

Coveberry Limited

# Uplands Independent Hospital

## Inspection report

61 Park Lane  
Fareham  
PO16 7HH  
Tel: 01329221817  
[www.uplandsindependenthospital.co.uk](http://www.uplandsindependenthospital.co.uk)

Date of inspection visit: 19 October 2022 and 20 October 2022  
Date of publication: 17/01/2023

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?

Requires Improvement



Are services effective?

Requires Improvement



Are services caring?

Requires Improvement



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



# Summary of findings

## Overall summary

Our rating of this location improved. We rated it as requires improvement.

The Care Quality Commission conducted an unannounced inspection of Uplands Independent Hospital on 19 and 20 October 2022 to check that the improvements detailed in the warning notice served following our inspection January 2022 had been made. In January 2022 we rated the hospital inadequate and placed it in special measures.

On 28 and 29 June 2022 we undertook a focussed inspection to check whether improvements had been made. We found that the provider had made some improvements but needed more time for improvements to be fully implemented. The provider gave us assurance that they would continue to improve. We decided to give the provider more time to make the required improvements but to monitor it closely. The hospital remained in special measures and continued to be rated inadequate.

During this inspection we saw that the provider had maintained the improvements we found in June 2022 and had continued to make progress with the areas that required improvement outlined in their action plan. They had started work to improve the environment, installed a new fire alarm system, ensured staff undertook mandatory training and commenced recruitment for a range of clinicians so they could offer a full multidisciplinary team input to patient care. Whilst the provider had developed a comprehensive rehabilitation and recovery care model this had not yet been fully implemented or embedded within the services practice. Staff had involved patients in developing the new model of care and we also saw that staff were more engaged with patients; offering more one to one engagement time. Senior managers were visible across the hospital and staff felt they were approachable, listened to them and acted on their concerns. However, the provider was clear that they still had actions to complete and that they needed to continue embedding the improvements they had already made.

Our rating of this location improved. We rated it as requires improvement because:

At this inspection we found:

- The provider had not yet fully addressed all of the improvements to the environment identified in their action plan. For example, some ligature anchor points remained although these could have been removed and these were not all included in the ligature risk assessment. Not all patients had access to a nurse call system in their bedrooms so would be unable to call for help if they needed to.
- The provider had reduced the number of registered nurses on duty, since our last inspection, as the number of patients admitted to the hospital had reduced. However, the staffing ladder used to identify the number of registered nurses required on the ward focussed more on the number of patients rather than the care they needed.
- Care plans were not as person centred or recovery focused as they could have been. For example, they did not detail how patients could gain the skills needed to live in the community. Staff did not always document how patients had been involved, in care planning, recorded best interest decisions for patients that lacked capacity or if they had understood changes to their treatment.
- Staff told us that they sometimes had to cancel escorted community leave because of staffing numbers.
- We found that one medication record did not have a completed section 62(1) urgent treatment form attached to it. A section 62(1) urgent treatment form is needed to authorise treatment which has not been agreed by the patient when a patient does not or cannot consent and treatment has been agreed by a second opinion appointed doctor.
- The provider did not actively seek feedback from families and carers about the service.
- The female lounge was a long distance from the main areas of the hospital so not easy for female patients to access.

# Summary of findings

- The provider was in the early stages of implementing a new governance process across all of its services. Managers at Uplands were still introducing this structure so not all governance process were working effectively.
- The provider had identified a new rehabilitation and recovery focused model of care, but this had not been fully implemented at the time of the inspection.

However:


- The ward remained clean and there were maintenance plans in place to improve the environment.
- The hospital had reduced the number of agency staff it used. All staff received an induction before working at the hospital. The service held regular multidisciplinary team (MDT) meetings and was actively recruiting to ensure they had a complete MDT available to the patients.
- The care plans in place met and identified patients' physical and mental health needs. Staff supported patients to access physical health care. Staff used rating scales to identify and meet patients' needs. All patients' records we reviewed had a positive behaviour support plan in place, which staff understood, and a discharge plan.
- Staff ensured that the clinic room was fully equipped and clean and the provider had introduced an electronic prescription system to reduce errors.
- Interactions we witnessed between patients and staff were caring and respectful, patients told us they felt safe in the hospital and knew how to complain. Staff completed a daily risk assessment for each patient and reported incidents appropriately.
- The provider had opened a female lounge and was preparing a room to be used as a gym for the patients.
- There was a new hospital director in post and the provider had agreed a long hand over period with the interim hospital director to ensure consistency.

As a result of the improvements, we will remove the hospital from special measures.

# 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

<b>Summary of this inspection</b>	<b>Page</b>
Background to Uplands Independent Hospital	6
Information about Uplands Independent Hospital	7
<hr/>	
<b>Our findings from this inspection</b>	
Overview of ratings	9
Our findings by main service	10
<hr/>	

# Summary of this inspection

## Background to Uplands Independent Hospital

Uplands Independent Hospital provides treatment for patients who require long stay and rehabilitation services, aged over 18 who may be informal or detained under the Mental Health Act 1983. It offers assessment, treatment and continuing care for up to 24 people. At the time of the inspection there were 13 patients, one on section 17 leave, all were detained under the Mental Health Act. The hospital takes referrals from acute and low secure inpatient wards.

Uplands Independent 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.

Uplands Independent Hospital is based in a grade 2 listed building on the outskirts of Fareham. It is set within its own grounds. When originally established, the service was set up to provide for patients who had long term mental health issues and was considered a placement for life.

As national guidance and best practice for patients with a long-term mental illness changed to encompass a recovery focus to support patients to live more independently in the community the hospital began to accept patients with more complex mental health issues.

The model of care provided by the hospital is in the process of changing and staff are receiving training to provide care that is recovery focused. However, at the time of the inspection staff had not been trained in the new care model.

There was a hospital director in place who had not yet been registered with the CQC.

The service was last inspected in June 2022.

### What people who use the service say

Patients we spoke with felt safe at the service and one explained that staffing, locking their bedroom and their compatibility with other patients gave them a sense of safety.

Patients were able to make day to day decisions such as times to rise and retire, their appearance and activities. They also said they had support from staff with taking some decisions.

Overall patients gave positive feedback about the meals and the service catered for their dietary requirements. For example, the chef could provide vegetarian meals.

Patients knew the conditions of their legal status at the service and said staff read them their section 132 rights.

Patients with unescorted leave went into the local community daily. Some patients said they were bored. Daily activities were limited and not specific for people to develop and maintain their daily living skills.

# Summary of this inspection

Patients knew who to approach with complaints, although they were not confident, they would be resolved to their satisfaction.

Patients were positive about the staff and about the improvements since the last inspection. We saw staff engage with patients and the staff knew how to approach individual patients.

Patients knew the managers and said they were regularly seen on the ward

## How we carried out this inspection

The team that inspected the hospital consisted of two Care Quality Commission inspectors and a specialist professional advisor.

Before the inspection we:

- reviewed information we held about the service.

During the inspection we:

- Spoke with 5 patients
- Spoke with 12 members of staff including, qualified nurses, health care support workers, the activities co-ordinator, chef, consultant and senior managers
- Reviewed 5 medication records
- Reviewed 7 patients records
- Toured the ward looking at the quality and safety of the premises
- Looked at other documents and paperwork relating to the quality of the care provided.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **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 provider must ensure that all environmental risks are identified, and appropriate plans are in place to safely manage the risk. Regulation 12: Safe care and treatment, 2(d).
- The provider must ensure that all patients have access to an appropriate nurse call system to call for help in the event of an emergency Regulation 12: Safe care and treatment, 2(d).
- The provider must ensure that the staffing ladder used to identify staff number focusses on patient need and not just the number of patients admitted. Regulation 18: Staffing, 1.
- The provider must ensure that care plans focus on patients developing the skills need for discharge. Regulation 9: Person centered care, 1.

# Summary of this inspection

- The provider must ensure that patients have access to escorted leave and when this is cancelled, they record the reason and identify when the leave can be taken. Regulation 18: Staffing, 1.
- The provider must ensure that all care plans are recovery focused. Regulation 9: Person-centred care, 1.
- The provider must ensure patients' views are incorporated within their care plans and that all patient records reflect the patients views and wishes. Regulation 9: Person-centred care, 1(c) and 3(b).
- The provider must ensure that they follow the new governance process and continue to embed to ensure oversight of the service. Regulation 17: Good governance,1.

## **Action the service SHOULD take to improve:**

- The provider should consider how to actively seek the views of families and carers.
- The provider should ensure they provide suitable secure storage within patients' bedrooms.
- The provider should ensure they record best interest decisions for patients who do not have capacity to consent to care and treatment.
- The provider should consider an overall maintenance plan that considers who to ensure the environment is of an appropriate standard and how this will be maintained.
- The provider should ensure they fully implement the identified rehabilitation model and train staff to deliver care in accordance with the model



# 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	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement



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

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

Requires Improvement



Our rating of safe improved. We rated it as requires improvement.

### Safe and clean care environments

**There were still issues with the nurse call system and the ligature risk assessment. However, the hospital was clean and maintained.**

### Safety of the ward layout

Staff completed risk assessments for all areas in the hospital. We saw that the hospital carried out a regular environmental check which included identifying actions to address any concerns they found. The hospital had employed an estate manager who could then carry out the identified repairs or arrange repairs.

Uplands Independent Hospital was in a listed building. This meant that the layout of the building did not make it easy for staff to observe patients. There were poor lines of sight throughout the hospital. For example, nurses could not observe patients from the office and the ward was made up of interconnecting rooms with narrow corridors and there were blind spots throughout the hospital. However, the provider had reduced the risks caused by the layout of the building with mirrors and CCTV. We saw a gate was used to prevent patients going down a staircase, but this would not have prevented someone from climbing over it and falling down the stairs. A set of stairs that had some access from a patient area, led to a ladder which provided access to a disused water tank. We raised these concerns with the provider during our visit as they had not considered the risk. The provider told us they would review the risks around this and take action where needed.

The hospital did not fully comply with guidance around same sex accommodation. The hospital was now a single ward but there were no designated male and female bedroom areas. However, no females had to walk past male bedrooms to use toilet or bath facilities. The hospital had introduced a female only lounge. However, it was a long way from the main lounge and there were no signs directing female patients towards it. The lounge was quite small, offering seating for 2 people. On the day we visited it did not look as if it was in regular use and senior managers told us they were planning to encourage patients to use it by offering activities such as pampering session in the room.

There were many potential ligature anchor points throughout the service. Staff carried out a regular ligature assessment, however staff had not recorded all the risks on this document. Senior managers told us this was not the

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

comprehensive ligature assessment that included every risk. We viewed the most recent comprehensive ligature assessment and saw staff had not updated it since 2020. The provider told us they would complete an up-to-date full ligature assessment the next week. This was completed and we were sent a copy and saw that included the risk we had identified that were not on the regular assessment.

Staff had easy access to alarms and most patients had access to a nurse call system. The provider was in the process of replacing the alarm system with a system that would meet the needs of the service better. However, this meant that not all bedrooms currently had nurse call alarms for the patients to call for assistance. We were told by senior managers that seven alarms were missing. We were told that the missing alarms would be replaced by the 13 December 2022. The provider was using observations and the patients risk level to manage patients who did not have access to a nurse call alarm in emergencies.

## Maintenance, cleanliness and infection control

Ward areas were clean, maintained and well-furnished. The hospital was visibly clean and we saw contracted housekeeping staff on site. During the inspection we witnessed staff cleaning all areas of the building. There were several plans related to large building works across the hospital, for example the roof and alarm system. However, décor and building in general was still tired looking and in need of an up lift.

We reviewed the last month of cleaning records and saw that they were signed off to show that cleaning had been completed. However, there was very limited information recorded in the cleaning records. For example, records did not mention broken skirting boards, areas in need of painting and ground in dirt.

Staff completed infection control audits and recorded information about actions taken. Posters about wearing appropriate Personal Protective Equipment (PPE) were on display, and staff were following the guidance. However, the laundry had domestic washing machines that did not have a sluice function for cleaning soiled clothing. Some staff members were not sure of the procedures around washing soiled clothes. For example, that clothes could be washed in red dissolvable bags to reduce infection risk. We discussed this with senior managers and they told us they would remind staff.

## Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. However, when asked not all staff members knew the location of the ligature cutters and had to ask other members of staff where they were kept.

Staff checked, maintained, and cleaned equipment. A new fridge had been installed in the clinic room two days before the inspection and staff advised us they had been without a medicine fridge for several weeks. Staff told us they got advice from the pharmacist on ensuring medication was safe to use and had discarded any medication that needed to be stored in a fridge once the new one had been supplied.

## Safe staffing

**The service had improved the staffing level. However, there were insufficient staff to guarantee regular community leave.**

## Nursing staff

Since the last inspection, the provider had been working to improve the staffing numbers at the hospital and reduce their reliance on agency staff. They had merged the two wards and moved to a model where there was only one qualified nurse on duty working directly with patients. We saw that this nurse spent their time on mainly office-based

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

tasks such as writing care plans and reports and completing tasks that required a qualified nurse such as administering medication. Therefore, the qualified nurse was not available to lead care delivery and role model good practice for health care support workers. Senior managers did not monitor or record how much time the qualified nurse could spend providing direct care to patients. The provider had developed a staffing ladder. However, the number of staff only increased once the patients increased and did not focus on the needs of the patients or the amount of time the nurse spent providing direct care.

The number of agency staff used was reducing and the service only deployed agency staff who were familiar with the patients and the service.

There was an induction checklist in place that was completed for all agency staff before they worked at the hospital.

The ward manager could not fully adjust staffing levels according to the needs of the patients, for example the staffing ladder prevented the ward manager from deploying more qualified nurses.

Staff told us that there was not enough staff on duty and as a result patients had their escorted leave cancelled. Managers told us they rearranged cancelled leave as soon as possible but no record was kept of when leave was cancelled to ensure this always happened.

## Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward in an emergency.

Managers could call locums when they needed additional medical cover.

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

## Mandatory training

Staff had completed and kept up to date with their mandatory training. At the time of the inspection 83.4% were up to date with their mandatory training. The only training we identified that had a low compliance rate was infection control; only 10% of staff completed the training, but the remaining staff had been booked on the training for the following month.

The mandatory training programme was comprehensive and met the needs of patients and staff. The provider told us that they were introducing the care certificate training for health care support staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

## Assessing and managing risk to patients and staff

**Staff followed best practice in anticipating, de-escalating, and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed.**

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

## Assessment of patient risk

Staff completed risk assessments for each patient, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 7 care records and saw that 6 included comprehensive risk assessments that were updated appropriately following incidents. One record had the wrong person's name in the risk management plan and the plan did not relate to the risks identified for the patient. This had not been identified and corrected by the provider as they were not completing audits of the patient records at the time of our inspection.

## Management of patient risk

Staff knew about risks relating to each patient and acted to prevent or reduce risks. However, we found evidence of smoking in one of the bedrooms and although staff were aware of the risk and actively encouraged patients to follow the smoking policy, they had not made changes to the environment to mitigate the risk. For example, ensuring the bin, clearly used as an ashtray, was fireproof.

Staff followed procedures to minimise risks where they could not easily observe patients. Staff used observations to manage the risk of patients. There was CCTV throughout the hospital and mirrors were used on areas that would have been blind spots.

Staff followed the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

## Use of restrictive interventions

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. Staff told us that they used very little restraint in the hospital and this was confirmed by incident reports. Staff received training in how to de-escalate incidents and were able to explain to us how they would do this.

## 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 could explain what they would report as abuse and how they would report this.

Staff kept up-to-date with their safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Qualified nurses could explain how they would report concerns and health care support workers told us they would report their concerns to the nurse in charge.

## Staff access to essential information

The service was in the process of moving to an electronic record system. Patient notes were comprehensive and all staff could access them easily. As the provider was introducing the system some staff still needed additional support to access the system.

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Records were stored securely.

## Medicines management

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely. There was an electronic prescription and administration system in place, which minimised the risk of medication errors.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. However, we saw that a regular intra-muscular injection had been given by staff without the correct authorisation. The injection was not included on the patients T3 form, completed T3 form allow doctors to prescribe medication when a patient refuses or lacks capacity to agree to a medication and are approved by a second opinion appointed doctor (SOAD). If the patient's consultant needs to give prescribed medication not included on the T3 form they can if they complete a section 62(1) urgent treatment form. We discussed this and found out that the correct document had been completed but was still waiting to be uploaded on the electronic prescribing system. Nurses should not administer medication unless the correct authorisation is attached to the medication record at the time it is administered.

Staff stored and managed all medicines safely. The service had just received a new clinic fridge and had received advice on what to do with medication that need to be refrigerated while they were without a fridge. The service had destroyed any medication that needed refrigeration.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

The service ensured patients' behaviour was not controlled by excessive and inappropriate use of medicines. There were high dose anti-psychotic (HDAT) medication monitoring forms in place for patients that needed them. HDAT form are used to remind staff of their responsibilities in the safe management of high dose medication.

Staff were not using a recognised side effects monitoring scale to monitor the effects of each patient's medicines on their physical health in according to National Institute of Clinical Excellence (NICE) guidance.

## Track record on safety

### Reporting incidents and learning from when things go wrong

**Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.**

Staff knew what incidents to report and how to report them. There was an electronic incident reporting system in place that staff were trained to use.

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

Managers debriefed and supported staff after any serious incident. There was reflective practice available to staff following incidents.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service. However, the service governance processes were not embedded and were not identifying possible trends and themes from incidents.

Managers shared learning with their staff about never events that happened elsewhere.

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

Requires Improvement 

Our rating of effective improved. We rated it as requires improvement.

### Assessment of needs and planning of care

**Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. However, not all care plans were recovery focussed.**

We saw that the quality of the care plans had improved, staff now developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 7 patient records and saw that they all had care plans in place to meet their needs. Staff told us that they were having to change care plans as the commissioners kept asking them to change the format.

However, none of the care plans we reviewed were personalised or recovery orientated. For example, they did not focus on gaining the skills needed to be discharged or included information about how the patient had contributed to them. Staff told us that patients often did not want to be involved but they had not recorded this in the care plan.

### Best practice in treatment and care

**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.**

Staff identified patients' physical health needs and recorded them in their care plans. We reviewed 7 patient records and saw that staff had identified physical health needs and had developed plans to manage these needs and reviewed these regularly.

Staff made sure patients had access to physical health care. They supported patients to access their GP and communicated with them when they needed support.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. For example, national early warning sign (NEWS2) used to identify the physical signs and symptoms of a deteriorating patient and the pressure wound assessment tool (Waterlow scale).

Staff promoted a healthy diet and worked with the chef to ensure patients had access to healthy food. Staff recorded patients' dietary intake on food and fluid monitoring charts when needed so that they could encourage patients to eat a balanced healthy diet.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

All patient records we reviewed had a positive behaviour support plan in place.

## Skilled staff to deliver care

**The ward team did not include the full range of specialists required to meet the needs of patients on the ward.**

The service did not currently have access to a full range of specialists to meet the needs of the patients on the ward. There was no clinical psychologist or occupational therapist employed to work with the patients. This meant that patients did not have access to staff with the skills to develop their independence and prepare them for discharge or staff to provide therapy to address emotional difficulties.

Under the current staffing model there was only one qualified nurse on duty across the day. During the inspection there were other registered nurses within the hospital, the provider had not deployed them to provide nursing care to the patients. This meant that the nurse, on duty, had limited time to lead care and role model best practice across the hospital.

Managers gave each new member of staff a full induction to the service before they started work. Staff we spoke to told us that they had received an induction before starting to work on the ward and that it had prepared them for working at the hospital.

Managers supported staff through regular, constructive appraisals of their work. At the time of the inspection 66% of staff had received their annual appraisal and the other staff had their appraisal booked.

Medical staff were given time to attend peer support groups. Managers encouraged them to take the lead with their appraisals and to identify what development needs they had.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. The service had introduced regular team meetings and daily flash meetings to discuss patients' needs.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers recognised poor performance, could identify the reasons and dealt with these. There were no staff under performance monitoring procedures during the inspection, but we were given examples about how they had supported staff who were under performing.

## Multi-disciplinary and interagency teamwork

Staff held regular multidisciplinary meetings to discuss patients and improve their care. At the time of the inspection the number of different professional groups attending the meetings was limited due to vacancies across the MDT. We saw that these meetings happened regularly. Staff told us that their contribution to the meeting was valued.

The staff team liaised with external agencies such as commissioners to ensure discharge planning took place.



# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Staff reviewed each patient's risk level during hand over and recorded it on a board in the office so that staff could see the level of risk across the hospital.

## 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. We saw that staff were receiving Mental Health Act training on the first day of the inspection.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. There was a full time Mental Health Act administrator employed at the hospital.

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 staff referred patients who lacked capacity to the service automatically. We saw that there was information about advocacy displayed at the hospital.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

We reviewed patients access to escorted section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician or with the Ministry of Justice. We reviewed 5 patients access to leave between the 01 October 2022 until 19 October 2022 and saw that patients had not accessed their escorted leave regularly. For example, one patient had left the hospital twice in that time and one patient had not left the hospital at all. Staff told us that patients often choose not to access their leave but this was not recorded in the records.

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.

There was not a sign on the door advising informal patients that they could leave the ward freely. We asked the hospital to address this.

## Good practice in applying the Mental Capacity Act

**Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005.**

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.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

There were no Deprivation of Liberty Safeguards applications made in the last 12 months.

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.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. We saw evidence in 5 of the 7 records we reviewed that staff offered patients a choice around treatments and daily activities.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision. However, staff did not always record best interest decision when patients were assessed as not having capacity. For example, no best interest decision was recorded where patients lacked capacity to agree to treatment.

Governance process had not identified the issues with the recording of best interest decisions identified during the inspection.

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

Requires Improvement 

Our rating of caring improved. We rated it as requires improvement.

### 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.**

We saw that staff were engaging with patients more than on previous visits. Staff were discreet, respectful, and responsive when caring for patients. Staff we spoke with used appropriate language when discussing patients and we saw staff engaging well with the patients in the hospital.

Patients said staff treated them well and behaved kindly. Some patients told us that they did not get on with all staff but always felt safe in the hospital.

Staff understood and respected the individual needs of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff told us that managers visited the ward regularly and they could approach them.

Staff followed policy to keep patient information confidential.

### Involvement in care

**Staff did not always involve patients in planning their care.**

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

## Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. The staff team had developed a new patient induction booklet for new admissions. The introduction booklet covered all areas of admission and treatment at Uplands Independent Hospital.

Staff told us that they involved patients and gave them access to their care planning and risk assessments. However, patients often declined to be involved, staff did not always record this in the patient's record.

Patients were invited to their multi-disciplinary meetings and staff used these meeting to explain the treatment the patient was receiving and any changes that were needed. However, staff had not clearly documented this in the patient's record or how well the patient understood this and what was needed to help communicate this with the patient.

Patients could give feedback on the service and their treatment and staff supported them to do this. For example, the ward had a "you said we did" board to demonstrate any changes that were made following patient suggestions. We saw that patients had asked for hot food to be an option for the evening meal and that soup was now available.

Staff made sure patients could access advocacy services.

## Involvement of families and carers

**Staff informed and involved families and carers appropriately.**

Staff supported, informed and involved families or carers in the patients care. Staff made sure that families or carers were invited to multi-disciplinary meetings and other relevant meetings when appropriate. Staff made sure that families and carers could join meeting via video link if they could not attend face to face. We were told that this had increase the amount of involvement families and carers had with the patients' care.

At the time of the inspection the service did not actively seek feedback from families and carers but were planning to introduce this soon.

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

Good 

Our rating of responsive improved. We rated it as good.

## Access and discharge

**Staff had improved the discharge planning and managed patient discharge well.**

Managers reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of stay had reduced since our last inspection as they had now discharged some of the patient that had been at the hospital the longest. The current average length of stay was now 4 years. The provider did not record how they involved patients in the discharge process.

Managers and staff worked to make sure they did not discharge patients before they were ready.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

When patients went on leave there was always a bed available when they returned. During the inspection we saw that staff had arranged for patients to have extended leave so they could make sure it was suitable for the patient before they were discharged.

Staff did not move or discharge patients at night or very early in the morning. All discharges from the service were planned and took place at an appropriate time.

## Discharge and transfers of care

Managers now monitored the number of patients whose discharge was delayed. All patients now had a discharge plan in place so that the staff could identify if their discharge were delayed. However, staff had not recorded what support they offered patient around delayed discharges.

Patients did remain in the hospital once they were well enough to leave, while a suitable alternative placement was found.

Staff carefully planned patients' discharge and worked with care managers and coordinators to make sure this went well.

## Facilities that promote comfort, dignity, and privacy

**Each patient had their own bedroom with an en-suite bathroom. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time. When clinically appropriate, staff supported patients to self-cater.**

Each patient had their own bedroom, which they could personalise.

Patients could lock their bedrooms if they had a key or ask staff to lock the bedroom for them. Patients did not have a suitable secure place to store personal possessions. Since the last inspection, the provider had supplied each patient with a small cash box that they could lock to store valuables. However, this was only the size of a small wallet and it could not be fixed in place so it could be removed from the room easily.

Staff did not use the full range of rooms and equipment available to them to support treatment and care. Since the last inspection we were told that the hospital now had a female only lounge, gym and multi faith room. We were advised that none of these rooms were in regular use at the time of the inspection and when we visited them we saw that the female only lounge was small, only had seating for two and did not have a television. Senior managers told us that they were planning to offer pamper sessions in the room to encourage its use. When we visited the multi faith room we were told it was not being used currently as they had recently put filing in the room. When we viewed the room, it was clear it could not be used even when the filing was complete as it had not been decorated and there was damaged plaster on the walls. Senior managers agreed the room had not been made available to patients at the time of the inspection.

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

Patients could make phone calls in private.

The service had an outside space that patients could access easily. The hospital was set in large grounds and patients had continuous access to the back garden.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Patients could make their own hot drinks and snacks and were not dependent on staff.

The service offered a variety of good quality food. We spoke to the chef and they demonstrated that they could meet all dietary needs and worked flexibly to ensure patients received a suitable diet.

## Patients' engagement with the wider community

**Patient's who need escorted leave had limited opportunities to access the community, for work, education and family relationships.**

There was no occupational therapist in post to ensure patients leave was used to optimise their recovery and most recorded leave focussed on patients smoking.

Staff helped patients to stay in contact with families and carers.

## Meeting the needs of all people who use the service

**The service met the needs of all patients – including those with a protected characteristic.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

## 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 knew how to complain or raise concerns. However, some patients told us they did not have faith that complaints would be investigated correctly, and that staff would be believed over patients.

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 but the governance procedure did not currently identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

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

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

# Long stay or rehabilitation mental health wards for working age adults

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.**

Staff told us and we saw that the senior leadership team was visible on the ward and approachable for patients and staff. Patients clearly recognised the senior leadership team and told us they could speak to them if they needed to. Staff told us that the senior managers listened to and acted on their concerns.

A new hospital director had taken up post since the last inspection and there was a new clinical lead. However, they had only been in post for 5 weeks at the time of the inspection. The hospital director had previous experience in a similar role delivering similar services. The provider had arranged for the interim hospital director to remain at the hospital until the new year to support the new hospital director and offer consistency to the staff and patients.

## Vision and strategy

**The provider was developing a new service model, vision and values and how they were going to be applied to the work of their team.**

Since our last inspection the senior leaders were focussed on developing a care pathway for patients this included introducing a new model of care for the hospital. Wellness Recovery Action Plan (WRAP) had been identified as the approach the service would adopt. WRAP focusses on the principles that underpin recovery, how people recover from mental illness and the support they need during the different periods of their recovery. The service had begun training staff and patients in WRAP at the time of the inspection, but the model was not in place.

They had developed a clear inclusion and exclusion criteria to prevent admitting patients that were not suitable for the service.

The senior leadership team had identified key areas where the service needed to continue improving. This included continuing to improve the environment and the other areas included in an overall service improvement plan.

## Culture

**Staff felt respected, supported and valued and felt able raise any concerns without fear.**

The culture of the service was moving towards providing patient centred recovery focussed care. They had identified a new model and were using a co-production method to introduce the model, this involved training both staff and patients in how the model would work and affect the care provided at the hospital. However, it had not been introduced at the time of the inspection and some current aspects of care did not fully focus on patients developing the skills they needed to begin their recovery journey.

Staff told us that they now felt confident to raise concern about the service with the senior management team. Staff also felt they would be listened to if they did need to raise concerns.

## Governance

**The provider had introduced new governance process. However, at the time of the inspection these not fully embedded.**

The provider has introduced a new governance structure since the last inspection. Although this was a comprehensive structure the hospital had only used it their latest meeting so were not using it effectively at the time of the inspection.

# Long stay or rehabilitation mental health wards for working age adults

Requires Improvement 

Therefore, the senior leadership team did not have oversight of the quality and effectiveness of the care provided at the hospital. Senior leaders were also unable to identify themes and trends relating to incidents and complaints as they were not being analysed for the hospital governance meetings. There was no system being followed to review and improve the quality of patient records within the hospital. We saw that one risk assessment we reviewed had the wrong patient's name in and did not relate to the risks presented by that patient.

## Management of risk, issues and performance

Most of the care records we reviewed had identified current risks and gave staff the information they needed to provide care to the patients admitted to the hospital. Staff were reviewing the risk of each patient and recording this so that staff could see the individual and hospital wide risk level at a glance.

## Information management

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

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

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

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider must ensure that all environmental risks are identified, and appropriate plans are in place to safely manage the risk.

This is a breach of Regulation 12: Safe care and treatment, 2(d).

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider had not ensured that all care plans were recovery focused. This is a breach of Regulation 9: Person-centred care, 1.

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The provider had not ensured that the staffing ladder used to identify staff number focusses on patient need. This is a breach of Regulation 18: Staffing, 1.

#### Regulated activity

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care



This section is primarily information for the provider

## Requirement notices

The provider had not ensured that patients' views were incorporated within their care plans and that all patient records reflected the patients views and wishes. This is a breach of Regulation 9: Person-centred care, 1(c) and 3(b).

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider had not ensured that care plans focused on patients developing the skills need for discharge. This is a breach of Regulation 9: Person centered care, 1.

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider had not ensured that they were following their new governance process and had not fully embedded it to ensure oversight of the service. Regulation 17: Good governance,1.

### Regulated activity

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

Treatment of disease, disorder or injury

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider had not ensured that all patients have access to an appropriate nurse call system to call for help in the event of an emergency. This is a breach Regulation 12: Safe care and treatment, 2(d).

### Regulated activity

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

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

## Requirement notices

Treatment of disease, disorder or injury

The provider had not ensured that patients had access to escorted leave and when this is cancelled, they record the reason and identify when the leave can be taken.  
Regulation 18: Staffing, 1.