff did not ensure that all four documents were fully completed specifically the National Early Warning Score (NEWS) form. Due to the duplicated records we found it difficult to ascertain baseline observations for patients and if staff had fully addressed all physical health concerns.

Summary of this inspection

- There was no alert in place at the beginning of the patient's case records to inform staff that the patient had physical healthcare issues that needed to be closely monitored. Whilst case records held this information we found it difficult to locate it quickly.
- Whilst weekly multi-disciplinary meetings took place to discuss patient care and treatment this was not always reflected with the patients case notes.
- Staff reviewed care plans on a monthly basis and recorded the review on a separate document. However, it was not clear that the patients had been involved in the reviews. Staff had not fully recorded if any changes had been made to the care plan or if the care plans supported the patient's to make progress.
- Mental Health Act papers were not examined by a suitable trained member of staff.
- We reviewed ten section 17 leave forms. We found the forms were originally typed. However, the responsible clinician had made numerous handwritten additions and amendments to the forms. The forms were, because of this, difficult to follow at times.
- We found errors on two certificate of consent to treatment (T2) forms.
- Staff had informed patients both verbally and in wiring about their rights in line section 132 of the Mental Health Act. However, the most up to date paperwork had not been filed correctly. This meant that the records were not contemporaneous.
- The Mental Health Act detention paperwork was stored in the MHA administrator's office. Due to this staff did not have immediate access to it.Whilst we found that detention paperwork appeared in order, we found a missing a renewal of authority detention form and another with the incorrect date.
- We also reviewed the detention paperwork of two informal patients, who had previously been detained under the MHA. We found the staff had not kept these patients' folders up to date.
- When we asked to see a copy of the MHA 1983: Code of Practice, the MHA administrator gave us a copy of the 2008 edition. The code was updated in 2015. The MHA administrator said they would order the most current edition.

However:

- Multidisciplinary handovers and briefing meetings between shifts were effective. The notes taken in handover were comprehensive, and showed that staff had discussed staffing levels, the physical health care needs of patients and specific nursing duties that needed to be carried out during the shift.

Summary of this inspection

- Managers had taken action in response to the Mental Health Act review carried out in March 2017 where two unlawful detentions were found. Managers reported that they had an action plan in place to address the identified concerns.
- 80% of staff had received regular in line with the services policy of four supervision sessions per year. In addition to this the managers provided supervision to regular bank staff that worked at the hospital.
- Managers ensured that 84% of staff had received an annual appraisal in the last 12 months.

Are services caring?

- Staff interacted with patients in a caring and respectful manner.
- Patients we spoke with told us that staff were supportive with their mental health issues and any physical health issues. They felt that staff understood their individual needs.
- Patients reported that they had been involved in their care planning and staff would give them copies of the care plans if they wanted them.

Are services responsive?

- Since the last inspection carried out in November 2016 managers had adapted rooms on a closed ward so that patients had space to have one to one time in a private, quiet area of the hospital.

Are services well-led?

- Whilst managers had a clear oversight of incidents that had taken place within the hospital they did not have a robust system in place to ensure that incident forms were fully completed.
- Managers did not have a robust system to ensure that patients detained under the Mental Health Act had their rights explained to them and that the paperwork remained in order and up to date.
- The management of incident reporting was unclear. Managers could not fully explain why they continued to use a process that duplicated incidents forms which we found to be incomplete. Managers did not have processes in place to ensure that all incidents were fully recorded within the patient case notes.
- Policies and procedures were in place for staff to follow and were available online. However, the manager had not kept the paper copies of polices in date. This increased the risk of staff not adhering to the most up to date policies.

Summary of this inspection

- Managers did not have a robust recording system in place for monitoring patient's physical health. Although staff had comprehensive discussions about the physical health needs of the patients the paperwork was duplicated and incomplete.
- Managers had formulated an action plan to address issues that were identified form the last CQC inspection in November 2016. We reviewed this during the inspection. We found that although some actions were highlighted as achieved this was not the case.
- Managers had developed a red, amber green (RAG) rating system to assess patient's risk. However, there was no guidance or procedures in place for staff to use the system.

However:

- Throughout the inspection we observed positive team working and mutual support for staff. Staff commented that they felt supported by all members of the team form the clinical staff to housekeeping.
- Managers had implemented an annual audit programme to ensure that they could monitor and improve practice. When audits were completed they were sent to the director of compliance who then formulated an action plan. The outcomes of audits were discussed within governance meetings.

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.

- Mental Health Act papers were not examined by a suitably trained member of staff. The Mental Health Act administrator was new to their role and although they had some informal training from MHA administrators working at the provider's other locations formal training had not taken place. However, they were due to receive one days' formal training about the MHA in June 2017.
- Staff knew how to contact the Mental Health Act administrator if required.
- We reviewed the section 17 leave of absence forms of ten patients. The leave forms had been signed by the responsible clinician, so it was clear as to who had authorised the period of leave. The leave forms set out the escort arrangements and any conditions of leave. We noted that whilst the forms were originally typed, the responsible clinician had made numerous handwritten additions and amendments to the forms. The forms were, because of this, difficult to follow at times. The responsible clinician and other members of the multidisciplinary team regularly reviewed the patients' section 17 leave at the ward rounds and at daily team meetings.
- 17 out of 22 eligible staff had completed training in the Mental Health Act. This had improved since our last inspection in November 2016.
- We reviewed 11 certificate of consent to treatment (T2) forms. The completion of the forms was in line with the MHA 1983: Code of Practice. Staff kept the T2 forms with the medication charts. This meant that nursing staff administering the treatment could check to be sure that they had the legal authority to do so. However, we saw that one patient was receiving a medication on an 'as required' basis, though this did not appear to be authorised by the responsible clinician on the T2 form.
- Staff had informed patients both verbally and in writing about their rights in line section 132 of the Mental Health Act. From the information available to us at the start of the inspection, we saw staff had explained to patients their rights several months ago. For example, staff had informed three patients of their rights in September 2016. At the end of our inspection, the MHA administrator informed us they had added the current forms to the files confirming that staff had informed patients of their rights. However, due to the time of the day, we were unable to check this information. The MHA administrator told us staff repeated explaining patients' rights on a three monthly basis or when there were changes to the patients' sections.
- Administrative support and legal advice on implementation of the Mental Health Act and the code of practice was not available from a central team.
- The Mental Health Act detention paperwork was stored in the MHA administrator's office due to this staff did not have immediate access to it. We reviewed the MHA detention paperwork of twelve patients. Overall, the detention paperwork was complete and appeared to be in order, in relation to the patients' detention under the MHA. However, in one patient's case, when we checked the chronology of their section 3, we found a subsequent H5, 'Section 20 – renewal of authority detention', form recorded the 'date authority for detention was due to expire' as 8 February 2017, though this should have read 9 February 2017. In a second patient's case, page 2 of the H5 form was missing from the file, however the MHA administrator located this during our inspection. We found the detention paperwork evidenced the need for the patients' detention under the MHA.
- We reviewed the detention paperwork of two informal patients, who had previously been detained under the MHA. We found the staff had not kept these patients' folders up to date. For example, the responsible clinician had discharged both patients from their sections, under section 23 of the MHA. However, the MHA administrator had not filed the forms with the detention paperwork. In one patient's case, we noted the responsible clinician had signed the discharge form in October 2016.
- We checked to see if there were outline reports by the approved mental health professional in the nine out of the 12 patient records. We only found six reports. We were unable to locate the reports in the records of three further patients. Such reports give the reasons for the application, under the MHA, and any practical matters

about the patient's circumstances, which the hospital should know. Three patients' records did not require the outline report due to the type of section the patient was detained under.

- The service did not have a copy of the amended MHA 1983: Code of Practice. The code was updated in 2015. The MHA administrator said they would order the most current edition.
- Managers had taken action in response to the Mental Health Act review carried out in March 2017 where two unlawful detentions were found. Managers had commissioned an external auditor who had recently carried out an audit of MHA detention paperwork. They said work was in progress in addressing the action plan created by the external auditor, which was recently submitted to the CQC. The MHA administrator was in the process of developing a spreadsheet to monitor the use, and comply with the requirements, of the MHA. We saw evidence of this.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- Senior managers did not have access to the services ligature audit during the inspection. . We requested that this be sent to the CQC without delay. The CQC received the ligature audit on 05 May 2017. However, on reviewing the audit we found that this had not been updated after the service had commissioned an independent assessor to complete the audit. The provider's action plan highlighted that work had been carried out to reduce potential ligature points across the service. We raised this with the provider, who confirmed that the audit we received was the most up to date audit and noted that the auidt had not been updated to reflect the action points. They informed us that they would complete another audit during the week commencing the 15 May 2017 and submit the completed audit once complete.

Safe staffing

- Compliance with mandatory training for the service was 93%. The mandatory training covered 14 topics which included safeguarding, medication management, Mental Capacity Act and Mental Health Act and the management of actual or potential aggression.

Assessing and managing risk to patients and staff

- Staff used the Short-Term Assessment of Risk and Treatability (START) risk assessment tool. Staff completed a risk assessment of every patient on admission. We reviewed six risk assessments and found that staff had updated them every four months. However, staff did not update the risk assessments after incidents.
- In addition to the START risk assessment, staff used a red amber green (RAG) rated risk assessment for individual patients. If patients were RAG rated green the multidisciplinary team met and reviewed patients on a monthly basis, if patients had a rating of amber or red the team discussed them daily. We observed this meeting and noted that the discussions were comprehensive and patient focussed. These discussions were recorded on the risk assessment form and in the case records. Although this risk assessment was comprehensive and determined how patients were to be nursed in order to minimise the risk they posed, there was no guidance for staff to use these forms or how to rate the risk. This was discussed with senior staff and although they fully understood this process they acknowledged that staff that were new to the service or agency and bank staff would have to contact the on call senior manager out of hours to ensure they had completed the risk assessment correctly. Staff did not file the completed RAG rating forms in patient's notes. After a 24 hour period the form was archived in a cardboard box.
- Staff followed robust procedures for observing and searching patients. Staff sought consent from patients who needed to have searching procedure in place due to individual risks. Staff clearly documented patients consent to be searched on a specific form within the patient case records.
- During the last CQC inspection in November 2016 we raised concerns about restrictive practices, specifically in relation to patients not having access to bedrooms keys. Managers addressed this issue. All bedrooms locks had been changed and patients could have keys to their bedrooms doors after they had been risk assessed.

Long stay/rehabilitation mental health wards for working age adults

- 83% of staff were trained in safeguarding and knew how to make a safeguarding alert. This was evidenced within the incident reporting system. The electronic form highlighted if it was a safeguarding incident and logged the date the local authority had been notified. When the local authority investigation had been completed the date of this was recorded and the outcome.
- We reviewed 10 medication charts. We found some patients had two medication charts in use. We found medication had been prescribed on both charts and, if administered to the patient would increase the risk of overdose. For example, one chart had up to four grams of paracetamol in a 24 hours period prescribed and the second chart had a prescription for co codoamol four times a day. If both medications had been administered in a 24 hour period this would have been above the British National Formulary limit and resulted in an overdose of paracetamol.
- Staff completed comprehensive advanced decision with patients which recorded the patient's views and wishes with regards to medication.

Track record on safety

- From July 2016 to the date of the inspection the service had reported two unexpected deaths. Also two unlawful detentions were found during a routine Mental Health Act review visit.
- Managers ensured that both deaths were investigated. These investigations found areas of practice that needed to be improved and actions taken in order to prevent similar incidents occurring again. Managers worked with staff to ensure that these actions were implemented as soon as practically possible. Discussion took place within morning meetings with staff to share the changes in practice and in monthly clinical governance meetings.
- Managers had partially addressed the concerns highlighted in regards to the two unlawful detentions. However, we found that the action plan was not robust and did not fully address the concerns.

Reporting incidents and learning from when things go wrong

- Whilst staff knew what incidents to report and how to report, the system in place for reporting incidents resulted in incident forms being duplicated. Staff reported incidents initially on a paper incident report. A copy of this was filed in the patient notes. Administrators then copied this information on to an electronic record. The electronic incident form had a section for managers' reviews. However, we found that managers had not completed this section.
- Managers reported that they were aware that incident reports were duplicated and had raised this with the provider as an issue. However, there were no plans to review this system.
- We reviewed 19 electronic incident forms and found 18 had not been reviewed by a manager. One incident had not concluded and therefore a manager's review had not been required. The majority of the 'treatment' sections of the incident forms were blank. In addition, we found that it was not clear if all incidents had been discussed within the ward round as ward round summaries were missing from patients case records. However, staff did ensure that they completed a full description of the incident, classified the incident correctly and recorded if the incident needed to be reported as a safeguarding incident.
- Staff had not recorded an entry in patient's daily case notes for two out of the 19 incidents forms we reviewed. For example one patient's last completed incident form was dated in April 2017. However, we found staff had recorded three more incidents in the case notes since this date.
- Staff did not seek medical intervention after monitoring a patient's physical health. One incident we reviewed involved a incident concerning physical health. The incident form noted that blood pressure, temperature, pulse and blood sugars were taken. The patient's daily case notes recorded that all were within normal limits. However, the blood sugar was 15.7 millimoles. This was outside of the normal range of 3.9 and 5.5 millimoles. There was no evidence within the case notes or incident form that this had been followed up by a doctor.
- Managers ensured they shared the feedback from the investigation of incidents with staff in the morning meetings. Staff reported that they were aware of changes that had been made as a result of this feedback. For example, there were now more robust procedures for the monitoring of patients physical health. Managers had put measures in place to count cutlery after a serious incident had taken place. Whilst staff were following this new process, we found that the records showed a spoon had been missing for over five days. When we spoke with managers they were aware of this but no action had been taken to address it.

Long stay/rehabilitation mental health wards for working age adults

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

Assessment of needs and planning of care

- Staff completed comprehensive and timely assessments of patients prior to and after admission to the service.
- Staff completed a physical examination of patients at the point of admission and six months thereafter. Staff referred patients with individual physical health problems to specialised services when required. Care records had electrocardiogram and blood results, which doctors reviewed. When staff completed the monitoring of patients' blood pressure, temperature and pulse they were required to document this in three separate documents, the National Early Warning Score (NEWS) form, daily case record's and daily handover forms. Managers could not explain why these recordings needed to be duplicated. Whilst we found that physical health was clearly documented within daily case records and the handover forms, the NEWS was not regularly completed. All NEWS forms we reviewed were incomplete. Staff also used an acute physical health care folder. This folder highlighted what action had been taken for individual patients when they become unwell. Due to the duplicated records we found it difficult to ascertain baseline observations for patients and if staff had fully addressed all physical health concerns.
- Staff completed comprehensive assessments for all patients, which they completed within a timely manner. We reviewed 36 care plans and they were personalised, holistic and recovery orientated. We saw evidence that patients had been involved in writing their care plans and had signed them. Staff reviewed care plans on a monthly basis and recorded the review on a separate document. However, it was not clear that the patients had been involved in the reviews. Staff had not fully recorded if any changes had been made to the care plan or if the care plans supported the patient's to make progress.
- The information needed to deliver care and treatment effectively was stored securely within paper based records. Whilst permanent staff reported that, they did not have any difficulties in locating information easily. We found during the inspection patients case records were difficult to navigate through to find important information. For example, physical health care was in section 15 of the folder. Although the information within this section was comprehensive, we wondered if bank or agency staff would be able to locate this information quickly, when required.

Best practice in treatment and care

- Staff referred patients with individual physical health problems to specialised services when required.
- Staff used health of the nation outcome scales to assess and record severity of symptoms and outcomes for patients.

Skilled staff to deliver care

- Patients received care and treatment from a range of professionals including nurses, doctors, clinical psychologists, occupational therapists, occupational therapy coordinators and a social worker.
- The staff we spoke with were experienced and qualified to carry out their duties.
- 80% of staff had received regular supervision in line with the services policy of four supervision sessions per year. In addition to this the managers provided supervision to regular bank staff that worked at the hospital.
- Managers ensured that 84% of staff had received an annual appraisal in the last 12 months.

Multi-disciplinary and inter-agency team work

- Weekly multi-disciplinary meetings took place to discuss patient care and treatment; this was attended by staff and patients. Staff recorded the minutes of these meetings within case records. Staff told us that administrative staff typed up an additional multidisciplinary meeting record after the meeting. However, we found that this did not happen for all meetings that were held. For example, in one case record we found only two typed sets of minutes since January 2017.
- Staff reported and we observed that multidisciplinary handovers between shifts were effective. The notes taken in handover were comprehensive and showed that staff had discussed staffing levels and specific nursing duties that needed to carried out during the shift. In addition to this meeting, a briefing meeting was held for staff that were not part of the multidisciplinary

handover; this included the chef, health care assistants, a qualified nurse and reception staff. Staff discussed all patients and were encouraged to give their views and to ask questions.

Adherence to the MHA and the MHA Code of Practice

- Mental Health Act papers were not examined by a suitable trained member of staff member. The Mental Health Act administrator was new to their role and although they had received some informal training from MHA administrators working at the provider's other locations formal training had not taken place. However, they were due to receive one days' formal training about the MHA in June 2017.
- Staff knew how to contact the Mental Health Act administrator if required.
- We reviewed the section 17 leave of absence forms of ten patients. The leave forms had been signed by the responsible clinician, so it was clear as to who had authorised the period of leave. The leave forms set out the escort arrangements and any conditions of leave. We noted that whilst the forms were originally typed, the responsible clinician had made numerous handwritten additions and amendments to the forms. The forms were difficult to follow at times, because of this. The responsible clinician and other members of the multidisciplinary team regularly reviewed the patients' section 17 leave at the ward rounds and daily meetings.
- 17 out of 22 eligible staff had completed training in the Mental Health Act. This had improved since out last inspection in November 2016.
- We reviewed eleven certificate of consent to treatment (T2) forms. The completion of the forms was in line with the MHA 1983 Code of Practice. Staff kept the T2 forms with the medication charts. This meant that nursing staff administering the medication could check to be sure that they had the legal authority to do so. However, we saw that one patient was receiving a medication on an 'as required' basis, though this did not appear to be authorised by the responsible clinician on the T2 form. One other T2 form gave authorisation for one medication to be prescribed orally. However the medication form showed the medication had been prescribed in patch form.
- Staff had informed patients verbally and in writing about their rights in lime with section 132 of the Mental Health Act. From the information available to us at the start of the inspection, we saw staff had explained patients' rights to them several months ago. For example, staff had explained to three patients their rights in September 2016. At the end of our inspection, the MHA administrator informed us they had added the current forms to the files confirming that staff had informed patients of their rights. However, due to the time of the day, we were unable to check this information. The MHA administrator told us staff repeated patients' rights on a three monthly basis or when there were changes to the patients' sections.
- Administrative support and legal advice on implementation of the Mental Health Act and the Code of Practice were not available from a central team.
- The Mental Health Act (MHA) detention paperwork was stored in the MHA administrator's office, due to this staff did not have immediate access to it. We reviewed the MHA detention paperwork of twelve patients. Overall, the detention paperwork was complete and appeared to be in order, in relation to the patients' detention under the MHA. However, in one patient's case, when we checked the chronology of their section 3, we found a subsequent H5, 'Section 20 – renewal of authority detention', form indicated the 'date authority for detention is due to expire' as 8 February 2017, though this should have read 9 February 2017. In a second patient's case, page 2 of the H5 form was initially missing from the file, however the MHA administrator located this during our inspection. We found the detention paperwork evidenced the need for the patients' detention under the MHA.
- We also reviewed the detention paperwork of two informal patients, who had previously been detained under the MHA. We found the staff had not kept these patients' folders up to date. For example, the responsible clinician had discharged both patients from their sections, under section 23 of the MHA. However, the MHA administrator had not filed the forms with the detention paperwork. In one patient's case, we noted the responsible clinician had signed the discharge form in October 2016.
- We expected to see outline reports by the approved mental health professional in the nine out of the 12 patient records. We only found six reports. We were unable to locate the reports in the records of three further patients. Such reports give the reasons for the application, under the MHA, and any practical matters

Long stay/rehabilitation mental health wards for working age adults

about the patient's circumstances, which the hospital should know. Three patients' records did not require the outline report due to the type of section the patient was detained under.

- The service did not have a copy of the amended MHA 1983: Code of Practice. The code was updated in 2015. The MHA administrator said they would order the most current edition.
- Managers had taken action in response to the Mental Health Act review carried March 2017 were two unlawful detentions were found. Managers had commissioned an external auditor had recently carried out an audit of MHA detention paperwork. They said work was in progress in addressing the action plan created by the external auditor, which was recently submitted to the CQC. The MHA administrator was in the process of developing a spread sheet to monitor the use, and comply with the requirements, of the MHA. We saw evidence of this.

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

Kindness, dignity, respect and support

- Staff interacted with patients in a caring and respectful manner.
- Patients we spoke with told us that staff were supportive with their mental health issues and any physical health issues. They felt that staff understood their individual needs.

The involvement of people in the care they receive

- Patients reported that they had been involved in their care planning and staff would give them copies of the care plans if they wanted them.

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

The facilities promote recovery, comfort, dignity and confidentiality

- Since the last inspection carried out in November 2016 managers had adapted rooms on a closed ward so that patients had space to have one to one time in a private, quiet area of the hospital.

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

Good governance

- Managers ensured they monitored their team's compliance with mandatory training.
- Staff were appraised and had access to supervision.
- Whilst managers had a clear oversight of incidents that had taken place within the hospital they did not have a robust system in place to ensure that incident forms were fully completed.
- Managers did not have a robust system to ensure that patients detained under the Mental Health Act were informed of their rights and that the paperwork remained in order and up to date. However, when required managers had outsourced an independent auditor to review all paperwork.
- Managers had implemented an annual audit programme to ensure that they could monitor and improve practice. When audits were completed they were sent to the director of compliance who then formulated an action plan. The outcomes of audits were discussed within governance meetings.
- The management of incident reporting was unclear. Managers could not fully explain why they continued to use a process that duplicated incidents forms which we found to be incomplete. Managers did not have processes in place to ensure that all incidents were fully recorded within the patient case notes.
- Policies and procedures were in place for staff to follow. Staff could access these on the services intranet. However, there were also printed copies of polices in folders in the office. The printed polices were out of date. Due to this there was an increased risk that staff could follow the out of date policy which could be different to the revised version. This was raised and the time of the inspection and manages stated they would address it.
- Managers had a system in place for monitoring patient's physical health. However, staff had to record this

information in three separate documents. We found that only the daily case notes held full details of what monitoring had taken place. It was unclear as to why the information had to be recorded three times when we spoke with managers.

- Managers had formulated an action plan to address issues that were identified from the last CQC inspection in November 2016. We reviewed this during the inspection. We found that although some actions were highlighted as achieved this was not the case. For example, multidisciplinary team pathway care plans had been changed to multidisciplinary team discharge pathway and recovery plans within case records. We found that only three case records had the new care plans in place.
- Managers had developed a red, amber, green (RAG) rating system. Staff used this to determine the level of risk that a patient posed and what actions staff needed to take in order to minimise this risk. For example, increased nursing observations. Although staff were knowledgeable and able to describe how they would use the system, there was no procedure or guidance for new staff to follow. Managers told us that if a bank member of staff were working they would receive phone calls out of hours to determine the RAG rating of a patient after a risk incident had occurred.

Leadership, morale and staff engagement

- Throughout the inspection we observed positive team working and mutual support for all staff. Staff commented that they felt supported by all members of the team from the clinical staff to housekeeping.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that records relating to the care and treatment of each patient are complete and up to date including Mental Health Act paperwork.
- The provider must ensure that incidents are fully completed and recorded that they have been reviewed by senior staff.
- The provider must ensure medication is prescribed safely and in line with guidance and the Mental Health Act.
- The provider must ensure that the physical healthcare needs of individual patients are clearly highlighted in case notes to alert staff and that physical health monitoring is fully recorded.
- The provider must ensure they have an effective system in place to assess, monitor and improve the services provided, in relation to patient's case records

Action the provider SHOULD take to improve

- The provider should ensure that individual care plans are reviewed regularly with patients.
- The provider should ensure staff are following the up to date policies.

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 Safe care and treatment The provider did not ensure that incident forms were fully completed and reviewed by senior staff. The provider did not ensure that medication was prescribed safely and in line with guidance and law which increased the risk of potential overdose. The provider did not clearly highlight in case notes patients physical healthcare needs. This was a breach of regulation 12.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good Governance The provider did not ensure that records relating to the care and treatment of each patient were complete and up to date including Mental Health Act paperwork. The provider did not ensure they had an effective system in place to assess, monitor and improve the services provided, in relation to patient's case records. This was in breach of regulation 17.